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	12/13/2024

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

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on review of complaint, medical records, and interview, it was determined that the facility failed to review the admission agreement, which includes a notice of the resident's rights, with a resident and/or the Resident's responsible party at the time of admission and failed to ensure the admission agreement was signed and documented (Resident #906). This was evident for 1 of 33 complaint residents reviewed during a recertification/complaint survey. The findings include: On 12/10/24 a review of complaint MD00186565 was conducted and alleged that an admissions agreement was never executed. Review of Resident #906's electronic and paper medical record failed to produce a signed copy of the admissions agreement. Further review of Resident #906's medical record revealed the Resident was admitted to the facility on [DATE] and was alert and oriented times 1. Alert and oriented times 1 means that a person knows who they are but not where they are, what time it is, or what is happening to them. On 12/10/24 at 2:05 PM an interview was conducted with Staff #13, the Admissions Coordinator. Staff #13 stated she was not employed by the facility at the time of Resident #906's stay. Staff #13 stated the facility now uploads admissions contracts into the residents' medical record. Staff #13 stated she also looked for the Resident's admissions contract and was not able to find one for Resident #906. Interview with the Director of Nursing on 12/11/24 at 8:45 AM confirmed there is no evidence of an admissions contract with Resident #906.

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 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** 31145 Based on observation of resident rooms and equipment and staff interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment. This was evident on 2 of 3 nursing units observed during a recertification/complaint survey. The findings include: On 12/12/24 at 11:50 AM an environmental tour was conducted related to a complaint regarding the facility not being clean and in disrepair. The following concerns were observed: In the shared bathrooms of rooms 116-118 there was toilet paper sitting on the grab bar across from the toilet. The toilet paper holder on the wall was broken off the wall. In room [ROOM NUMBER] the drywall to the right of the door inside the bathroom was pushed in from the base leaving an open gap between the base and drywall approximately 1 foot in height from the base. In the hall dining room Resident #89 was sitting in a wheelchair eating lunch. There was no armrest on the left side of the wheelchair. Resident #24 was also sitting in a wheelchair eating lunch. There was no armrest on the left side of the wheelchair. Resident #44 was sitting in a wheelchair in the dining room. The vinyl on the left wheelchair armrest was ripped off and there was no padding on the armrest. In the activities dining room Resident #14 was sitting in a wheelchair. The vinyl on the left armrest was cracked throughout exposing the underneath padding. Resident #51 was sitting in a wheelchair in the dining room. The vinyl on the right armrest was torn. On 12/12/24 at 12:13 PM an interview was conducted with the Maintenance Director, Staff #23. Staff #23 stated he audited wheelchairs once a week. Staff #23 stated he looked at brakes, handgrips, tires, frames, and cushions. Staff #23 also stated that nursing sends him work orders and he audits rooms once a month. At that time the surveyor went on a tour with Staff #23 and all of the above concerns were shown to Staff #23. Staff #23 stated he would get right on the issues. On 12/12/24 at 3:15 PM the corporate team was informed of the environmental concerns.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 34484 Based on review of a closed medical record and staff interview, it was determined that the facility staff failed to complete a resident's discharge summary (Resident #913). This was evident for 1 of 33 complaint residents reviewed during the recertification/complaint survey. The findings include: Review of Resident #913's closed medical record on 12/9/24 revealed that Resident #913 was discharged from the facility on 12/21/23. Resident #913's electronic medical record and paper record failed to reveal a completed discharge summary from Resident #913's attending physician that included: a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of all pre-discharge medications with the post discharge medications, and a post discharge plan of care. An interview with the Director of Nursing on 12/11/24 at 4:41 PM confirmed that Resident #913's medical record did not include a completed discharge summary.

