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	03/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined that the facility failed to provide necessary respiratory care services. This was evident for 5 (Residents #102, #33, #22, #8 and #136) of 6 residents reviewed for respiratory care during the recertification survey. The findings include: Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. A nasal cannula is a thin, flexible tube that delivers O2 through the nose. A humidifier in O2 therapy is a device that adds moisture to dry, concentrated O2 to prevent drying and irritation of a patient's nasal passages, throat, and lungs. These humidifiers typically consist of a bottle filled with water that attaches to an O2 concentrator. On 3/09/2026, during the initial tour of the facility, the following were observed: At 6:11 AM, an unlabeled O2 tubing for Resident #102. At 6:17 AM, a humidifier bottle on the floor, an O2 tubing left on top of the nightstand without any protective bag and no Oxygen in Use sign posted outside Resident #33's room. At 6:25 AM, an unlabeled 02 tubing and humidifier bottle, no Oxygen in Use sign posted outside Resident #22's room. At 6:36 AM, an unlabeled 02 tubing of Resident #8. At 6:41 AM, no Oxygen in Use sign posted outside Resident # 136's room. On 03/11/2026 at 9:40 AM, during an interview with Staff #16, he/she confirmed that when caring for residents on O2 therapy, it was expected that nurses would label the O2 tubing and mask based on facility's policy and should be stored inside a clean plastic bag when not in use. On 3/11/2026 at 9:59 AM, the Director of Nursing (DON) was notified of the concern and acknowledged the findings. On 3/12/2026 at 8:35 AM, a review of the facility's Oxygen Administration policy reviewed on 1/20/26 confirmed the following:- Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.- Oxygen warning signs must be placed on the door of the residents' room where oxygen is in use.- Cleaning and care of equipment shall be in accordance with facility policies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Sterling Care Bel Air		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on a review of employee files and interviews with facility staff, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) demonstrated competency in essential skills and techniques prior to providing resident care. This deficiency was identified in 4 out of 4 of the newly hired GNA employee charts (Staff #23, #24, #25, and #26) reviewed during the recertification/complaint survey.The findings include:The American Nurses Association defines nursing competence as an expected level of performance that integrates knowledge, skills, abilities, and judgment.On 3/10/26 at 9:52 AM, the surveyor requested employee files for four randomly selected GNAs. A review of these records confirmed that Staff #23 was hired in March 2025, Staff #24 and #25 were hired in October 2025, and Staff #26 was hired in January 2026. However, none of the files contained competency records to verify that their skills were assessed before providing care to residents.During an interview with Staff #11 (Educator) on 3/10/26 at 12:35 PM, she stated that the facility provided education to newly hired nursing department staff, including both nurses and aides. Upon reviewing Staff #23's file with the surveyor, the Educator verified there were no skill verifications or evaluations for GNAs upon hire. Staff #11 stated, I do nurses' skill checklists, but not for aides.In an interview with the Nursing Home Administrator (NHA) on 3/10/26 at 1:03 PM, the surveyor shared the above concerns. The NHA stated, The facility gave a checklist to new hires; they just didn't return them. The NHA acknowledged that there was no supportive evidence to prove the competencies of newly hired GNAs had been completed.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure residents were properly evaluated for decision-making capacity, specifically failing to document the rationale for incapacity, and failed to ensure a resident either had an Advance Directive or was offered the forms to create one. This was evident for 4(#4, #147, #30, and #157) residents out of the 7 reviewed for Advance Directives during the recertification/complaint survey. The findings include:A physician's certification of decision-making capacity confirms whether a patient can understand their medical situation, appreciate the consequences of their choices, use reasoning, and communicate a treatment preference. Under specific legal standards, such as Maryland law, a certification of incapacity requires the signatures of two physicians (one being the attending physician) and must include a documented reason for the incapacity to ensure the process remains consistent with patient rights. 1) A review of Resident #147's medical record on 3/09/26 at 9:10 AM revealed a Brief Interview for Mental Status (BIMS) score of 6 on 1/28/26, indicating severe cognitive impairment. Although two physicians completed the certification of decision-making capacity on 1/27/26 and 1/28/26 marking the resident as unable to make decisions, neither physician documented a diagnosis or specific rationale for the incapacity. 2) A review of Resident #4's medical record on 3/09/26 at 9:36 AM revealed a Medical Orders for Life-Sustaining Treatment (MOLST) form completed on 1/09/26 as Full Code per the patient's surrogate. A review of the physician certification forms found that while one form (dated 1/09/26) listed dementia as the reason for incapacity, the second required form (also dated 1/09/26) lacked any diagnosis or rationale. During an interview on 3/11/26 at 7:52 AM, Staff #19 (Social Worker) stated that all newly admitted residents are required to be evaluated for decision-making capacity. She noted that physicians are expected to complete the certification form with a diagnosis or reason, which social workers then review. Upon reviewing the forms for Resident #4 and #147 with the surveyor, Staff #19 validated the concerns, acknowledging that the documentation should have included the diagnosis or reasons for incapacity. 