STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215312	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Bel Air	410 East McPhail Road Bel Air, MD 21014

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint, medical record review, and interview, it was determined the facility violated the rights of a resident's representative (RP) by failing to follow the RP's wishes in where to send their loved one following their death in the facility. This was evident for 1 (#2) of 3 residents reviewed for death during a complaint survey.The findings include:On [DATE] at 10:00 AM a review of complaint 302938 was conducted. The complainant alleged that Resident #2 passed away in the evening on [DATE] and the nurse called the wrong place for Resident #2's body to be transferred. The complaint alleged that Resident #2 was to be transferred to the Anatomy Gifts Registry, however the facility called the State of Maryland Anatomy Board to pick up the resident.Review of Resident #2's medical record revealed on [DATE] Resident #2 signed that the healthcare agent's power to make decisions for the resident was effective immediately after the resident signed the form. Further review of the medical record revealed the resident had dementia and was receiving Hospice services.Review of Resident #2's medical record revealed a [DATE] Social Services (SS) note that documented SS spoke with Resident #2's daughters to inquire about end-of-life arrangements for the resident. The note documented that the resident's body was to be donated to Anatomy Gifts Registry.A [DATE] at 19:30 (7:30 PM) nursing note documented that Resident #2 was noted with no palpable pulse, no respirations and was pronounced deceased at 19:15. Hospice and the family along with the Nurse Practitioner were notified.A [DATE] at 2:48 AM nursing note documented, body released to Maryland State Anatomy Board at 0220 as noted in social worker progress note.Review of the miscellaneous section of Resident #2's medical record revealed a document dated [DATE] that stated, the donor is officially registered with our program. The note continued that after the passing occurred their office was to be called, and they would arrange transportation. The note was from the Anatomy Gift Board.Continue review of the miscellaneous section of Resident #2's medical record revealed a form dated [DATE], that was signed by Resident #2 that stated the resident was donating his/her body to the Maryland State Anatomy Board and in the event the resident died, the anatomy board was to be called immediately.On [DATE] at 3:10 PM the Director of Nursing (DON) was interviewed and stated the family wanted Resident #2's body to be donated to the Anatomy Gift Registry and prior to that the resident had already set up something with the state anatomy board. The DON stated that they called the gift registry first and they didn't come to pick the resident up and they deferred to the anatomy board.On [DATE] at 3:20 PM an interview was conducted with Staff #35, the RN supervisor who stated that she looks at the resident's face sheet as to who to call when the resident passes. The face sheet has demographic information.On [DATE] at 8:23 AM a call was placed to the Anatomy Gifts Registry. The staff member from the gift registry stated it was within the residents' rights to sign up for both boards. The staff member pulled up the information in her system and stated the facility never called the Anatomy Gift Registry, and they did not know the resident passed away until the RP called and was looking for the body. The staff at the Anatomy Gift Registry called and confirmed the body was sent to the Maryland State Anatomy Board. By the time the family called the anatomy board it was too late as the body was already injected with fluid. The staff member stated that the family was upset because the state board would have the body for 2 years and the gift registry would only have the body 4 to 6 weeks. The family wanted to [NAME] the ashes with the spouse.On [DATE] at 8:48 AM the Director of Social Work (DSW) was interviewed and stated, the family wishes were for the resident's body to be donated to the gift registry. The DSW stated that she was aware that the resident was registered with the state anatomy board and the family was aware too, but they wanted the resident to go to the gift registry. When asked who was responsible to put on the face sheet where the body was to go once the resident passed, the DSW stated, I guess I am.On [DATE] at 9:13 AM a second interview was conducted with the DON. Resident #2's face sheet was reviewed with her, and she confirmed the external facility (where the body was to go once deceased) was blank. The DON stated, it is not a solid system as to who puts the information on the face sheet. It is evolving.On [DATE] at 9:14 AM Staff #29 was interviewed and stated, I called the anatomy board. I was told later it should have been the gift registry. Staff #29 stated the information was usually on the face sheet as who to call but she got the information out of the resident's chart. She stated, I do not know whose responsibility it is to put it on the face sheet. Staff #29 stated it was an honest mistake as she didn't know there were 2 different anatomy boards.On [DATE] at 9:15 AM an interview was conducted with the complainant who was also the RP. The complainant stated, they had all the paperwork in the file to go to

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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. Based on complaint, medical record review, and staff interview, it was determined the facility staff failed to timely notify a resident's physician/nurse practitioner of a change in condition. This was evident for 1 (#6) of 9 residents reviewed for complaints during a complaint survey. The findings include: On 8/18/25 at 11:10 AM a review of complaint 302921 alleged unacceptable and negligent care provided to Resident #6 while under the care of the facility. Review of Resident #6's medical record revealed Resident #6 was admitted to the facility in December 2024 from an acute care facility with diagnoses including but not limited to generalized weakness, peripheral artery disease, COPD, slurred speech, history of falls, and hypertension. Review of a 1/10/25 at 8:58 AM eMar - Medication Administration Note documented, amlodipine Besylate tablet 10 mg. give 1 tablet by mouth one time a day for HTN (hypertension). Med not given due to low b/p (blood pressure). On 8/20/25 at 1:45 PM an interview was conducted with Nurse Practitioner #19 (NP). NP #19 stated that she did not see Resident #6 that morning and that she was not notified of the low blood pressure. There were no parameters as to when the nurse should have held the medication, so she would have expected to be notified. I was in the building that morning and I was not notified. I could have seen the resident and started [him/her] on IV fluids or Midodrine. They informed me at lunch that the resident's condition changed, but they did not notify me about the low blood pressure and holding the medication. Normally I would tell all the managers that if I am at the building call me and let me know. They did not tell me until [he/she] was not arousable. I was concerned because [he/she] was a stable patient. I was concerned that [he/she] went down that quickly. I feel I could have stabilized [him/her] and [his/her] b/p. On 8/21/25 at 10:55 AM the concern was reviewed with the Director of Nursing (DON). The DON agreed that the NP should have been notified about the low blood pressure and holding the medication.

