STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215194	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Forest Hill	109 Forest Valley Drive Forest Hill, MD 21050

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, and staff interview it was determined that the facility staff failed to ensure resident rooms were maintained in a homelike environment. This was evident for 5 of the resident rooms observed during the initial tour of the facility during this recertification survey. The findings include: Members of the survey team made observations of the environmental conditions of certain rooms while touring the facility on 12/17/25. room [ROOM NUMBER] had a hole in the wall at the end of the bed and a patched area, room [ROOM NUMBER] had scraping on the wall below the window on the left side of the bed, room [ROOM NUMBER] had peeling behind the bed, room [ROOM NUMBER] had a sink that appeared to be coming off of the wall and had a sign on the bathroom door that said, do not use with a date of 6/8/25, Resident #77 in room [ROOM NUMBER] told surveyor on 12/17/25 at 9:19 AM that the bathroom door does not lock for privacy, and room [ROOM NUMBER] had peeling paint on the walls. This surveyor toured the facility on 12/22/25 starting at 11:00 AM. room [ROOM NUMBER] was observed to have a hole in the wall and an area that was patched with spackling still visible. room [ROOM NUMBER] had a sign on the door that said, do not use bathroom. The sign was dated 6/8/25. This surveyor observed that room [ROOM NUMBER] had bathroom doors that did not lock. The bathroom is shared with another room. Resident #77 was interviewed on 12/22/25 at 12:17 PM. Resident #77 was asked how long the doors have not been able to be locked. The resident replied that it has been like this since the resident was admitted . Resident said when he/she backs the wheelchair into the bathroom it sometimes hits the door to the neighboring room, and it opens. This surveyor observed room [ROOM NUMBER] B and observed scratched up areas on the wall by the B bed resident's bed as well as some missing paint. Resident #120 was interviewed on 12/22/25 at 12:35 PM. This surveyor asked how long the scratches were on the wall and if he/she knew how they got there. The resident said the scratches were from the bed hitting the wall. This surveyor toured the facility with the Administrator and Maintenance Director (#21) on 12/22/25 at 1:00 PM. The Administrator and Staff #21 took notes and photos as appropriate. They offered potential solutions for the sinks and the assorted issues with the walls -- such as using a type of protective sheet that protects the wall while still being cleanable.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility staff failed to ensure a call bell was in reach of a resident. This was evident for 2 (#37 and #85) out of 43 residents reviewed as part of the survey sample. The findings include: A member of the survey team observed on 12/17/25 at 10:36 AM the call light cord on the floor on the left side of Resident #37's bed in room [ROOM NUMBER] during the initial tour of the facility. This surveyor toured several rooms noted by the survey team for further observation on 12/22/25. This surveyor observed at 11:13 AM a call light cord below the bed of Resident #85 (roommate of #37) in room [ROOM NUMBER]. Staff #6 was interviewed at 11:15 AM. She identified herself upon request and was informed of the call bell cord being below Resident #85's bed. She asked to be shown and upon observing it herself she said she would take care of it. She knocked on the door, entered the room, and retrieved the call bell cord.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview, record review, and observation, it was determined the facility failed to provide ADL care related to urine incontinence timely. This was evident for 1 of 1 resident (Resident # 6) reviewed for Activities of Daily Living during the recertification survey.The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, toileting, and mobility.On 12/17/2025 at 9:10 AM during an interview, Resident #6 expressed a concern regarding the timeliness of incontinence care. Resident #6 elaborated, When I get up and they put me in the wheelchair, I am raw on my skin from the urine; it hurts and burns my skin. They do not change me the way that they should. I get up in the morning and sometimes it may not be until 3 or 4 pm until I get changed again. On 12/18/2025 at 10:48 AM, a review of Resident #6's medical record showed that the last documented incontinence care, as recorded by the GNA in the TASK section (where the care provided is documented), was at 2:39 AM on 12/18/2025 in the bladder section.On 12/18/2025 at 10:49 AM, continued record review revealed a physician ordered on 10/06/2025 for Resident Toileting Schedule to offer and provide toileting/urinal upon arising, before meals, after meals at bedtime and as needed as tolerated.On 12/18/2025 at 11:35 AM, further review of Resident #6's medical record, specifically a Care Plan dated 10/06/2025, focused on bladder incontinence. Interventions, also dated 