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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. 31145 Based on complaint, medical record review, and interview with facility staff, it was determined that the facility failed to provide needed showers for residents' dependent on assistance with care. This was evident for 2 (#907, #912) of 33 residents reviewed for complaints during a recertification/complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 12/11/24 at 1:22 PM a review of complaint MD00187130 revealed an allegation that Resident #907 complained that he/she had not received regular bathing. Resident #907's medical record was reviewed and revealed the resident was admitted to the facility in April 2021 and had diagnoses which included Cerebral Palsy and osteoarthritis. Review of the MDS assessment with an assessment reference date of 12/12/22 documented that Resident #907 was totally dependent on staff for bathing. Resident #907 was assigned to receive showers on Mondays and Thursdays. Review of Resident #907's documentation report for bathing for December 2022 documented the resident only had bed baths for the entire month. Resident #907 did not receive a shower. There were no other shower or skin sheets for December 2022 that were provided to the surveyor. Review of nursing notes for Resident #907 failed to produce documentation that the resident refused showers. On 12/12/14 at 1:48 PM Geriatric Nursing Assistant (GNA) #14 was interviewed and stated she did not know if the resident refused the showers because it was not documented. GNA #14 stated they were supposed to fill out a skin sheet when a shower was given. GNA #14 stated she usually would tell the nurse if the resident refused a shower. 2) On 12/11/24 at 2:33 PM a review of complaint MD00199751 alleged that Resident #912 and Resident #907, who were roommates, had not received showers within one to two weeks. According to the complaint, a relative had checked the shower log and discovered that both residents had not received any showers within that time frame. The complaint alleged that the NHA (nursing home administrator) stated they had not showered any of the residents due to a previous COVID outbreak. Resident #912's medical record was reviewed and revealed the resident was admitted to the facility in August 2021 and had diagnoses which included dementia, heart disease and osteoarthritis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment with an assessment reference date of 10/14/23 documented that Resident #912 was totally dependent on staff for bathing. Resident #912 was assigned to receive showers on Mondays and Thursdays. Review of Resident #912's nursing notes documented that Resident #912 tested positive for COVID on 11/9/23. Review of the documentation report for bathing and showers for November 2023 for Resident #912 documented that there was a missed shower on 11/9/23 (day of COVID diagnosis) and a bed bath was given. On 11/13/23, 11/16/23, and 11/20/23 the resident received a bed bath. Resident #912 did not receive a shower until 11/23/23. Review of the documentation report for bathing and showers for November 2023 for Resident #907 documented that Resident #907 only received bed baths in November 2023, no showers. There was no documentation of refusal of showers anywhere in the medical record. There was only 1 bathing/skin sheet provided to the surveyor for November 2023 dated 11/17/23. It documented a bed bath was given. On 12/12/24 at 10:00 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed and stated that the GNAs gave showers during the time period when residents tested COVID positive. They stated that the COVID positive residents were the last showers given for the day and then the shower was cleaned and sanitized. On 12/12/24 at 1:48 PM GNA #14 was interviewed and stated that Resident #912 usually did not refuse showers and that GNA #14 could not recall if she was assigned to the resident and the roommate while they had COVID. GNA #14 stated, well, they were on isolation so technically they were not supposed to come out of their room. I was not aware of their policy that they could get a shower at the end of the shift. I don't know if they refused the shower because I didn't document that. On 12/12/24 at 3:15 PM the corporate nurse and DON were informed of the showers that were not given during a COVID outbreak.

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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. 34484 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 #904, #914, #918). This was evident for 3 of 33 complaint residents reviewed during a recertification/complaint survey. The findings include: 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. 1. The facility staff failed to properly perform neuro checks after a fall for Resident #914. Review of Resident #914's medical record on 12/9/24 revealed a nurse's note on 3/22/24 at 5:34 PM that stated: the writer saw resident get out of bed and sit on the floor. He/she did not hit his/her head on the floor. Head to toe assessment showed no signs of injury, resident was assisted back in bed with help of two people. Nurse practitioner and Resident representative was informed about fall. During interview with the Director of Nursing (DON) on 12/11/24 at 11:15 AM, the DON provided the Surveyor with the facility's neurological checklist schedule protocol that details at what intervals the facility staff should do neuro checks. The neuro check schedule is to obtain baseline neuro assessment, then every 15 minutes for 1 hour, every hour times 4, and every 4 hours times 6. Further review of Resident #914's medical record revealed the facility staff completed neuro checks at the following times: 3/22/24 at 7:47 PM, 8:04 PM, 11:49 PM and 3/23/24 at 5:36 AM, 6:55 AM, 11:11 AM and 1:53 PM. Review of the 3/22/24 7:47 PM and 8:04 PM neuro checks revealed the facility staff used vital signs from 11:08 AM, 8 hours earlier and N/A (not applicable) for movement of extremities. The 3/22/24 11:49 PM neuro checks still used vital signs from 11:08 AM. The 3/23/24 5:36 AM and 6:55 AM neuro checks used vital signs from 12:33 AM, 5 hours earlier. The 3/23/24 11:11 AM and 1:53 PM used vital signs from 8:50 AM, at least 3 hours earlier. Review of a physician telehealth visit note on 3/23/24 at 4:11 PM, the physician documented transfer to emergency room per family request. Interview with the DON on 12/11/24 at 11:55 AM confirmed the facility staff completed neuro checks for Resident #914 at incorrect time intervals per facility protocol and inaccurately on 3/22 and 3/23/24. 