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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. Based on observation and interviews, it was determined the facility staff failed to provide maintenance services necessary to maintain resident wheelchairs. This was evident for 15 (#25, #26, #27, #14, #12, #28, #29, #30, #19, #20, #13, #16, #33, #34, #8) of 37 residents reviewed during a complaint survey. The findings include:The following maintenance concerns were observed during the initial rounds of the facility on 8/18/25 at 7:30 AM and throughout the survey until 8/21/25.Resident #25: There was no armrest on the left side of the wheelchair and the vinyl on the right side was cracked throughout.Resident #26: The vinyl on the left wheelchair armrest was torn approximately an inch from the top of the armrest exposing yellow foam. This could be seen from the hallway.Resident #27: There was no wheelchair armrest on the right or left side of the wheelchair. Resident #27 was noted with several bruises to the resident's arms.Resident #14: There was no armrest on the left side of the wheelchair.Resident #12: The vinyl was cracked along the edge of the left wheelchair armrest, and the yellow foam padding was exposed.Resident #28: The vinyl was cracked on the left wheelchair armrest.Resident #29: There was no padding on the left wheelchair armrest as the vinyl was pulled back and there was nothing underneath.Resident #30: There was no left or right wheelchair armrest on the wheelchair.Resident #19: The vinyl was cracked on the left and right wheelchair armrests.Resident #20: There was no wheelchair armrest on the right side of the wheelchair.Resident #13: The vinyl on the right wheelchair armrest was torn along the edges.Resident #16: The vinyl on the right and left wheelchair armrests was torn along both edges.Resident #33: There was a piece of vinyl approximately 1 inch that was missing from the left wheelchair armrest exposing the underneath foam padding.Resident #34: There was no left or right wheelchair armrest.Resident #8: The vinyl on the entire left wheelchair armrest was ripped and frayed.On 8/21/25 at 10:40 AM an interview was conducted with the Director of Maintenance, Staff #31. Staff #31 stated that most of the repair orders came through the electronic system, TELS. Staff #31 stated that all staff, including the geriatric nursing assistants (GNAs) had access to put work orders in when they saw that repairs were needed. Staff #31 stated that a lot of times staff would just tell him about the issue, and he would fix it when told about it. Staff #31 stated that they do maintenance on the wheelchairs once a month that includes armrests and brakes. Staff #31 stated it was his expectation that staff would notify him of the issues with the wheelchairs. At that time Staff #31 and the Director of Nursing were informed of the condition of the wheelchair armrests. Staff #31stated, we have extra wheelchairs, and they (staff) can swap out the wheelchairs and can put a notification in TELS.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on medical record review, review of facility documentation and interview, it was determined the facility staff failed to prevent abuse of a resident resulting in psychosocial harm to the resident (Resident #5). This was evident for 1 of 3 residents reviewed for abuse during a complaint survey. The findings include: The findings include: A review was conducted on Facility Reported Incident 302934 on 8/18/25 related to Resident #5's allegation of sexual abuse by Staff #11 on 1/25/25. Resident #5 alleged on 1/29/25 to Staff #12 that Staff #11 kissed the Resident on the lips and attempted to kiss the Resident's private area during care on 1/25/25. Review of Resident #5's medical record on 8/18/25 revealed the Resident was admitted to the facility in July 2024 with a diagnosis to include cerebral infarction (stroke). The facility staff conducted an MDS (Minimum Data Set) assessment on 8/6/25 and coded the Resident as dependent on facility staff for toileting. During interview with Resident #5 on 8/18/25 at 11:05 AM, the Resident was asked if he/she was okay telling the Surveyor what happened on 1/25/25, the Resident stated he/she was but began crying while giving his/her statement. The Resident stated on 1/25/25 Staff #11 kissed him/her on the lips and then attempted to kiss his/her private area. Resident #5 stated he/she told Staff #11 F*** No. The Resident then stated Staff #11 put the Resident in a wheelchair and took the Resident to the bathroom where Staff #11 took the Resident's hand and put it on Staff #11's penis on top of Staff #11's clothes. Resident #5 stated he/she has to go to court in September 2025 for the incident and Staff #11 is currently in jail and has a history of the same thing. The Resident stated he/she has been interviewed by the States Attorney over the phone. The Surveyor reviewed Maryland Judiciary Case Search on 8/18/25 which revealed Staff #11 was found guilty from a 5/31/19 case of 2nd degree assault and 4th degree sexual assault. Further review of Maryland Judiciary Case Search revealed on 3/18/25 Staff #11 was charged with abuse of vulnerable adult, 2nd degree rape and 4th degree sexual offense for an offense date of 1/25/25 and a hearing is scheduled for September 2025. During interview with Resident #5 on 8/19/25 at 7:28 AM, the Resident was asked if he/she could review the incident again with the Surveyor, the Resident stated no he/she can't because he/she had nightmares last night regarding the incident. The Surveyor asked the Resident if he/she is seeing a counselor, the Resident stated he/she did after the event, but that Counselor (Staff #23) has left and has not even met the new Counselor (Staff #27). The Resident states he/she is stressed about going to court, he/she doesn't want to mess up because he/she wants to make sure he (Staff #11) is not able to do this to someone else. The Resident stated after the incident he/she feels like he/she has become more withdrawn. During interview with the DON on 8/19/25 8:08 AM, the DON stated the Counselor (Staff #23) left in May 2025 and a new counselor (Staff #27) started in June 