10/06/2025, included a Toileting Schedule to offer and provide a urinal or assist with toileting upon waking, before and after meals, at bedtime, and as needed. Additionally, frequent toileting/incontinence care was to be provided every shift, as tolerated. Further review of Resident #6's care plan dated 03/06/2025 revealed Resident #6 has a rash of the peri region related to incontinence.On 12/18/2025 at 11:40 AM, continued review of Resident #6's medical record revealed a skin and wound progress note dated 11/05/2025, that included a recommendation of Resident #6 related to incontinence of (stool/urine) and therefore measures to change Resident #6 should be changed when soiled to prevent breakdown.On 12/18/2025 at 9:51 AM, during a second interview, Resident #6 expressed concern that he/she had last received incontinence care between 5:00 and 6:00 AM and was not offered to be toileted upon awakening and/or prior to breakfast meal. On 12/18/2025 at 9:55 AM, interview with Geriatric Nursing Assistant (GNA) Staff # 4, shared Residents should be provided with incontinent care every 2 hours and as needed. Informed surveyor that GNA Staff # 5 was assigned to care for Resident #6 on this day. On 12/18/2025 at 10:07 AM an interview with GNA #5, confirmed that Resident #6 had not yet received incontinence care or been offered toileting. According to Staff #5, incontinence care should be provided every two to three hours. However, Staff #5 stated that care is not provided to Resident #6 until 11:00 AM, when the resident gets out of bed, claiming this is Resident #6's preference.On 12/18/2025 at 10:11 AM, interview with Resident #6, reported consistent leakage due to the diuretic Lasix, which causes frequent urination. He/She declined to wear an incontinence brief, stating he/she was raw down there. When the Surveyor inquired, he/she agreed to incontinence care and, upon being asked if he/she was wet, he/she responded, I think so. He/She explained the reluctance to request assistance, saying, I try not to bother them as they have a lot of people, and it takes a long time for them to come when you put the light on.On 12/18/2025 10:27 AM, approximately 5.5 to 6 hours after Resident #6's last reported incontinent care, an observation of incontinence care provided by Staff #5 to Resident #6, multiple absorbent materials were noted beneath an open brief (a folded towel, two under pads, and a folded blanket). Staff #5 provided care, and the surveyor observed that Resident #6 had irritated pink skin in the perineal area. Staff #5 confirmed that Resident #6 experienced frequent urination, and wetness was visible through the open brief and folded towel and blanket. After a new brief was applied, Resident #6 voided and voiced, oh gosh, it feels like fire, it hurts, and itches. The resident then added, This has been going on for a year, it just hurts so bad when I pee.On 12/18/2025 at 11:44 AM in an interview, the Director of Nursing (DON) explained the process of incontinence care, that it should be during GNA rounds. The DON (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued to explain that incontinence care should be administered frequently, with an expectation of every two hours. A toileting schedule should also be followed as stated in the Physician orders and plan of care for the residents. The DON shared the use of multiple absorbent items underneath a resident; this practice posed a risk for skin breakdown. The concern was shared at this time.On 12/18/2025 at 1:00 PM, during an observation/interview, Resident # 6, was observed sitting in a chair and eating lunch. Resident #6 reported that they had not received incontinence care and were not offered the use of a toilet prior to the meal.On 12/18/2025 at 1:25 PM, the Director of Nursing (DON) provided the surveyor with a paper document, signed by the DON on 12/18/2025, regarding Resident #6. The DON stated she was investigating the surveyor's concern but maintained that the issue was about preference, not timeliness, as Resident #6 preferred bathing and incontinence care at 11:00 AM.On 12/18/2025 at 2:12 PM, during an interview with the complainant for Resident #6 , he/she expressed a concern of excessively long wait times for incontinence care. On 12/18/2025 at approximately 12:15 PM, an observation was conducted of Staff #5 provided toileting assistance to Resident #6. This observation occurred nearly four hours after the surveyor's previous observation at 10:27 AM.On 12/18/2025 at 2:20 PM, during an interview, Resident #6 was shown the paper document, signed by the DON on 12/18/2025, concerning a daily incontinent care schedule at 11:00 AM. Resident #6 explicitly denied that this was their requested choice, stating that a 5-to-6-hour wait was unacceptable and would cause burning and hurt. Resident #6 clarified that this schedule was Staff #5's suggestion. The Speech Therapist (Staff #7) and Resident #6's complainant were present and verified that Resident #6 did not agree to the incontinence care preference detailed in the DON's document. On 12/18/2025 2:45 PM, DON made aware of the continued concern.