2. The facility staff failed to properly perform neuro checks after a fall for Resident #918. Review of Resident #918's medical record on 12/10/24 revealed a nurse's note on 2/23/24 at 8:26 PM that stated: Resident was observed lying on his/her left side on the hallway. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Nursing (DON) on 12/11/24 at 11:15 AM, the DON provided the Surveyor with the facility's neurological checklist schedule protocol that details at what intervals the facility staff should do neuro checks. The neuro check schedule is to obtain baseline neuro assessment, then every 15 minutes for 1 hour, every hour times 4, and every 4 hours times 6. Further review of Resident #918's medical record revealed the facility staff completed neuro checks at the following times: 2/23/24 at 9:27 PM, 10:00 PM, 10:15 PM, 10:33 PM and 2/24/24 at 6:17 AM, 4:40 PM and 11:04 PM. Review of the 2/23/24 10:15 PM, 10:33 PM and 2/24/24 6:17 AM neuro checks revealed the facility staff used vital signs from 2/23/24 9:42 PM. The 2/24/24 11:04 PM neuros checks still used vital signs from 4:40 PM. Interview with the DON on 12/11/24 at 4:41 PM confirmed the facility staff completed neuro checks for Resident #918 at incorrect time intervals per facility protocol and inaccurately on 2/23 and 2/24/24. 3. The facility staff failed to order eye drops accurately for Resident #904. Review of Resident #904's medical record on 12/12/24 revealed on 2/6/24 the facility staff entered a physician order for antibiotic eye drops in left eye every 4 hours for 1 day for conjunctivitis. Antibiotic eye drops are recommended to be used for 7 to 10 days for conjunctivitis. Review of Resident #904's February 2024 MAR (Medication Administration Record) revealed the facility staff failed administer eye drops to Resident #904 2/6/24 and 2/7/24. On 2/9/24 the eye drops were reordered for 7 days and were administered to Resident #904 on 2/9/24 at 6:00 PM. Interview with the Director of Musing on 12/13/24 at 10:30 AM confirmed the facility staff inaccurately ordered eye drops for Resident #904 on 2/6/24 which lead to a 3 day delay in administering eye drops to the Resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to assess and evaluate the nutrition needs of residents in a timely manner. (Resident #901, #902, #904, #906, #911, #910). This was evident for 6 of 33 complaint residents reviewed during a recertification/complaint survey. The findings include. 1. Review of Resident #902's medical record on 12/9/24 revealed the Resident was admitted to the facility on [DATE] and facility staff documented the Resident weight as 129 pounds. Review of the nutritional assessment revealed it was done on 1/27/22, 8 days after admission. The nutritional assessment stated At nutritional risk for weight loss On 2/3/22 at 2:27 PM a dietary note states Resident presents with poor intake, less than 25% of meals. Current weight is 126.2 pounds. A physician order on 2/3/22 is for weekly weights. Further review of Resident #902's medical record revealed the Resident is reweighed on 2/10/22 and the Resident's weight is 114 pounds, 15 pounds less than the Resident's weight on 1/19/22 at Admission. Further review of Resident #902's medical record revealed no documentation the facility staff were aware of the weight loss, no assessment from the dietitian or further interventions after the documented weight loss on 2/10/22. The Resident was discharged from the facility on 2/14/22. Interview with the Director of Nursing (DON) on 12/10/24 at 10:15 AM confirmed Resident #902 was not assessed by the dietitian until 8 days after admission and interventions were not put in place until that time. The DON also confirmed when the Resident had a documented weight loss on 2/10/22, no further assessments or interventions were put in place. 2. Review of Resident #904's medical record revealed the Resident was admitted to the facility on [DATE] and the facility staff documented the Resident's weight was 148.3 pounds. The Resident was assessed by the dietitian on 2/2/24. Review of the Nutritional Assessment completed by the dietitian with an effective date of 2/2/24 and a signed date of 2/6/24, revealed the weight included was from 2/3/24, 1 day after the effective date. Further review of the nutritional assessment revealed it was incomplete and did not include: estimated nutritional needs, goal or plan. Further review of Resident #904's medical record revealed on 2/27/24 the facility staff documented the Resident's weight was 134 pounds, 14.3 pound weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #904's medical record revealed no documentation the facility staff were aware of the weight loss, no assessment from the dietitian or further interventions after the documented weight loss on 2/27/24. The Resident was discharged from the facility on 3/1/24. Interview with the Director of Nursing (DON) on 12/13/24 at 10:45 AM confirmed Resident #904's 2/2/24 Nutritional Assessment was incomplete. The DON also confirmed when the Resident had a documented weight loss on 2/27/24, no further assessments or interventions were put in place. 