2025. The Surveyor asked for a list of residents receiving counseling services. Review of the list revealed Resident #5 wasn't on the list. The last documented visit by a Counselor was on 2/10/25. The Resident was seen by the Psychiatrist on 1/29/25, 2/22/25 and 5/19/25. Further review of Resident #5's medical record revealed the Resident had diagnoses to include anxiety and depression. After admission the Resident was seen by the Counselor (Staff #23) on 8/5/24 and 10/14/24. After the allegation of sexual abuse was made on 1/29/25 by Resident #5, the Resident was seen by the Counselor on 1/29/25, 2/3/25 and 2/10/25. Review of the Counselor's note on 1/29/25 revealed it stated: I was asked to see the patient to provide support as he/she had accused a male aide of sexually inappropriate behaviors. Patient reports feeling very anxious related to the situation. Mood testing reflects symptoms exacerbated by this situation as well as his/her general sadness about being in this setting. Review of the Counselor's note on 2/10/25 revealed it stated: I feel alright now, I just have to decide what I am going to do. He/she reports he/she is not anxious about the incident and feels safe. The Counselor documented will follow up with 1:1 therapeutic visits. During interview with the Psychiatrist on 8/19/25 at 9:02 AM, the Psychiatrist was asked why he changed the Resident's medications on 5/19/25 and he stated the Resident has a history of chronic anxiety and depression, he was aware of the Resident's allegation but can't say the medication change was related to the incident or the Resident's chronic anxiety and depression. The Psychiatrist stated he did tell the facility the Resident should not have male care givers. The psychiatrist was asked if he was aware the Resident has not been seen by a Counselor since 2/10/25, the Psychiatrist stated no that is a third party and not sure how that works but the Resident should be followed by a counselor regularly. Review of Resident #5's medical record on 8/19/25 revealed the Resident was seen by the Primary Care Physician on 3/7/25, 4/4/25, 5/27/25, 6/17/25 and 7/26/25 who documented under Assessment and Plan for Anxiety: We are continuing to provide the patient with emotional support. We will also have psych

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F 0606 Level of Harm - Actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on medical record review, review of facility documentation and interview it was determined the facility failed to ensure a criminal background check was completed on an agency GNA (geriatric nursing assistant) which allowed a GNA (Staff #11) with a criminal background of assault and sexual assault to care for vulnerable residents. This was evident for 1 of 4 agency GNAs reviewed for criminal background checks during a complaint survey. Resident #5 alleged Staff #11 sexually abused him/her on 1/25/25. This resulted in psychosocial harm to Resident #5. The findings include:A review was conducted on Facility Reported Incident 302934 on 8/18/25 related to Resident #5's allegation of sexual abuse by Staff #11 on 1/25/25. Resident #5 alleged on 1/29/25, to Staff #12, that Staff #11 kissed the Resident on the lips and attempted to kiss the Resident's private area during care on 1/25/25.Review of Resident #5's medical record on 8/18/25 revealed the Resident was admitted to the facility in July 2024 with a diagnosis to include cerebral infarction (stroke). The facility staff conducted a MDS (Minimum Data Set) assessment on 8/6/25 and coded the Resident as dependent on facility staff for toileting. During interview with Resident #5 on 8/18/25 at 11:05 AM, the Resident was asked if he/she was okay telling the Surveyor what happened on 1/25/25, the Resident stated he/she was but began crying while giving his/her statement. The Resident stated on 1/25/25 Staff #11 kissed him/her on the lips and then attempted to kiss his/her private area. Resident #5 stated he/she told Staff #11 F*** No. The Resident then stated Staff #11 put the Resident in a wheelchair and took the Resident to the bathroom where Staff #11 took the Resident's hand and put it on Staff #11's penis on top of Staff #11's clothes. Resident #5 stated he/she has to go to court in September 2025 for the incident and Staff #11 is currently in jail and has a history of the same thing. The Resident stated he/she has been interviewed by the States Attorney over the phone. Review of Staff #11's employee file on 8/18/25 provided by the Director of Nursing revealed a criminal background check that was conducted 1/12/24 and it was incomplete. The criminal background check did not indicate if Staff #11 had a criminal background or not. During an interview with Human Resources (HR) on 8/18/25 at 1:41 PM, HR stated the agency provides the agency staff's criminal background checks. HR stated she reviews all criminal background checks the agency provides prior to the agency staff working at the facility. HR stated she missed that Staff #11's was incomplete.The Surveyor reviewed Maryland Judiciary Case Search on 8/18/25 which revealed Staff #11 was found guilty from a 5/31/19 case of 2nd degree assault and 4th degree sexual assault. Further review of Maryland Judiciary Case Search revealed on 3/18/25 Staff #11 was charged with abuse of vulnerable adult, 2nd degree rape and 4th degree sexual offense for an offense date of 1/25/25 and a hearing is scheduled for September 2025. During interview with Resident #5 on 8/19/25 at 7:28 AM, the Resident was asked if he/she could review the incident again with the Surveyor, the Resident stated no he/she can't because he/she had nightmares last night regarding the incident. The Surveyor asked the Resident if he/she is seeing a counselor, the Resident stated he/she did after the event, but that Counselor has left and has not even met the new counselor. The Resident states he/she is stressed about going to court, he/she doesn't want to mess up because he/she wants to make sure he (Staff #11) is not able to do this to someone else. The Resident stated after the incident he/she feels like he/she has become more withdrawn. During interview with HR on 8/19/25 at 7:45 AM, HR stated Staff #11 began working at the facility on 1/26/24. HR stated the facility stopped using agency staff on 7/6/25.Interview with the Director of Nursing (DON) on 8/19/25 at 8:37 AM confirmed the facility failed to have a complete background check on Staff #11 that included Staff #11's criminal record. The DON confirmed Resident #5 made an allegation of sexual abuse by Staff #11 on 1/25/25 and the Resident has no other allegations of sexual abuse by staff since admission in July 2024.