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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. Based on interview, observation, and record review it was determined that the facility failed to ensure an ordered consultation that necessitated an outside scheduled appointment was completed. This was evident for 1 of 28 residents (Resident #6) reviewed during the recertification/complaint survey.The findings include:On 12/17/2025 at 9:10 AM, an interview was conducted with Resident #6 who voiced concern of irritated skin with incontinent episodes. On 12/18/2025 at 10:27 AM, during an observation while GNA Staff #5 was providing incontinent care to Resident #6, the resident stated, They said I have a yeast infection, and it just won't go away. They keep using the same stuff. This has been going on for a year, and it hurts so bad when I pee.On 12/18/2025 at 10:46 AM, a review of Resident #6's medical record revealed a physician order dated 9/23/2025 for Gynecology (GYN) consultation related to continuous vaginal discomfort.On 12/18/2025 at 10:50 AM, in an interview, Resident #6 denied that he/she had been to a GYN doctor. On 12/18/2025 at 10:57 AM, in an interview with Licensed Practical Nurse (LPN) Staff #6, the process for consults was discussed. She stated the appointment would be scheduled, the facility would set up transportation, and family would be notified. On 12/18/2025 at 11:30 AM, continued review of Resident #6's medical record revealed a progress note dated 10/10/2025 at 10:25 AM, which indicated that Resident #6's continuous vaginal irritation was discussed at an Interdisciplinary meeting. The record revealed that a GYN consultation was scheduled for December, and the RN was attempting to expedite the appointment. On 12/18/2025 at 11:12 AM, during an interview with Registered Nurse (RN) Unit Manager, Staff #3, he/she confirmed that a GYN appointment for Resident #6 had been scheduled for either December 4th or 5th of 2025 but was subsequently canceled. Staff #3 stated that all appointment-related cancellations would be documented in the electronic medical record's progress notes; however, no documentation regarding the cancellation of the appointment was found.On 12/18/2025 at 12:58 PM, Staff #3 notified the Surveyor that an appointment had been rescheduled for Resident #6 in March. However, this was following surveyor intervention, and six months after the initial September GYN consult ordered by the Physician.On 12/18/2025, at 2:12 PM, an interview was conducted with Resident #6's complainant. The complainant confirmed that the GYN appointment process has been lengthy and stated they had not requested any cancellation. Resident #6's complainant speculated that the delay was related to transportation or an insurance issue.On 12/18/2025 at 3:04 PM in an Interview, Unit Receptionist, Staff #8 confirmed her process of appointment scheduling and transport arrangement as: receive a referral, schedule the appointment and transport, inform the family, and post it on the communication board. She vaguely recalled speaking with Resident #6's complainant, and confirmed the transport van allows two people to accompany the resident.On 12/18/2025 at 3:49 PM, during an interview with the Director of Nursing (DON) and Staff #3 they provided the surveyor with an Appointment request form for a December 4th, 8:30 AM appointment, including physician, address, and phone details. The form also noted if family or transport were contacted, however there was no further detail that this occurred. The DON stated she was unsure why the appointment was canceled. Staff #3 claimed that the Resident's spouse wanted to attend, but only one person could use the transport van, leading the facility to assume the spouse wanted the appointment canceled. At this time the DON was made aware of the concern.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview it was determined the facility failed to assist a resident with known difficulty swallowing (dysphagia) with feeding and failed to provide liquids during a meal. This was evident for 1 (Resident #37) of 4 residents reviewed for Nutrition during the recertification survey. The findings include:On 2/17/2025 upon initial tour at 8:40 AM, an observation was made of Resident #37 hollering out in bed, with a breakfast meal tray in front of them on the bedside table positioned over the bed and no staff was present. On 12/18/2025 at 8:07 AM, an observation was made of Resident #37 self-feeding with the head of the bed elevated and leaning