3) A review of Resident # 30's medical record on 3/09/2026 at 12:03 PM revealed that resident was admitted on [DATE] and had a Brief Interview for Mental Status (BIMS) of 05 indicating severe cognitive impairment. Further review of the medical record on 03/09/2026 at 12:15 PM, noted 2 signed copies of physician certifications related to medical condition, substitute decision making and treatment limitations forms, dated 10/15/2025 and 10/17/2025, indicating that resident is unable to comprehend information and make decisions based on examination. However, there was no documented diagnosis or specific rationale for the resident being incapable of comprehending information and or making decisions. During an interview on 3/11/26 at 7:52 AM, Staff #19 (Social Worker) stated that all newly admitted residents are required to be evaluated for decision-making capacity. She noted that physicians are expected to complete the certification form with a diagnosis or reason, which social workers then (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review. The surveyor reviewed the form with staff #19, who validated the concern that the documentation on the forms should have included the diagnosis or reasons for any incapacity. 4) A review of Resident #157's clinical record on 3/10/26 at 10:04 AM revealed that a copy of the resident's Advance Directive, if it existed, was not in the clinical record. A review of the social worker notes revealed that the social worker did not ask the resident if they had one or offered an Advance Directive to complete. The Director of Social Services (Staff #19) was interviewed on 3/12/26 at 8:42 AM. She confirmed that there wasn't a note showing that she asked the resident if they had an Advance Directive or had provided the resident with a copy to be completed later. She replied that the section had not been completed yet. This surveyor stated that the resident had been in the facility almost two weeks and that it should have been completed on admission. She acknowledged that she should have asked if the resident had an Advance Directive or offered if they did not. The Administrator was in the room during the interview.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record reviews, and interviews, it was determined that the facility failed to provide adequate privacy to the resident by exposing their body parts. This was evident for 1 (Resident #136) of 1 resident sampled for privacy during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. On 3/09/2026 at 8:40 AM, Resident #136 was observed with incontinent brief and blanket pulled down, and the privacy curtain was pulled all the way to the wall, making the resident's mid to lower body visible to visitors and staff. Staff #6 was immediately notified. On 3/10/2026 at 12:54 PM, a review of Resident #136's medical records revealed a BIMS (Brief Interview for Mental Status) score of 11.0 which indicated moderately impaired cognition. Further review of the medical records indicated the following:-admission MDS Section GG (Functional Assessment)with an Assessment Reference Date (ARD) 2/4/2026, Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.-A Care Plan initiated on 1/29/2026, Activities of Daily Living (ADL) self-care performance deficit related to disease process. Resident #136 will receive the appropriate staff support with (bed mobility, transfers, eating, dressing, toilet use, personal hygiene, through next review. Dressing: The resident is able to: one person assist On 3/11/2026 at 9:34 AM, Staff #17 confirmed that staff were expected to provide privacy to the residents. On 3/11/2026 at 9:59 AM, the Director of Nursing (DON) was notified of the concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record reviews, and interviews, it was determined that the facility failed to develop and implement comprehensive care plans for oxygen therapy. This was evident for 3 (Residents #22, #8 and #136) of 31 residents reviewed for care planning during the recertification survey.The findings include: A care plan is a guide that addresses the unique needs of each Resident. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. The care plan consists of focus, goal and interventions. Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. On 3/9/2026 between 6:25 AM and 6:41 AM, Residents #22, #8 and #136 were observed using O2 via nasal cannula.On 3/11/2026 at 9:10 AM, a review of the active physician orders confirmed the following:-Resident # 22- O2 continuous at 2 liters via nasal cannula (NC) every shift.-Resident #8- O2 at 2 liters via NC continuous every shift for oxygen supplement.-Resident #136- O2 continuous at 2 liters via NC every shift. However, a review of the medical records revealed no evidence that care plans have been initiated or implemented to address the use of O2 therapy for Residents #22, #8 and #136. On 3/11/2026 at 9:40 AM, Staff #16 confirmed that care plans were initiated by the nurse supervisors on admission. It is then reviewed and completed by the Unit Managers (UM) the following day. On 3/12/2026 at 8:35 AM, the Nursing Home Administrator (NHA) provided copies of oxygen care plans for Resident #22, #8, and #136 which were only initiated on 3/12/26 after surveyor intervention. The facility's O2 Administration Policy revised on 1/20/26 confirmed that The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. On 3/12/2026 9:11 AM, the Director of Nursing (DON) was notified of these findings.