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interview, it was determined that the facility staff failed to meet professional standards of practice as evidenced by licensed nursing staff documenting assessments, administration of medications, and treatments were completed when the resident was not in the facility (Resident #7 and #9). This was evident for 2 of 9 residents reviewed during a complaint survey. The findings include: According to the American Nurses Association Standards for documentation emphasize that records should be clear, accurate and accessible is essential element of safe, quality, evidence-based nursing practice. Accurate entries must be factual and reflect the patient's status and care without errors.A violation of the American Nurses Association standards for documentation includes inaccuracies and falsification. 1. The facility staff documented completed assessments and medication administration of Resident #7 when the Resident was not in the facility. Review of Resident #7's medical record on 8/18/25 revealed the Resident was admitted to the facility in April 2025 for rehabilitation following a hospitalization with a diagnosis to include muscle weakness. Review of Resident #7's medical record revealed a Change in Condition Assessment on 5/10/25 at 3:35 AM that stated During rounds around 2 AM patient was found in the bathroom on the floor lying on his/her right side. Patient was assisted back to bed with the help of the nursing supervisor, nursing aide and another nurse on duty. Patient vitals was assessed blood pressure 135/76, temperature 97.2, oxygen saturation 98 %, respirations 18, heart rate 89. Neuro checks was assessed and range of motion was performed, patient was noted with weakness to the right hand and was unable to talk, patient was also noted with the mouth switch to the side. On call APN (Advanced Practice Nurse) was made aware and order given to transfer to ER. After the fall, Resident #7 was transferred to the emergency room on 5/10/25 at an unknown time and the Resident did not return to the facility. Further review of Resident #7's medical record revealed on 5/11/25 the following assessments were completed by Staff #13 even though the Resident had been discharged from the facility: Change in Condition Follow up, Neurological Check List, Pain Assessment, and Nursing Skilled Charting. Review of Resident #7's May 2025 Medication Administration Record revealed on 5/11/25 Staff #13 documented he administered the following medications on 5/11/25 to the Resident even though the Resident had been discharged from the facility: Albuterol Inhaler 12 AM and 4 AM, Levothyroxine 175 mcq at 6 AM, Calcium Carbonate 500 mg at 6 AM and Sevelamer Carbonate at 6 AM. Interview with the Director of Nursing on 8/19/25 at 2:45 PM confirmed Staff #13 inaccurately documented nursing assessments and administration of medications to Resident #7 on 5/11/25. 2.The facility staff documented medication and treatment administration for Resident #9 even though the Resident was not in the facility. Review of Resident #9's medical record on 8/19/25 revealed the Resident was admitted to the facility in October 2024.Further review of Resident #9's medical record revealed a nurse's note on 2/11/25 at 3:06 PM that stated the Resident was transferred to the hospital. The Resident did not return to the facility. Review of Resident #9's February 2025 Medication Administration Record revealed Staff #18 documented she administered Aspirin 81 mg, Clopidogrel Bisulfate 75 mg, Metoprolol 100 mg, Prednisone 5 mg, Cyclosporine 5 ml, Levetiracetam 5 ml, flushed the Resident's tube feeding with 200 ml water on 2/12/25 when the Resident was not in the facility. Review of Resident #9's February 2025 Treatment Administration Record revealed Staff #18 documented they cleansed the Resident's gastric tube site, did a left buttock wound treatment, did a sacrum wound treatment, applied betadine to the Resident's right great toe, applied skin prep to the Resident's heels, elevated the Resident's heels and provided catheter cleaning on 2/12/25 when the Resident was not in the facility. Interview with the Director of Nursing on 8/21/25 at 11:54 AM confirmed Staff #18 inaccurately documented administration of medications and treatments to Resident #9 on 2/12/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health (Resident #7, #8, #4, #6). This was evident for 4 of 9 complaint residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to properly perform, and document neuro checks after a fall for Resident #7. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #7’s medical record on 8/18/25 revealed the Resident was admitted to the facility in April 2025 for rehabilitation following a hospitalization with a diagnosis to include muscle weakness. Review of Resident #7’s medical record revealed a Change in Condition Assessment on 5/10/25 at 3:35 AM that stated “During rounds around 2 AM patient was found in the bathroom on the floor lying on his/her right side. Patient was assisted back to bed with the help of the nursing supervisor, nursing aide and another nurse on duty. Patient vitals were assessed blood pressure 135/76, temperature 97.2, oxygen saturation 98 %, respirations 18, heart rate 89. Neuro checks was assessed and range of motion was performed, patient was noted with weakness to the right hand and was unable to talk, patient was also noted with the mouth switch to the side. On call APN (Advanced Practice Nurse) was made aware and order given to transfer to ER. Further review of the Resident’s medical record revealed an APN note on 5/10/25 at 2:28 AM stating “Patient found on floor unresponsive. Patient seen he/she is not responding to his/her name or any directions. Transfer to Emergency Department”. The only neuro check documented after the fall for Resident #7 was on 5/10/25 at 3:24 AM with vitals signs from 5/10/25 at 3:24 AM. No other neuro checks documented. After the fall, Resident #7 was transferred to the emergency room on 5/10/25 at an unknown time and the Resident did not return to the facility. During interview with the Director of Nursing (DON) on 8/19/25 at 2:45 PM, the DON stated the expectation is neuro checks are to be done every 15 minutes for the first hour after a fall. The DON confirmed the neuro checks for Resident #7 are inaccurately documented since the Resident fell on 5/10/25 at approximately 2 AM and there is only one neuro check documented at 3:24 AM. 2a. The facility staff failed to properly perform, and document neuro checks after a fall for Resident #8. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8’s medical record on 8/18/25 revealed the Resident was admitted to the facility in April 2023 with a diagnosis to include weakness. Further review of Resident #8’s medical record revealed a nurse’s note on 3/28/25 at 8:57 PM that stated: around 7 PM writer was passing medication and found resident sitting on the floor beside his/her wheelchair. Further review of Resident #8’s medical record revealed an APN note on 3/28/25 that stated the Resident was seen 3/28/25 at 7:02 PM for fall with injury and to transfer to Emergency Department. Review of Resident #8’s neuro checks after the fall on 3/28/25 revealed neuro checks were completed for 3/28/25 at 8:00 PM with vital signs from 3/29/25 at 6:00 AM. The next neuro checks are documented for 3/29/25 at 12:02 AM with vital signs from 3/28/25 at 9:00 PM. During interview with the Director of Nursing (DON) on 8/20/25 at 9:20 AM, the DON stated the expectation is neuro checks are to be done every 15 minutes for the first hour after a fall. The DON confirmed the neuro checks for Resident #8 are inaccurately documented since the Resident fell on 3/28/25 at approximately 7:00 PM and there is only one neuro check documented on 3/28/25 8:00 PM and the next is documented at 3/29/25 at 12:02 AM using vital signs from 3/28/25 at 9:00 PM. 2b. The facility staff failed to accurately assess Resident #8 during a change in condition. Review of Resident #8’s medical record revealed the Resident had a change in condition 8/7/25 at 1:29 PM. Review of the Change in Condition Assessment on 8/7/25 revealed the Resident was noted to be coughing and lungs sound noted congested. Further review of the Change in Condition revealed vital signs including oxygen saturation level from 8/7/25 at 3:08 AM, 10 hours earlier. Interview with the Director of Nursing on 8/20/25 at 9:20 AM confirmed the facility staff failed to get current vital signs to accurately assess Resident #8 when there was a change in condition on 8/7/25. 3) On 8/18/25 at 10:14 AM a review of Resident #4’s medical record revealed Resident #4 was admitted to the facility in August 2019 and was currently on Hospice care. Review of Resident #4’s August 2025 physician’s orders revealed the order, “float bilateral heels when in bed.” Review of Resident #4’s care plan, “has the potential for pressure ulcer development r/t immobility and incontinence of B&B (bowel and bladder)” and the care plan, “has potential for actual and impaired skin r/t immobility, incontinence, and pain” had the interventions, “float heels.” On 8/19/25 at 1:55 PM observation was made of Resident #4 lying in bed. With permission from the resident, the surveyor looked at the resident’s feet and the resident’s feet were not elevated off of the mattress. The heels were lying directly on the mattress. Review of the August 2025 Treatment Administration Record (TAR) had documented the nurse had signed off for that shift that Resident #4’s heels were elevated while in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 8:55 AM observation was made of Resident #4 lying in bed. There was a pillow between the resident’s knees, however the heels were not elevated and were lying directly on the mattress. On 8/20/25 at 2:55 PM a second observation that day was made of Resident #4 lying in bed. The resident’s family was visiting, and they looked at the resident’s heels with the surveyor. The heels were lying directly on the mattress and were not elevated. The nurse had already signed off on 8/20/25 at 2:55 PM on the TAR that the heels were elevated. On 8/20/25 at 3:00 PM the Director of Nursing (DON) went into the resident’s room with the surveyor and observed the resident’s heels. The DON confirmed the heels were not elevated and at that time placed a pillow under the resident’s heels. The DON was informed that the nurse had signed off for 2 consecutive days that the resident’s heels were elevated when they were observed not elevated. 4) On 8/18/25 at 11:10 AM a review of complaint 302921 alleged unacceptable and negligent care provided to Resident #6 while under the care of the facility. Review of Resident #6’s medical record revealed Resident #6 was admitted to the facility in December 2024 from an acute care facility with diagnoses including but not limited to generalized weakness, peripheral artery disease, COPD, slurred speech, history of falls, and hypertension. Review of a 1/10/25 at 8:58 AM eMar – Medication Administration Note documented, “amlodipine Besylate tablet 10 mg. give 1 tablet by mouth one time a day for HTN (hypertension). Med not given due to low b/p (blood pressure). Review of the medical record failed to reveal what the low blood pressure was as it was not documented on the MAR (medication administration record) or the vital sign section of the medical record or in any nursing progress notes. Continued review of the medical record failed to produce documentation that a follow-up blood pressure was taken or that the physician/nurse practitioner (NP) was made aware that the blood pressure medication was held, what the blood pressure was, and if any interventions should be put in place. The next documentation related to Resident #6 was on 1/10/25 at 15:04 (3:04 PM) that documented a change in condition that stated, “resident observed by staff with increased confusion, lethargic, unable to swallow at this time, low b/p.” Review of the b/p on the change in condition documented it as 76/56. The resident was transferred to the emergency room. Review of the hospital emergency room triage notes documented, “altered mental status: BIBA (brought in by ambulance) from [name of facility] for AMS (altered mental status) starting at 1245. Decreased LOC and low BP 87/40. SpO2 (oxygen level) 87 on room air, rhonchi. Received 1L fluids from EMS.