3. Review of Resident #906's medical record on 12/10/24 revealed the Resident was admitted to the facility on [DATE] with a documented weight of 195 pounds. Further review of Resident #906's medical record revealed the facility staff completed a Nutritional Assessment on 11/26/22 with a plan to add house shake at breakfast and Glucerna or equivalent at lunch and dinner. Review of the Resident's physician orders revealed although the Glucerna was ordered on 11/26/22, the house shake was not ordered until 12/2/22, 6 days later. Further review of Resident #906's medical record revealed the Resident was not weighed again until 12/5/22, 13 days after admission. Review of the facility's Weight Management Guideline revealed the weight schedule for newly admitted patients is to obtain weight upon admission and weigh weekly for total of 4 consecutive weeks. Interview with the DON on 12/11/24 at 8:30 AM confirmed the facility staff failed to order house shakes timely for Resident #906 and failed to obtain a weekly weight on 11/29/22. 4. Review of Resident #911's medical record on 12/9/24 revealed the Resident was admitted to the facility on [DATE] and the facility staff documented the Resident's weight as 243.3 pounds. Further review of Resident #911's medical record revealed on 2/14/23 the facility staff documented the Resident's weight as 225.6 pounds. Review of Resident #911's medical record revealed no nutritional assessment was completed during the Resident's stay from 2/3/23 until 2/26/23. Interview with the Director of Nursing (DON) on 12/10/24 at 1:10 PM confirmed no nutritional assessment was completed for Resident #911. The DON also confirmed when the Resident had a documented weight loss on 2/14/23, no further assessments or interventions were put in place. 31145 5. On 12/11/24 at 9:46 AM a review of complaint MD00178592 alleged that the facility staff skipped tube feedings and meals for Resident #901. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #901's medical record revealed Resident #901 was admitted to the facility in February 2022 from an acute care facility for rehabilitation after a stroke which resulted in the resident having dysphagia (difficulty swallowing food and/or liquids. Resident #901 received a peg tube while in the hospital for bolus feedings. A PEG (percutaneous endoscopic gastrostomy) tube is a feeding tube that is surgically placed through the skin and into the stomach. The tube allows patients to receive nutrition, fluids, and medications directly into their stomach. Peg tubes are used when patients are unable to eat or drink due to conditions such as a stroke. A bolus feeding is a method of administering liquid nutrition through a feeding tube in large doses over a short period of time. When a feeding was administered the nurse would sign the MAR/TAR with a check mark and the nurse's initials. If a feeding was held, the nurse would document the number 4 or number 8 if there was an issue. Review of Resident #901's March 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) had several blank spaces with no initials or numbers; therefore, it was unknown if the resident received the bolus feedings. This occurred on the following days: 3/1/22, 3/4/22, 3/822, 3/9/22, 3/20/22, and 3/28/22 at 6 AM 3/2/22 at 6 AM and 2 PM 3/3/22 at 6 AM, 7 PM, and 11 PM 3/5/22, 3/6/22, and 3/7/22 at 6 AM and 2 PM 3/10/22, 3/11/22, 3/14/22, 3/18/22, 3/21/22, and 3/25/22 On 12/11/24 at 1:50 PM an interview was conducted with the Corporate Nurse and a review of the March 2022 MAR/TAR was conducted. There were several blanks of which a week's worth were for the early morning feeding that the staff were trialing to hold the bolus feeding due to trying to get the resident to eat more, however there was no documentation on the MAR/TAR that a trial was ongoing. Additionally, there was no explanation for the other missing nurse's initials for the feedings. The Corporate Nurse confirmed the surveyor findings and could not confirm if the resident received those feedings. 6) On 12/10/24 at 9:57 AM a review of complaint MD00191037 alleged that Resident #910 was not receiving tube feedings that were ordered and not receiving water regularly through the PEG tube. Review of Resident #910's medical record revealed Resident #910 was admitted to the facility in March 2023 following hospitalization for a fall at home. While in the hospital Resident #910 received a PEG tube for dysphagia. Review of Resident #910's physician's order revealed the orders for enteral feeds 240 ml. 6 times per day while awake. There was also an order for 75 ml. of water flush before and after each feed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #910's March 2023 TAR documented the check of gastric residual 6 times per day at 12 AM, 4 AM, 8 AM, 12 PM, 4 PM, and 8 PM. The TAR failed to have documentation of the water flushes. There was no documentation as to the amount of water flushes given. Review of Resident #910's March 2023 MAR documented the enteral feed order that stated, every day and evening shift for nutrition; give 240 ml. 6 times per day while awake. The nurses could initial off day shift and evening shift. There was no evidence provided that the nurses gave at the 6 specific times and how much was given. On 12/10/24 at 10:35 AM an interview was conducted with Registered Dietician (RD) #9. RD #9 stated she would expect to see each time the tube feed was administered and the water flushes spelled out on the MAR/TAR. On 12/10/24 at 11:12 AM an interview was conducted with the DON. The DON printed out the physician's order that documented the 3 times during day shift and 3 times during evening shift that the resident was supposed to receive the enteral feeding and the times the nurses were supposed to do the water flushes. On 12/12/24 at 1:50 PM an interview was conducted with the DON and ADON. They confirmed that the amount of enteral feed and water flushes were not documented correctly and confirmed the surveyor's findings that they could not state how much enteral feed and water flushes Resident #910 received.