to the right side, there was no staff present. The breakfast tray was missing the thickened milk (8 oz) and orange juice (4 oz) indicated on the meal ticket.On 12/18/2025 at 8:13 AM, review of Resident #37's medical record revealed a physician order dated 9/24/2025 that indicated 1:1 assist with meals.On 12/18/2025 at 8:14 AM, continued medical record review for Resident #37 revealed an 08/06/2020 ADL care plan noting an ADL self-care deficit due to weakness, with a 10/11/2024 intervention for 1:1 assist with meals. Further review showed a 06/08/2023 care plan, revised 10/01/2025, focused on dysphagia (difficulty swallowing), with an intervention to monitor for signs of difficulty swallowing, including choking, coughing, holding food in mouth, and multiple swallowing attempts. On 12/18/2025 8:19 AM a continued observation of Resident #37 was conducted, which revealed no staff present in the room. Resident #37 continued to lean to right side self-feeding with left hand, and their head leaning on the side rail. On 12/18/2025 at 8:21AM, during an interview with Registered Nurse (RN) Staff #3, he/she stated that any liquid items listed on a resident's meal ticket should be present on the resident's tray. Furthermore, for residents requiring 1:1 meal assistance as ordered, a staff member is expected to be present and aiding. Staff #3 confirmed that Resident #37 was eating unassisted and that milk and juice were missing from the residents' breakfast tray. At the time of the interview, Staff #3 was notified of this concern. On 12/18/2025 at 8:30 AM, in an interview, the Director of Nursing (DON) expressed her expectation that a staff member must be present to provide one-to-one (1:1) assistance for any resident requiring that level of support. The DON was informed of the concern at this time.

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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. Based on observation, record review, and staff interview, it was determined that the facility failed to label oxygen tubing and humidifier bottles with date of change to indicate maintenance of respiratory equipment for proper hygiene and safety. This was evident of 3 (Resident #1, #24, #66) of 4 residents observed for respiratory care during this recertification/complaint survey.The findings include:During the initial screening phase of the survey process on 12/17/2025 at 11:20 AM, the surveyor observed Resident #1 and Resident #24 receiving oxygen through an unlabeled (not dated) Nasal Cannula (N/C) tubing. Resident #1 did not have a dated label on the humidifier bottle. On 12/18/2025 at 9:37 AM the surveyor observed Resident #1 and Resident #66 sitting in their wheelchairs in the dayroom; both residents were receiving oxygen through unlabeled (not dated) nasal cannula tubing that was hooked to their oxygen tanks.A record review on 12/18/2025 at 10:02 AM noted the following:Resident#1 had an order: Oxygen at 2L/min via nasal cannula PRN for shortness of breathResident # 24 had an order: Oxygen at 2L/min via nasal cannula continuous for shortness of breathResident #66 had an order: Oxygen at 3L/min via nasal cannula continuous for COPDOn 12/19/2025 at 12:45 PM, an additional observation was made that Resident #24 was hooked up to an empty humidifier bottle and both Resident #24 and Resident #1 were hooked up to unlabeled (not dated) N/C tube.On 12/19/2025 at 12:50 PM, the surveyor requested that the unit manager (staff #16) verify that the Resident #24's humidifier bottle was empty, not labeled, and that the N/C tubing was not dated for Resident #24 and Resident #1. Staff #16 verified the concerns and requested that staff change the humidifier bottle and N/C tubing immediately. Staff #16 also stated that all N/C tubing and humidifier bottles should be labeled with a date at the time of a change. During an interview on 12/19/2025 at approximately 1:20 PM with Staff #14, the surveyor asked about the protocol for oxygen administration. Staff #14 stated that oxygen is administered when there is an order. The oxygen tubing and/or the N/C tubing are labeled with the date when they are placed on the resident and are changed every 7 days, and as needed; the humidifier bottles are dated when they are replaced. Staff #14 also verified that there was no date on the N/C tubing for Resident # 66.On 12/19/2025 at 2:27 PM, the DON was made aware of the concern that the oxygen tubing and humidifier bottles were not labeled with a date for the identified residents. The DON acknowledged the concern.