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 12:17 PM an interview was conducted with geriatric nursing assistant (GNA) #18 who stated, “when I was getting [him/her] ready to go to the hospital, [he/she] did not look good.” GNA #18 stated Resident #6 ate very little that morning, maybe about 25 percent of the food which was unusual for the resident. GNA #18 stated she thought that the resident didn’t feel well. On 8/20/25 at 1:45 PM an interview was conducted with Nurse Practitioner #19 (NP). NP #19 stated that she did not see Resident #6 that morning and that she was not notified of the low blood pressure. There were no parameters as to when the nurse should have held the medication, so she would have expected to be notified. “I was in the building that morning and I was not notified. I could have seen the resident and started [him/her] on IV fluids or Midodrine. They informed me at lunch that the resident’s condition changed, but they did not notify me about the low blood pressure and holding the medication. Normally I would tell all the managers that if I am at the building to call me and let me know. They did not tell me until [he/she] was not arousable. I was concerned because [he/she] was a stable patient. I was concerned that [he/she] went down that quickly. I feel I could have stabilized [him/her] and [his/her] b/p. On 8/21/25 at 10:55 AM the concern was reviewed with the Director of Nursing (DON). The DON agreed that the NP should have been notified about the low blood pressure and holding the medication and there should have been more follow-up from the nurse.

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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. Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by administering a medication not ordered by the physician (Resident #5). This was evident for 1 of 9 residents reviewed for complaints during a complaint survey. The findings include:Review of Resident #5's medical record on 8/19/25 revealed the Resident was admitted to the facility with diagnosis to include mood disorder, depression and anxiety.Further review of Resident #5's medical record revealed on 5/18/25 the Resident was seen by the Psychiatrist. Review of Psychiatry Progress Note on 5/18/25 stated depressed very anxious. A nurse's note on 5/18/25 at 9:15 PM states at 8:57 PM the psych doctor new medication and made change in psych dose as follow: Hydralazine 50 mg every 8 hours for anxiety for 14 days. Hydralazine is a medication that is used for hypertension (high blood pressure) and heart failure.During interview with the Psychiatrist on 8/19/25 at 9:02 AM, the Psychiatrist stated the medication should have been hydroxyzine not hydralazine. Hydroxyzine is a medication that can used to help control anxiety.Review of Resident #5's MAR (Medication Administration Record) revealed the Resident was administered Hydralazine 50 mg every 8 hours for anxiety from 5/19/25 at 10:00 PM until 5/30/25 at 10:00 PM for a total of 34 doses.Interview with the Director of Nursing on 8/19/25 at 2:45 PM confirmed Resident #5 was administered Hydralazine 50 mg instead of Hydroxyzine from 5/19/25 until 5/30/25.

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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 observation, staff interview, and documentation review, it was determined that facility staff failed to keep treatment and medication carts locked when unattended, failed to date medications when opened, discard medications/biologicals when expired, and refrigerate medication that required refrigeration. This was evident on 1 of 2 nursing units observed during random observations made during a complaint survey. The findings include:On [DATE] at 12:08 PM observation was made of an unlocked and unattended treatment cart on the Sunset Unit sitting in front of the nurse's station. The surveyor was able to open the cart and found in the top-drawer prescription creams and ointments. In the second and third drawers were dressing supplies and in the fourth drawer were prescription ointments and creams that included Diclofenac gel. In the fifth drawer was a 500 ml. bottle of Sterile water irrigation G176170 for Resident #24. There was 100 ml. left in the bottle. There was no date on the bottle as to when it was opened. Sterile water is only good for 24 hours once it is opened.On [DATE] at 12:14 PM there were no staff members that had noticed the surveyor at the treatment cart, so the surveyor started looking for a staff member on the unit. The surveyor proceeded to walk around the corner of the nurse's station and saw an unlocked and unattended medication cart sitting in the hallway outside of room [ROOM NUMBER]. Resident #21 was standing at the medication cart looking at the computer that was sitting on top of the cart. The surveyor walked up to the cart and Resident #21 proceeded to walk down the hallway. There were no nursing staff in the hallway. The surveyor opened the top drawer of the medication cart and observed insulin pens, syringes, and a cell phone.Resident #23's insulin vial was opened with no date opened along with an opened Insulin Aspart Pen that was dispensed on 6/2 7/25. The insulin pen was not dated. There was another opened insulin flex pen for Resident #23 that was not dated when it was opened. According to the manufacturer's directions, the insulin is only good for 28 days once it is opened.Resident #22's Lyumjev Kwick Pen was opened and dispensed on [DATE]. There was no date open on the Kwick Pen. Resident #21's Insulin pen was opened with no date opened. According to the manufacturer's directions, the insulin is only