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

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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. 31145 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 failing to monitor the blood pressure and heart rate prior to administering a blood pressure medication per physician's orders. This was evident for 1 (#901) of 33 residents reviewed for complaints during the recertification/complaint survey. The findings include: On 12/11/24 at 9:46 AM a review of Resident #901's medical record was conducted and revealed a physician's order for Lisinopril 20 mg (milligrams) to be given every day for hypertension. The order stated to hold the medication for a SBP (systolic blood pressure) less than 110 or HR (heart rate) below 60. The top number of the blood pressure refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. Review of Resident #901's March 2022 Medication Administration Record (MAR) failed to document that the blood pressure and the heart rate were being monitored when the 8:00 AM dose of Lisinopril was administered. Review of Resident #901's March 2022 Treatment Administration Record (TAR) documented vital signs were taken each shift, however it did not have the time that the vital signs were taken. Review of the vital sign section of Resident #901's medical record documented the blood pressure and heart rate were taken daily; however, the times did not correlate with the 8:00 AM administration of the Lisinopril. On 12/12/24 at 1:40 PM an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). Both were shown the MAR/TAR and the lack of monitoring the blood pressure and pulse when the Lisinopril had parameters. The DON and ADON confirmed the findings and stated that the blood pressure and heart rate should have been documented where the Lisinopril was located on the MAR. On 12/12/24 at 3:15 PM the Corporate Nurse was informed of the finding.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 34484 Based on staff interview and medical record review it was determined the facility failed to ensure that a resident's laboratory tests were completed in a timely manner (Resident #40). This was evident for 1 of 33 complaint residents reviewed during a recertification/complaint survey. The findings include: Review of Resident #40's medical record on 12/12/24 revealed on 2/24/24 at 10:49 AM STAT labs were ordered for the Resident that included a CBC (complete blood count) and a BMP (basic metabolic panel). A nurse's note on 2/24/24 at 10:13 PM stated, STAT labs ordered today, currently awaiting lab draw due to decreased blood pressure and elevated pulse. Further review of Resident #40's medical record revealed the Resident was seen by a telehealth physician on 2/25/24 at 8:25 AM and the physician documented, Patient has been having shortness of breath since yesterday. Patient is not doing well. Stat labs ordered however have not been done since yesterday. Transfer to Emergency Department. During an interview with the Assistant Director of Nursing on 12/12/24 at 12:35 PM, the ADON confirmed Resident #40's labs were not done on 2/24/24 and the expectation would be that STAT labs would have been drawn on 2/24/24.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and facility policy review, the facility failed to ensure snacks were available to eight out of 33 sampled residents (Residents (R) 12, R112, R79, R106, R115, R87, R48, and R32) who desired snacks. The facility did not provide snacks to residents during the day and the evening/hours of sleep (HS) snack was not available to all residents who desired snacks. Findings include: Review of the facility's policy titled, Offering/Serving Bedtime Snacks, dated 02/23 and provided by the facility, revealed It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis . Snacks are readily available to residents . 1. During an interview on 12/09/24 at 2:09 PM, R12 stated he/she did not always eat what was served and would like to be able to get a snack. R12 stated he/she was not offered snacks during the day or at night. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 in the electronic medical record (EMR) under the MDS tab, revealed R12 was admitted to the facility on [DATE]. R12's Brief Interview for Mental Status (BIMS) score of 15 out of 15 revealed R12 had intact cognition. R12 resided at the 200 Unit. 2. During an interview on 12/10/24 at 10:55 AM, R112 stated he/she did not always get enough to eat. R112 stated he/she had not been offered snacks but would like to be offered snacks. Review of the admission MDS with an ARD of 10/04/24 in the EMR under the MDS tab, revealed R112 was admitted to the facility on [DATE]. R112's BIMS score of 15 out of 15 revealed R112 had intact cognition. R112 resided at the 200 unit. 3. During an interview on 12/11/24 at 8:58 AM, R79 stated he/she was not offered a bedtime snack; however, would like to be offered one. Review of the annual MDS with an ARD of 10/16/24 revealed R79 was admitted to the facility on [DATE]. R79's BIMS score of 14 out of 15 revealed R79 had intact cognition. R79 resided on the 300 unit. 4. During an interview on 12/11/24 at 12:52 PM, R106 stated no snacks were offered or available during the day. R106 stated (on the 300 Unit) that snacks came to the unit at night and one of the nurses passed them out; however, if she was not working, the snacks did not get offered. R106 stated residents lined up to get the HS snacks and they could all be gone quickly. R106 stated he/she would like to have snacks available more often. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS with an ARD of 09/06/24 in the EMR under the MDS tab revealed R106 was admitted to the facility on [DATE]. R106's BIMS score of 15 out of 15 revealed R106 had intact cognition. 5. Observations during the survey by four surveyors on 12/09/24 from 8:45 AM to 4:45 PM, on 12/10/24 from 8:45 AM to 4:45 PM, and on 12/11/24 from 8:45 AM to 5:15 PM revealed snacks were not observed to be distributed to residents on any of the units. 6. During an interview on 12/11/24 at 10:00 AM, Geriatric Nursing Assistant (GNA) 3, who worked on the 300 Unit, stated the nursing stations used to receive bulk snacks from the kitchen during the day. GNA3 stated currently, In the daytime, there are no snacks. GNA3 stated the only snacks the nursing stations received now came at bedtime. GNA3 stated the nursing station received a tray of evening snacks with sandwiches, yogurts, crackers, and cookies. GNA3 stated residents lined up at the nursing station when the snacks arrived so they could get them. During an interview on 12/11/24 at 10:44 AM, Dietary Aide (DA) 1 stated her assignment included preparing the HS snack trays that went to the units. DA1 stated she prepared labeled snacks for specific residents and some general snacks for residents such as graham crackers, pies, pudding, and apple sauce. DA1 stated the snacks were taken to the nursing units between 7:30 PM - 8:00 PM. During an interview on 12/11/24 at 10:45 AM, The Dietary Manager (DM) stated the kitchen did not send any snacks to the units during the day and only sent the snack trays at HS. The DM stated she was brand new in her position and stated she had been wondering why more snacks had not been routinely sent to the units during the day. During an interview on 12/12/24 at 11:32 AM, the Registered Dietitian (RD) stated the dietary department provided a bedtime snack to residents but no snacks during the day. 7. During an observation on 12/09/24 at 9:30 AM, residents in the activity room were making Christmas cards, there was coffee and/or tea offered. There were no snacks offered to the residents. During the resident meeting interview on 12/10/24 at 2:09 PM, four of the seven residents, R32, R48, R87, and R115 stated they were not offered or received snacks during the daytime or before bedtime. They stated there were no free snacks offered. They stated if they wanted a snack, they would have to use the vending machine and pay for it. They stated there were other residents who received snacks at bedtime, but said those residents had special reasons for the snacks. They stated there was a coffee and tea cart offered three times a day, but there were no snacks offered. Review of R32's quarterly MDS with an ARD of 10/08/24 in the EMR under the MDS tab, revealed R32 was admitted to the facility on [DATE]. R32's BIMS score of eight out of 15 revealed R32 was moderately cognitively impaired. R32 lived on the 300 Unit. Review of R48's quarterly MDS with an ARD of 09/16/24 in the EMR under the MDS tab, revealed R48 was admitted to the facility on [DATE]. R48's BIMS score of 14 out of 15 revealed R48 had intact cognition. R48 lived on the 200 Unit. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R87's quarterly MDS with an ARD of 11/20/24 in the EMR under the MDS tab, revealed R87 was admitted to the facility on [DATE]. R87's BIMS score of 14 out of 15 revealed R87 had intact cognition. R87 lived on the 300 Unit. Review of R115's quarterly MDS with an ARD of 09/09/24 in the EMR under the MDS tab, revealed R115 was admitted to the facility on [DATE]. R115's BIMS score of 15 out of 15 revealed R115 had intact cognition. R115 lived on the 200 Unit. During an interview on 12/11/24 at 11:28 AM the Administrator stated he was not aware residents had not been receiving snacks during the day or at night. He stated residents should have snacks available for them during activities and before bedtime.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15406 Based on observation, interview, and facility policy review, the facility failed to ensure that the kitchen was maintained in a sanitary manner to prevent the potential spread of foodborne illness to all residents. Specifically, there were accumulated food and beverage spills, crumbs, and residue on kitchen surfaces such as on carts, shelving, tables, and the inside of the microwave; there was a black/grey substance on the wall above the dishwasher; there were unlabeled food items; and unclean cups and bowls stored as clean for one of one kitchen. This created the potential for the spread of foodborne illness for 105 out of 117 residents consuming food in the kitchen. Findings include: Review of the facility's policy titled, Environment, dated 09/17 and provided by the facility, revealed All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition . All non-food contact equipment will be clean and free of debris . Review of the facility's undated policy titled, Labeling and Dating, provided by the facility, revealed, Food labels must include: The food item name . 1. The initial tour of the kitchen was conducted on 12/09/24 from 9:45 AM through 10:24 AM with the Dietary Manager (DM), who stated this was her first day working as DM in the facility. The following concerns were observed: a. There was a food service cart covered with accumulated food/beverage residue and crumbs. b. The stainless-steel tables and shelving throughout the kitchen were observed with accumulated food/beverage residue and crumbs on the surfaces. c. A bulk storage container of white granules of food was not labeled with the name of the food. The DM stated it was salt. d. There were three plastic cereal bowls stored as clean that had food particles adhered to the interior surface of the bowls. The DM verified the bowls were not clean and stated they would be re-washed. e. There was a black/grey substance on the wall directly above the dirty side of the dishwasher. The black substance covered an area approximately four feet by two feet. The DM stated she did not know what the substance was. f. The interior of the microwave oven was covered with accumulated food spatters. 2. During an observation on 12/11/24 at 10:42 AM with the DM, the following concerns were noted: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The container of salt remained unlabeled, lacking the name of the food item (observed on 12/09/24). The DM stated she had forgotten to label it and stated salt, and sugar could be mistaken for each other. The DM stated the staff had cleaned the kitchen after the initial tour and the areas such as soiled kitchen surfaces, carts, wall above the dishwasher, and shelving/tables had been cleaned. b. Several plastic coffee cups stored as clean had food particles adhered to the interior drinking surfaces of the cups. The DM removed the cups and took them to be washed, confirming they were not clean.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 15406 Based on observation, interview, and facility policy review, the facility failed to ensure that the garbage dumpster area was maintained in a sanitary manner to prevent the harborage of pests and rodents having the potential to affect all residents. There was garbage strewn around the dumpster on three days of the survey. Findings include: Review of the facility's policy titled, Environment, dated 09/17 and provided by the facility, revealed All trash will be contained in covered, leak-proof containers that prevent cross contamination. 7. All trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris. During observation on 12/09/24 at 8:45 AM, the area around the garbage dumpster was strewn with garbage up to approximately 30 feet away from compactor along the grass by a parking area and surrounding the dumpster area. Garbage included single use disposable gloves, plastic bags, cups, lids, straws, and assorted pieces, cardboard, individual portioned food containers such as an ice cream cups opened with ice cream on the pavement. There was a bag of garbage stuck in the lower-level opening of the dumpster partially opened, and a garbage can on the pavement uncovered (55 gallon) without a lid and with garbage bags sticking out of the top. During an observation on 12/10/24 at 8:37 AM, single use disposable gloves, plastic bags and pieces, assorted refuse, cardboard, individual portioned food containers were observed. There was a bag of garbage stuck in the lower level of the dumpster partially open, and a garbage can on the pavement uncovered (55 gallon) without a lid and with garbage bags sticking out of the top. During an observation on 12/11/24 at 8:40 AM, there was garbage on the ground, bags and plastic around the dumpster and a garbage bag stuck in the lower level of the dumpster with garbage in and strewn. During an interview on 12/12/24 at 11:55 AM, the Housekeeping/Laundry Director (HKSD) stated it was a group effort to keep the outdoor dumpster area cleaned up. The HKSD stated she and the maintenance staff had been cleaning up the garbage around the dumpster area the last couple days, stating, There was too much garbage out there. The HKSD stated there was no schedule for cleaning the area; staff checked it periodically and picked up the garbage. The HKSD stated there should not be any garbage on the ground, around the dumpster, or garbage cans with garbage and no lids. The HKSD stated she had seen garbage pulled out of a hole near the bottom of the dumpster by animals such as cats and raccoons. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/12/24 at 1:05 PM the Maintenance Director (MD) stated he had assisted to clean up the garbage dumpster area starting on Monday. He stated it was usually done daily and staff tried to maintain cleanliness in the area as much as possible. The Maintenance Director stated the 55-gallon garbage can should have a lid on it and there should not be garbage bags exposed. The Maintenance Director stated the dumpster had a hole in it and that was where the bag was observed on 12/09/24 - 12/11/24. He stated they were working on getting the dumpster replaced so it would be completely sealed.