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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. Based on observation, interview and record review, it was determined that the facility failed to provide necessary personal hygiene to dependent resident. This was evident for 1 (Resident #136) of 1 resident reviewed for Activities of Daily Living (ADLs) during the recertification survey.The findings include:ADL care is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. On 3/09/2026 at 8:37 AM, during the initial tour of the facility, Resident #136 was observed with fingernails extending approximately half an inch beyond fingertips. Resident #136 stated he/she had repeatedly requested nail trimming from the staff without success.On 3/10/2026 at 12:39 PM, a medical record review of an admission MDS with an Assessment Reference Date (ARD) of 2/4/26 revealed that Resident #136 had a functional status of partial/moderate assistance for personal hygiene. (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort). Resident #136's care plan initiated on 1/29/26 also confirmed one person assist for personal hygiene.On 3/11/2026 at 9:33 AM, a follow-up visit confirmed that Resident #136 still had long fingernails.On 3/11/2026 at 9:40 AM, Staff #17 and Staff #16 confirmed that staff and Geriatric Nurse Assistants (GNA) were expected to provide nail care as part of regular ADL assistance.On 3/11/2026 at 9:59 AM, the Director of Nursing was notified of the concern and at 10:22 AM, the DON confirmed that Resident #136's fingernails had been trimmed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, clinical record review, resident interview, and staff interview it was determined that the facility failed to 1) follow a physician's order to turn and position a dependent resident and 2) failed to administer medications on time. This was evident for 1 (Resident #102) out of 1 resident reviewed for turning and positioning and for 1 (Resident #2) out of 2 residents reviewed for pain medication during the recertification/complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. 1) On 3/09/2026 at 6:11 AM, Resident #102 was observed sleeping on his/her left side and slanted leaning with head pushed against the left side rail. On 3/09/2026 at 8:34AM and 9:46 AM, during the follow-up visits, Resident #102 remained in the same position with his/her head against the left side rail and feet on the right side of the bed. On 3/11/2026 at 9:03 AM, a review of Resident #102's care plan confirmed the following: Activity of daily living self-care performance deficit related to activity intolerance, fatigue, limited Mobility, shortness of breath and morbidly obese. (initiated 2/12/2026) Bed Mobility: The resident is totally dependent on (2) staff for repositioning and turning bed as necessary. (initiated 2/12/2026) Further review of Resident #102's medical records revealed an admission MDS section GG (Functional Assessment)with an Assessment Reference Date (ARD) of 2/17/2026 that indicated: Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. An order also confirmed, Turning and Repositioning every 2 hours and as needed (PRN) as tolerated every shift. Although the Treatment Administration Record (TAR) was signed by nursing staff indicating this was performed, the observations on 3/09/2026 contradict these records. On 3/11/2026 at 9:34 AM, Staff #17 and #16 confirmed that dependent residents should be assisted with repositioning every 2 hours and as needed. On 3/11/2026 at 9:59 AM, the Director of Nursing (DON) was notified of these concerns. 2) Resident #2 was interviewed on 3/09/26 at 12:12 PM. The resident stated that their pain medication was often late. Resident said the pain medications often come every 10 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #2's clinical record revealed that the resident's primary physician ordered Acetaminophen 500 mg two tablets by mouth two times a day for pain. The resident was scheduled to be administered the medication at 8:00 AM and 8:00 PM. A review of the resident's Medication Admin Audit Reports for February and March of 2026 on 3/12/26 at 11:27 AM revealed that the resident received the ordered medication late on these dates: 2/3/26 at 9:16 PM, 2/4/26 at 9:56 AM, 2/5/26 at 9:34 AM, 2/9/26 at 10:02 AM, 2/11/26 at 10:19 AM, 2/13/26 at 9:32 AM, 2/14/26 at 11:32 AM, 2/15/26 at 10:01 AM, 2/16/26 at 9:35 AM, 2/16/26 at 9:19 PM, 2/19/26 at 9:41 AM, 2/20/26 at 10:18 AM, 2/21/26 at 9:49 AM, 2/22/26 10:44 AM, 2/23/26 at 9:54 AM, 2/24/26 at 9:54 AM, 2/26/26 at 10:31 AM, 1/26/26 at 9:33 PM, 2/27/26 at 9:51 AM, 2/28/26 at 9:39 AM, 2/28/26 at 9:33 PM, 3/2/26 at 10:00 AM, 3/3/26 at 9:42 AM, 3/4/26 at 9:30 AM, 3/6/26 at 9:58 AM, 3/7/26 at 9:43 AM, 3/9/26 at 9:44 AM, 3/10/26 at 9:28 AM, 3/11/26 at 9:16 AM, and 3/12/26 at 9:46 AM. The Director of Nursing (DON) was interviewed on 3/12/26 at 11:16 PM. She was shown the ordered times as well as the times the medications were administered. She confirmed that the medications were administered late.