good for 28 days once it is opened.There were other insulin pens in the top drawer that were not opened; however, they were in a plastic bag that stated to refrigerate until opened.After a couple of minutes of going through the unlocked medication cart, licensed practical nurse (LPN) #4 walked up to the surveyor. The surveyor asked which nurse was using the medication cart and she stated LPN #5. The surveyor informed LPN #4 that the cart was unlocked and unattended with Resident #21 standing at the cart. LPN #4 was also shown the undated insulin pens. At 12:25 PM, which was 11 minutes after the initial observation, LPN #5 walked up to the medication cart. LPN #5 stated she didn't realize she left the cart unlocked. The surveyor showed her the insulin pens, and she said she just came on duty that morning. The surveyor asked about refrigeration of the insulin pens, and she stated that they were there when she got there in the morning. The surveyor asked why the insulin pens were not refrigerated after LPN #5 took possession of the medication cart for the day. LPN #5 did not have any answer for the surveyor.On [DATE] at 1:30 PM a review of the Storage of Medications Policy, that was given to the surveyor from the Director of Nursing (DON), revealed Number 7; compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Number 9 documented, medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location.On [DATE] at 8:30 AM the DON was informed of the observation. The DON stated she was aware and had already started to in-service staff.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on review of complaint 302936, observation, interviews, review of resident council meeting minutes, attendance at the food committee meeting, and observations of the kitchen, it was determined that the facility failed to serve food that was attractive, palatable, matched what was on the tray ticket, timely, and at the proper temperature. This was evident for 19 (#34, #25, #18, #17, #19, #12, #13, #15, #16, #23, #10, #11, #35, #21, #31, #30, #32, #36, #5) of 19 residents interviewed or observed with the deficient practice having the potential to affect all residents. The findings include:On 8/18/25 at 10:14 AM a review of complaint 302936 was conducted and revealed concerns with meals. The complaint alleged that a resident for dinner received a scoop of mashed potatoes, string beans, and a peanut butter and jelly sandwich. The complaint alleged that the food service was contracted out and that they are not providing sufficient food. The complaint alleged that something needs to be done.On 8/18/25 at 11:30 AM observation was made of residents going into the dining room for lunch. Lunch was not served until 1:00 PM. Review of Resident #34's meal ticket documented that the resident was to have a turkey club sandwich and a peanut butter sandwich. The turkey club sandwich that was served was sparse. The tray ticket documented there was to be lettuce and tomato on the sandwich along with turkey. The club sandwich that was served consisted of 2 slices of white bread that was not toasted, 1 folded in half piece of turkey breast and 2 slices of rubbery bacon. There was no lettuce or tomato on the sandwich, no cheese, and no condiment on the sandwich. There was no peanut butter sandwich on the tray as stated by the tray ticket. The resident stated that the staff told them they were out of lettuce and tomatoes.Resident #25 and Resident #18 did not have lettuce or tomato on the sandwich. Resident #18 complained about the sandwich and that the facility served chicken too many times. Resident #17's family complained about the food's appearance and the meal being served late. Resident #19 was sitting at the same table, and his/her lunch was served on a napkin. They did not bring the resident a plate. Resident #19's tray ticket stated that he/she was to have the macaroni salad. There was no macaroni salad served to the resident.At that time the surveyor went into the kitchen to observe. There was chaos in the kitchen by the plating table. The Dietary Manager was attempting to plate the food and instruct the staff on the tray line what to do with the trays. The Dietary Manager stated that the cook called out and the other cook had quit and so she had to hire new people, therefore they were short a cook and there were new people on the tray line. There were piles of bread slice diagonally and no lettuce or tomatoes were observed. The surveyor walked out on the units and saw a pattern of the same appearance of club sandwich served to all residents that were to receive a sandwich.On 8/18/25 at 1:00 PM interview of LPN #10 revealed that lunch was to be served between 12:00 PM and 12:30 PM and it was late.On 8/19/25 at 7:10 AM a dietary staff member brought in decaffeinated coffee to the conference room. The dietary staff member stated, we don't have any regular coffee in the facility to give the residents this morning. When asked if the residents were aware that they would be served decaffeinated coffee, the response was, no. On 8/19/25 at 8:08 AM observation was made on the nursing units of the serving of breakfast. Resident #12's tray ticket was reviewed and revealed there was no coffee, no salt, pepper, or sugar packets. According to Resident #12, they sent 2% milk that the resident did not like.On 8/19/25 at 8:13 AM Resident #13 stated that they typically miss something that should be on the tray. Resident #14 did not have coffee on the tray per the tray ticket. On 8/19/25 at 8:15 AM Resident #15 stated they had taken the packets off the tray. Resident #15 stated, I never get coffee. I have to ask for it. Unless I ask for condiments I don't receive them with my food. Every single time I have to ask. I order food out daily because the food is horrible. It is embarrassing. No one will complain because they are afraid of retaliation.On 8/19/25 at 8:18 AM Resident #16 stated, I like to drink tea, but I don't because it tastes like coffee. The water is terrible. I only have tea at 10:00 AM. I never get sugar. I have to ask for it. Condiments are hard to get. They don't put condiments on the tray.On 8/19/25 at 8:20 AM Resident #23 complained, the toast is overdone, too crunchy.On 8/19/25 at 8:21 AM Resident #10 stated that he/she did not have coffee even though it was listed on the tray ticket. Resident #10 stated, I want coffee but never get it.On 8/19/25 at 8:23 AM Resident #11 stated, some days we have to wait to eat. Are we being punished? We complained and nothing changed. We have to ask for sugar packets and condiments. We are scared to say anything because the aides will get blamed. They don't take individual diets seriously. They only bring so much coffee. They run out of coffee.On 8/19/25 at 12:15 PM an interview was conducted with the Resident Council President, Resident #35. Resident #35 stated, every time we have a meeting the main complaint is the food doesn't get out on time. It is late as dinner does not come out until 7 PM. Lunch is late