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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. Based on record review and staff interviews, it was determined that the facility failed to act upon a pharmacy identified irregularities. This was evident for 1 (Resident #38) of 5 residents reviewed for unnecessary medications during the recertification survey.The findings includeOn 12/18/25 @10:05 AM review of the pharmacy's monthly medication review from February to November 2025 revealed recommendations for February, August, October and November. Further review revealed that the pharmacist recommended in February 2025 to add, Rinse mouth out after use of this medication to the order written as Fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 MCG/ACT, This pharmacy recommendation was reviewed, signed and approved by the attending physician.Further review of the medication administration record (MAR) from February to November 2025 on 12/18/25 at 1:40 PM indicated that this recommendation was not carried out as ordered.In an interview with the Director of Nursing (DON) on 12/19/2025 at 9:19 AM, she was asked about the process for reconciling pharmacy recommendations. She stated that once the pharmacists were done with the medication reviews, they email them to her to let her know that the reviews are ready for the physician's review and approval. She stated that once reviewed by the physicians the orders are given to the unit managers to enter in the electronic records. The DON was made aware of the pharmacy's recommendation that was not acted upon. She was unable to explain how this happened and was made aware that this was a concern. She acknowledged the concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and interview with staff, it was determined that the facility staff failed to properly store drugs and biologicals by not removing expired medications and supplies from the house stock medication cabinet. This was evident for 2 out of 3 stock medication cabinets observed during the recertification survey.The findings include:While conducting the medication storage and labeling facility task on 12/19/2025 at 09:10 AM, the surveyor observed the following expired medications in the house stock medication cabinet located on the 100 Hall: 16 FL OZ Liquid pain relief Acetaminophen 160 mg/5 ml exp date of 9/2025 12 FL OZ Geri Lanta Ant Acid regular strength exp 11/2025 Zinc 50 mg 100 tablets exp 11/2025 Docusate sodium liquid 50 mg/5 ml exp 7/2025 Aspirin 325 mg tabs, 100 tabs exp 8/2025 Gloke Gypopen Glucagon injection 1 mg per 0.2 ml exp 2024 [NAME] clearlink system continuous flo solution set 10 drpos/ml exp 3/15/2025The house stock medication drawer on 200 Hall: Zinc 50 mg 100 tablets exp 8/2025 on 200 hall An interview was conducted with Staff #10 on 12/19/2025 09: 25 AM who stated that the floor stock medications are done by the central supply technician and that staff were probably retrieving the cart replacement medications from the front and not the back of the cabinet. Staff #10 also stated that the nursing staff need to be educated on the rotation of stock. Staff #10 placed the expired medications in a container and informed the unit manager, who shook his/her head.An additional interview was conducted with the central supply Technician (Staff #15), Who stated that she/he supplied the unit with the over-the-counter house stock medications. He/she stated, I supply the units when they are low on meds, and I check the expiration dates. When surveyor asked if there was a log when items would expire, Staff #15 stated, no. The surveyor informed Staff #15 about the expired medications found on the units, and that it was a concern. Staff #15 stated that she/he would check the central supply area for any additional expired medications. On 12/22/2025 at approximately 11:00 AM, the surveyor informed the DON about the expired medications and voiced that this was a concern for medication storage. The DON acknowledged that concern and stated that she was also made aware of the concern by the staff.

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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. Based on a review of medical records and interviews with facility staff, it was determined that the facility failed to ensure that the provider accurately documented residents' current medications. This was evident for one resident (Resident #14) of the one resident reviewed for pain management during this recertification survey.The findings include:During an interview with Resident #14 on 12/17/25 at 11:40 AM, the resident reported that he/she was taking scheduled pain medication every six hours, which was not helping to reduce the pain.A review of Resident #14's medical records on 12/22/25 at 9:19 AM revealed that the resident was prescribed Hydromorphone 2mg every six hours for pain, starting in July 2025. However, the facility's attending Nurse Practitioner (Staff #12) consistently documented in progress notes for Resident #14: pain management: currently managed on Morphine Sulfate oral tablet 15mg, 1 tablet by mouth every 4 hours for pain since 4/21/25.Further review of Resident #14's medical records on 12/22/25 at approximately 10:00 AM revealed that the Morphine Sulfate order was discontinued on 6/11/25, and the Hydromorphone 2mg every 6 hours order was started on 7/01/25.During an interview with the Director of Nursing (DON) on 12/22/25 at 10:41 AM, she stated that attending providers document their assessment each time they assess a resident. She also explained that if a resident's orders changed, the progress notes should reflect those changes. The surveyor reviewed Resident #14's progress notes with the DON, who validated that there were discrepancies between the resident's current orders and Staff #12's progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215194	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Forest Hill	109 Forest Valley Drive Forest Hill, MD 21050