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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. Based on observation and staff interviews, it was determined that the facility failed to consistently monitor and document the temperatures of its medication refrigerators. This deficiency was identified in two medication refrigerators of two temperature logs reviewed during the recertification/complaint survey.The findings include:During an observation of the medication storage room on 3/10/26 at 7:05 AM, conducted with Staff #6 (Night Shift Supervisor), two refrigerators were identified: one for residents' prescribed antibiotics and another for the Pyxis (emergency medication storage). A review of the temperature logs for these refrigerators revealed the following omissions:-Pyxis Refrigerator Log: The log requires the recording of the exact time (AM/PM) along with staff initials for twice-daily checks. However, the log lacked staff initials for the period of 3/03/26 through 3/06/26. Additionally, only one temperature was documented per day during this period, despite the requirement for both AM and PM checks.-Prescribed Medication Refrigerator Log: This log lacked staff initials from 3/01/26 through the AM of 3/09/26. Furthermore, only a single checkmark was recorded for the dates of 3/07/26 through 3/09/26, failing to meet the twice-daily monitoring requirement.During the observation, Staff #6 validated the findings, acknowledging that the temperature logs were not appropriately completed or maintained.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to 1) ensure that residents' names were accurately displayed at their room entrances, 2) failed to perform an accurate oral assessment, and 3) failed to ensure a resident's clinical records were in their most accurate form and free of another resident's information. This was evident for 2 residents (#39 and #57) out of a sample of 141 residents reviewed for room identification, and 2 (#64 and #157) residents out of 43 residents reviewed as part of the survey sample. The findings include:1) During an initial tour of the facility on 3/09/26 at 6:10 AM, the surveyor observed that each resident's room had a nameplate posted on the wall using the designations D (Door side) and/or W (Window side). The posting for room [ROOM NUMBER] displayed: W – [Resident #39] D – [Resident #57] On 3/09/26 at 7:50 AM, Resident #39—who was physically located on the door side of room [ROOM NUMBER]—verbally confirmed their identity to the surveyor. During an interview on 3/09/26 at 7:55 AM, Staff #22 (Licensed Practical Nurse) confirmed that D indicates the door side and W indicates the window side. Upon reviewing the nameplates for room [ROOM NUMBER], Staff #22 stated, Oh. it should be changed. Resident #39 is inside [door side] and Resident #57 is on the window side. On 3/09/26 at 8:02 AM, the surveyor observed Staff #4 (Registered Nurse) performing vital signs for Resident #57 and documenting them on a paper labeled 306B. Staff #4 stated that she relies on the wall-mounted nameplates to identify residents. In an interview with Staff #5 on 3/09/26 at 8:05 AM, she stated that when assigned to unfamiliar residents, she relies on other staff, the residents themselves, and the nameplates outside the rooms for identification. During an exit interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 3/12/26 at 2:10 PM, the surveyor presented these findings. Both the NHA and DON validated the concerns, acknowledging the identification errors. 2) During the survey screening process on 3/9/2026 at 8:33 AM, the surveyor asked Resident #64 if she/he had any dental complaints. The Resident stated that she/he had dentures in the drawer, and that the bottom denture hurt at times. The surveyor noted that the Resident did not have any teeth in his/her mouth. A medical record review on 03/11/2026 at 9:20 AM for Resident #64, revealed the following oral assessments on 10/23/25 and 1/24/2026: Does Resident have dentures? No; Does Resident have upper dentures? No; Does Resident have lower dentures? No; Does Resident have natural teeth? Yes. On 03/11/2026 at 1:35 PM, an interview was conducted with the DON, who explained that the nursing staff performed quarterly oral evaluations, and if the resident complained about dental pain, they will (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Sterling Care Bel Air		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be added to a list to be seen by National Preventive Solutions (NPS), an outsourced dental company. The surveyor requested a copy of the most recent dental visit report for Resident # 64. On 03/11/2026 at 1:43 PM, the DON provided the NPS dental hygiene encounter form dated 10/9/2025 for Services Performed: D9410- skilled nursing facility visit; D1110 -Hygiene