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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. 31145 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. This was evident for 2 (#51, #901) of 33 residents reviewed for complaints during a recertification/complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On 12/9/24 at 12:03 PM a review of Resident #51's medical record was conducted and revealed a nursing note written on 5/3/23 at 18:41 (6:41 PM) that documented Resident #51 complained of lower back pain and Tylenol was given. Review of Resident #51's May 2023 Medication Administration Record (MAR) was blank for the administration of Tylenol on 5/3/23. On 12/12/24 at 1:40 PM an interview was conducted with the Director Of Nursing (DON) and Assistant Director Of Nursing. Both stated that the MAR should have been signed off by the nurse when the medication was administered. 2) On 12/11/24 at 9:46 AM a review of Resident #901's medical record was conducted. Review of Resident #901's March 2022 MAR/TAR (Treatment Administration Record) revealed an enteral feed order for Jevity to be given 4 times per day. An enteral feed is nourishment given through a tube that is surgically placed in the stomach. When a feeding was administered the nurse would sign the MAR/TAR with a check mark and the nurse's initials. If a feeding was held, the nurse would document the number 4 or number 8 if there was an issue. Review of the March 2022 MAR/TAR had several blank spaces with no initials or numbers, therefore it was unknown if the resident received the feedings. This occurred on the following days: 3/1/22, 3/4/22, 3/822, 3/9/22, 3/20/22, and 3/28/22 at 6 AM 3/2/22 at 6 AM and 2 PM 3/3/22 at 6 AM, 7 PM, and 11 PM 3/5/22, 3/6/22, and 3/7/22 at 6 AM and 2 PM 3/10/22, 3/11/22, 3/14/22, 3/18/22, 3/21/22, and 3/25/22 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 1:50 PM an interview was conducted with the Corporate Nurse and a review of the March 2022 MAR/TAR was conducted. There were several blanks of which a week's worth were for the early morning feeding that the staff were trialing to hold the feed due to trying to get the resident to eat more, however there was no documentation on the TAR that a trial was ongoing. Additionally, there was no explanation for the other missing nurse's initials for the feedings. The Corporate Nurse confirmed the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, interviews, record review, review of the facility policy, the facility failed to ensure that staff wore appropriate Personal Protective Equipment (PPE) for two of twelve residents (Resident (R) 13 and R51) reviewed for enhanced barrier precautions (EBP) when providing care, and staff failed to follow infection control practices and guidelines to prevent the development and transmission of disease on 2 of 3 nursing units. These failures could promote the spread of multi-drug-resistant organisms (MDROs) throughout the facility. Findings include: Review of the facility's policy titled, Enhanced Barrier Precautions, implemented on 03/25/24, indicated, under the section Policy/Definition: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Under the section Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 9. Enhanced barrier precaution should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 1. Review of R13's undated Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed a diagnosis of cerebral infraction, muscle wasting, and atrophy. Review of R13's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R13 was moderately cognitively impaired. During an observation in R13's room on 12/10/24 at 1:16 PM, Licensed Practical Nurse (LPN) 5 performed trach care to resident R13. LPN5 performed hand hygiene, explained to the resident what she was doing, as she set up trach care supplies on a barrier sheet on the clean bedside table, and began trach care. LPN5 performed hand hygiene multiple times throughout trach care and after completion of the task. LPN5 had access to PPE gowns in the bottom drawer of trach supply cart and in PPE isolation cart outside of R13's doorway but did not wear a gown any time throughout providing trach care. During an interview on 12/10/24 at 1:42 PM, R13 stated, I don't ever see staff wear gowns while in my room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 1:52 PM, LPN5 stated, I can't say that I've ever heard about EBP, but I can find out about it and let you know what it is. We keep gowns in the room in the trach cart in case R13 has a lot of secretions and we don't want to get them on us. Then we can wear one for protection. We get educated on infection control quarterly and reminders all the time. During an interview on 12/10/24 at 1:53 PM, LPN1 stated, All staff are to wear PPE if a resident is on EBP. This includes wounds, traches, foleys, g-tubes [gastric tubes], IVs [intravenous], or any areas that have open entries into the body. During an interview on 12/10/24 at 1:56 PM, Assistant Director of Nursing (ADON) stated, [LPN5] knows better and knows that she is to wear EBP during trach care. We will be reeducating her and the rest of the staff today. We use EBP for any staged wounds, foleys, traches, g-tubes, or