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on a review of medical records, facility records, and staff interviews, it was determined that the facility failed to monitor and track antibiotic usage effectively. Specifically, an antibiotic was prescribed to a resident without clinical evidence of infection, and the facility's Antibiotic Stewardship Program failed to document all prescribed antibiotics. This was evident in one (Resident #3) out of four residents reviewed for antibiotic use and stewardship during the recertification survey.The findings include:On 12/19/25 at 11:58 AM, a review of Resident #3's medical records revealed an order for Ceftriaxone 2g intravenously twice daily for a wound infection, scheduled for seven days starting 11/29/25. However, the medical record lacked detailed information, such as provider progress notes or laboratory results, to support the diagnosis of a wound infection.During an interview on 12/19/25 at 12:49 PM, the Director of Nursing (DON) explained the facility's antibiotic prescribing process: when a resident requires an antibiotic, the wound must be assessed, and the provider must document the specific signs and symptoms before issuing an order. The surveyor requested supporting documentation for the Ceftriaxone order for Resident #3 initiated on 11/29/25.At 1:46 PM on 12/19/25, the DON provided two wound culture reports for Resident #3 (sacral tissue). Both reports were for a specimen collected on 11/14/25.The first report (11/18/25) showed growth of several organisms but noted no further workup.The second report (11/21/25) explicitly stated, no anaerobic organism isolated and normal enteric flora, again noting no further workup.On 12/19/25 at 2:06 PM, the surveyor reviewed these reports with the Infection Preventionist (Staff #9). Staff #9 validated that the most recent report confirmed no active infection was present. Staff #9 also validated that there was no documentation from the provider regarding the wound status and no clinical evidence to justify the antibiotic treatment.Additionally, at 1:50 PM on 12/19/25, the surveyor noted that Resident #3's Ceftriaxone order was missing from the facility's Antibiotic Stewardship Line Listing. In an earlier interview at 8:29 AM, Staff #9 had stated that all antibiotics are reviewed weekly for criteria, risk/benefit, sign and symptoms, and duration, and that every antibiotic must be included on this list. Staff #9 subsequently validated that Resident #3's antibiotic was omitted from the stewardship tracking.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record reviews and staff interviews, it was determined the facility failed to ensure that influenza immunizations were consistently offered or administered during the active flu season. This was evidence one (Resident #124) out of a five-resident sample reviewed during the recertification survey.The Findings include:A review of medical records on 12/19/25 at 9:14 AM revealed that Resident #124, who was admitted in September 2025, lacked documentation of influenza vaccination. The electronic medical record (EMR) listed the resident's status as pending consent.During an interview on 12/19/25 at 10:41 AM, the Infection Preventionist (Staff #9) stated that all residents and staff are offered the vaccine during flu season and that the EMR should be updated to reflect vaccination or refusal.At 1:49 PM on 12/19/25, Staff #9 provided a consent form signed by the resident's family on 9/12/25. She confirmed that although the resident had been scheduled for vaccination on 12/06/25, the dose was not administered. Staff #9 acknowledged the oversight and stated that the vaccine would be administered that day, noting that the scheduling occurred only after the surveyor's intervention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215194	A. Building B. Wing	12/22/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that residents' COVID-19 vaccine statuses were monitored and maintained in a timely manner. This finding was evident for one (Resident #129) of five residents whose immunization records were reviewed during this recertification survey.The findings include:A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease.On 12/19/25 at 9:14 AM, the surveyor reviewed five randomly selected residents' vaccination records. The review revealed that Resident #129 was admitted in October 2025; however, the resident's immunization status for COVID-19 was documented only as pending consent.During an interview with the Infection Preventionist (Staff #9) on 12/19/25 at 10:41 AM, she stated that facility staff review residents' vaccination status upon admission and offer vaccines to those who are eligible. The surveyor reviewed Resident #129's Immunization Session tab in the electronic medical record with Staff #9. The review confirmed that the COVID-19 vaccination status remained documented as pending consent for more than 50 days following the resident's admission.On 12/19/25 at 1:49 PM, Staff #9 stated that the facility had contacted Resident #129's family and obtained consent for the COVID-19 vaccine. She stated, I am waiting for the provider to write the order and for the pharmacy to deliver the vaccine. Staff #9 clarified that the facility followed up on Resident #129's vaccination status after the surveyor's intervention. Prior to the surveyor's inquiry, the updated status was not documented in the medical record. The surveyor shared this concern, and Staff #9 validated the finding.