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #4, #7 and #9). This was evident for 3 of 9 residents reviewed for complaints during a complaint survey. The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1.The facility staff documented completed assessments and medication administration of Resident #7 when the Resident was not in the facility. Review of Resident #7’s medical record on 8/18/25 revealed the Resident was admitted to the facility in April 2025 for rehabilitation following a hospitalization with a diagnosis to include muscle weakness. Review of Resident #7’s medical record revealed a Change in Condition Assessment on 5/10/25 at 3:35 AM that stated “During rounds around 2 AM patient was found in the bathroom on the floor lying on his/her right side. Patient was assisted back to bed with the help of the nursing supervisor, nursing aide and another nurse on duty. Patient vitals was assessed blood pressure 135/76, temperature 97.2, oxygen saturation 98 %, respirations 18, heart rate 89. Neuro checks was assessed and range of motion was performed, patient was noted with weakness to the right hand and was unable to talk, patient was also noted with the mouth switch to the side. On call APN (Advanced Practice Nurse) was made aware and order given to transfer to ER.” After the fall, Resident #7 was transferred to the emergency room on 5/10/25 at an unknown time and the Resident did not return to the facility. Further review of Resident #7’s medical record revealed on 5/11/25 the following assessments were completed by Staff #13 even though the Resident had been discharged from the facility: Change in Condition Follow up, Neurological Check List, Pain Assessment, and Nursing Skilled Charting. Review of Resident #7’s May 2025 Medication Administration Record revealed on 5/11/25 Staff #13 documented he administered the following medications on 5/11/25 to the Resident even though the Resident had been discharged from the facility: Albuterol Inhaler 12 AM and 4 AM, Levothyroxine 175 mcq at 6 AM, Calcium Carbonate 500 mg at 6 AM and Sevelamer Carbonate at 6 AM. Interview with the Director of Nursing on 8/19/25 at 2:45 PM confirmed Staff #13 inaccurately documented nursing assessments and administration of medications to Resident #7 on 5/11/25. 2.The facility staff documented medication and treatment administration for Resident #9 even though the Resident was not in the facility. Review of Resident #9’s medical record on 8/19/25 revealed the Resident was admitted to the facility in October 2024.Further review of Resident #9’s medical record revealed a nurse’s note on 2/11/25 at 3:06 PM that stated the Resident was transferred to the hospital. The Resident did not return to the facility. Review of Resident #9’s February 2025 Medication Administration Record revealed Staff #18 documented she administered Aspirin 81 mg, Clopidogrel Bisulfate 75 mg, Metoprolol 100 mg, Prednisone 5 mg, Cyclosporine 5 ml, Levetiracetam 5 ml, flushed the Resident’s tube feeding with 200 ml water on 2/12/25 when the Resident was not in the facility. Review of Resident #9’s February 2025 Treatment Administration Record revealed Staff #18 documented they cleansed the Resident’s gastric tube site, did a left buttock wound treatment, did a sacrum wound treatment, applied betadine to the Resident’s right great toe, applied skin prep to the Resident’s heels, elevated the Resident’s heels and provided catheter cleaning on 2/12/25 when the Resident was not in the facility. Interview with the Director of Nursing on 8/21/25 at 11:54 AM confirmed Staff #18 inaccurately documented administration of medications and treatments to Resident #9 on 2/12/25. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/18/25 at 10:14 AM a review of Resident #4’s medical record revealed Resident #4 was admitted to the facility in August 2019 and was currently on Hospice care.Review of Resident #4’s August 2025 physician’s orders revealed the order, “float bilateral heels when in bed.” On 8/19/25 at 1:55 PM observation was made of Resident #4 lying in bed. With permission from the resident, the surveyor looked at the resident’s feet and the resident’s feet were not elevated off of the mattress. The heels were lying directly on the mattress. Review of the August 2025 Treatment Administration Record (TAR) had documented the nurse had signed off for that shift that Resident #4’s heels were elevated while in bed.On 8/20/25 at 8:55 AM observation was made of Resident #4 lying in bed. There was a pillow between the resident’s knees, however the heels were not elevated and were lying directly on the mattress.On 8/20/25 at 2:55 PM a second observation that day was made of Resident #4 lying in bed. The resident’s family was visiting, and they looked at the resident’s heels with the surveyor. The heels were lying directly on the mattress and were not elevated. The nurse had already signed off on 8/20/25 at 2:55 PM on the TAR that the heels were elevated.On 8/20/25 at 3:00 PM the Director of Nursing (DON) went into the resident’s room with the surveyor and observed the resident’s heels. The DON confirmed the heels were not elevated and at that time placed a pillow under the resident’s heels. The DON was informed that the nurse had signed off for 2 consecutive days that the resident’s heels were elevated when they were observed not elevated.