any indwelling devices. EBP is only for staged wounds because they must have drainage within a certain classification. The (Infection Preventionist) IP educates EBP with new hires or with any changes. We as a facility educate annually, quarterly, or whenever there are new residents or a new diagnosis requiring the use of EBP. During an interview on 12/10/24 at 2:01 PM, the Director of Nursing (DON) stated, We use EBP when giving direct care to patients with g-tube, peripherally inserted central catheter (PICC) lines and IVs (intravenous), indwelling devices into the body, or wounds not including those with skin tears or abrasions. We do education quarterly at least or when we observe someone is not following best practice or guidelines. We have a sign on the door and an isolation cart at the door. We keep it posted on the door and PPE outside the doorway as it's a good reminder for them to use EBP. We'll be doing reeducation today with all the staff now after learning it wasn't followed for trach care. 2. Review of R51's Face Sheet located under the Profile tab of the EMR, indicated R51 was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive pulmonary disease, and peripheral vascular disease. Review of R51's quarterly MDS, with an ARD of 10/31/24 and located under the MDS tab in the EMR, revealed R51 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R51's Care Plan located in the EMR under the Care Plan tab and last revised 10/31/24, revealed R50 had actual or potential for alteration in skin integrity related to impaired mobility and occasional incontinence. R51's skin would show signs of healing and be free from infection by/through next review date. Interventions included floating heels, the application of barrier cream with toileting/incontinence care, and observing skin for change and notify physician. Review of R51's Skin/Wound, dated 12/09/24 at 4:33 PM and located under the Progress Notes tab of the EMR, indicated Nursing reports change in skin. Resident noted with cluster of two open areas to LLE [left lower extremity]. 8.5 cm [centimeter] X [by] 8cm. Area is red with white maceration [condition when skin softens and breaks down due to prolonged exposure to moisture) on the edges. Surrounding tissue is red, warm, swollen and tender to touch. Moderate serous drainage. CRNP [certified registered nurse practitioner] made aware. New order Cleanse LLE wound with NS [normal saline] and apply calcium alginate cut to fit with ABD [abdominal dressing] and Kerlix with QD [every day] and PRN [as needed] soiled or compromised. Arterial/venous dopplers ordered. Resident to continue on Doxycycline 100mg [milligram] BID [two times a day] until 12/12/24 and Florastor 250mg BID until 12/15/24. Wound culture obtained by primary nurse. (continued on next page)

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	12/13/2024

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/10/24 at 9:15 AM, R51 was sitting on the side of her bed. LPN3 assisted her to a laying position. LPN3 did not wear a gown when she helped her. LPN1 then performed a dressing change to R51's left lower extremity, which had two open areas. LPN1 did not wear any PPE other than gloves. During an interview on 12/10/24 at 9:45 AM, LPN1 and LPN3 stated EBP only had to be followed for residents with pressure ulcers, sores with drainage, wounds with antibiotic resistant organisms, feeding tubes, and urinary catheters. They stated since R51's wound was not draining anymore; they did not have to follow EBP. They agreed she was receiving both oral and IV antibiotics due to the cellulitis on her leg and had drainage the day before which the CRNP wrote a strong IV antibiotic for. 31145 3)On 12/13/24 at 11:50 AM a tour of the facility was conducted and the following infection control concerns were observed. In the shared bathroom for rooms [ROOM NUMBERS] there was a urinal sitting on the grab bar behind the toilet that was not labeled. The resident in room [ROOM NUMBER] was on enhanced barrier precautions at the time. In the shared bathroom for rooms [ROOM NUMBERS] there was a urinal sitting on the bar behind the toilet that was not labeled. The resident in room [ROOM NUMBER] was on enhanced barrier precautions at the time. In room [ROOM NUMBER] where females resided, there was a urinal on the bar behind the toilet that was not labeled. There was a soiled washcloth lying on the sink. There was a toothbrush and tube of toothpaste that was sticking out of a roll of toilet paper that was sitting on the shelf in the bathroom. In the shared bathroom for rooms [ROOM NUMBERS] there was toilet paper sitting on the grab bar across from the toilet. The toilet paper holder on the wall was broken off the wall. There was a urinal sitting on the grab bar that was not labeled or stored correctly. In the shared bathrooms for 120 and 122 there was toilet paper in the holder and another roll of toilet paper sitting on top of the roll. There were soiled towels sitting on the sink. On 12/12/24 at 1:40 PM an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). They were informed of the observations. The DON stated they did not have a policy for the storage of bedpans and urinals.