prophylaxis; D5899- Denture Prophylaxis: Complete Maxillary Denture and D5899- Complete Mandibular Denture. Notes: Deliver tooth brush and toothpaste for individual use and Deliver denture case and cleansing tablets. On 3/12/2026 at 09:30 AM, a follow up interview was conducted with the DON to share the concern of staff inaccurate documentation of oral / dental assessment resulting in inaccurate information in the resident's medical record. The DON agreed with the concern and had nothing further to add. 3) During the initial screening of the facility residents, Resident #157 was interviewed on 3/9/26 at 1:26 PM and asked if they had been invited to their care plan meetings. Resident #157 alleged that they had not been invited to any care plan meetings. The clinical record was reviewed and evidence of attendance was found. Further review revealed that the resident's care plans included a care plan with another resident's name on it. The Director of Nursing (DON) was interviewed on 3/11/26 at 2:14 PM. She was shown the care plan with another resident's name on it. She said she would investigate. The DON was interviewed on 3/11/26 at 2:25 PM. She said Resident #157 does not have a CPAP (Continuous Positive Airway Pressure) machine and the goal was for another resident. She then said she thought the person who developed the goals probably had multiple computer screens up and wrote on the wrong resident's clinical record. She said she removed the care plan belonging to another resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and staff interview, it was determined that the facility failed to use appropriate infection control practices for 1) the use and care of oxygen administration equipment and 2) urinary catheter maintenance and 3) failed to ensure that resident food stored in the nourishment room was properly dated to minimize the potential spread of infection. This was evident for 3 (Residents #33, #8, #133) of 31 residents reviewed for infection control practices during the recertification/complaint survey. The findings include: Oxygen (O2) therapy is a treatment that provides a person with extra O2 to breathe in. It is also called supplemental O2. A nasal cannula is a thin, flexible tube that delivers O2 through the nose. A humidifier in O2 therapy is a device that adds moisture to dry, concentrated O2 to prevent drying and irritation of a patient's nasal passages, throat, and lungs. These humidifiers typically consist of a bottle filled with water that attaches to an O2 concentrator. A urinary catheter drainage bag is a sterile, soft plastic container that connects to a catheter to collect urine. 1) On 3/9/2026 at 6:17 AM, during the initial tour of the facility, the surveyor observed a humidifier bottle on the floor and an O2 tubing left on top of the nightstand without any protective bag in Resident #33's room. The surveyor immediately informed Staff #6. On 03/11/2026 at 9:40 AM, during an interview with Staff #16, he/she confirmed per facility policy, O2 tubing should be labeled and stored in a clean plastic bag when not in use. 2) On 3/09/2026 at 9:04 AM, the surveyor observed Resident #8's catheter drainage bag lying on the floor. On 3/11/2026 at 9:59 AM, the Director of Nursing (DON) was notified of these concerns and acknowledged the findings. On 3/12/2026 at 9:31 AM, Resident #8's catheter drainage bag was again observed lying on the floor. On 3/12/2026 at 11:49 AM, Staff #11 confirmed that infection prevention and control education is being provided to all the staff. He/she also stated that nursing staff must ensure that the foley catheter bags should be off the floor and below the level of the bladder to prevent backflow. Oxygen tubing or any respiratory equipment on the other hand should be changed based on facility policy and placed in bags when not in use. 3) During a tour of the medication storage rooms on 3/10/26 at 7:05 AM, conducted with Staff #6 (Night Shift Supervisor), it was noted that the facility utilizes two separate storage rooms. Staff #6 stated that one room is used for medication storage and the other for tube feeding materials, referred to as the nourishment room. An observation of the nourishment room refrigerator revealed a plastic bag labeled with Resident #133's name with room [ROOM NUMBER]; however, the bag lacked a documented date of entry or opening. Also, the record review on 3/10/26 at 9:00 AM revealed that Resident #133 was not in room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[ROOM NUMBER]. At the time of the observation, Staff #6 validated the concern, acknowledging that the residents' food did not have a date on it. During a meeting with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 3/11/26 at 2:10 PM, the surveyor shared the findings. Both the NHA and DON validated their concerns.