STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215194	A. Building B. Wing	08/14/2024

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

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observations and interviews it was determined that the facility failed to allow the residents on Unit 300 move freely throughout the facility as evidenced by the unit being locked and requiring a code to enter and exit. This deficient practice was discovered during the survey. The findings include: On 08/07/24 at 10:20 am the surveyor entered Unit #300 which required a code to gain entry onto the unit. Unit #300 is primarily used for residents who require rehabilitations services. On 08/07/24 at 10:37 am the surveyor asked Registered Nurse (RN) Unit Manager #35 why the unit was locked. RN Unit Manager #35 verbalized a resident on the unit was an elopement risk but was easily redirected. The resident's family and visitors receive the codes at the front desk. On 08/07/24 at 11:00 am while the surveyor was interviewing Resident #49 in their room, Geriatric Nursing Assistant (GNA) #34 knocked on the resident's door. Upon entry GNA#34 proceeded to give the resident a piece of paper with the code to enter and exit the unit. When asked does the residents have the code to enter and exit the unit, GNA#34 verbalized the staff usually give the code to the family members and some of the residents who go to the dining room have the code. The surveyor asked Resident #49 did they have the codes to the unit. Resident #34 responded, I've never had the code before. On 08/07/24 at 11:34 am during an interview with Resident #60 the surveyor asked if he/she had the codes to enter and exit the unit. Resident #60 verbalized not having the codes.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on resident interview, record review, and staff interviews, it was determined that the facility failed to address and/or follow up on an ophthalmologist's recommendation. This was evident for 1 (Resident #31) of 5 resident's reviewed for vision. The findings include: On 08/06/24 at 10:37 AM, an interview was conducted with Resident #31. The resident stated they needed their eyes checked. The resident stated, my last appointment was January, and nothing has been done about my cataracts. They said I was going to need surgery. On observation the resident was not wearing glasses and glasses were not at bedside. On 8/07/24 at 9:23 AM, Resident #31's medical record was reviewed. There was an order for an Optometrist consult placed on 10/19/2023. On 08/08/24 at 10:10 AM, an interview was conducted with the Unit Manager (Staff #24) for Unit 1. When asked about who schedules the specialty appointments for the residents, Staff #24 stated, I do. When asked about how often the residents see the specialists, Staff #24 stated, The specialists come to the facility at least once a month or see the residents as needed. When asked who updates the resident's care plans, Staff #24 stated, I do. On 08/08/24 at 10:24 AM, Resident #31's last Optometrist appointment consult form was reviewed. The Optometrist appointment was dated 4/18/2024 and stated, No improvement with refraction. Refer for cataract surgery consult. Referred to ophthalmologist. On 08/08/24 at 11:03 AM, an interview was conducted with Staff #24. When asked if there was an Ophthalmologist consult appointment made for Resident #31, Staff #24 states that attempts to schedule an appointment have been made but there were issues with the resident's insurance. On 08/08/24 at 2:30 PM, an interview was conducted with the business manager (Staff #16). When asked whether Resident #31 would have issues scheduling an Ophthalmologist appointment, Staff #16 stated that the resident has no insurance issues that would prevent scheduling an ophthalmologist appointment. On 08/09/24 at 09:40 AM, Staff #24 was interviewed. When asked if there was any progress on scheduling an Ophthalmologist appointment for Resident #31, Staff #24 stated an ophthalmologist appointment has been scheduled for Resident # 31. This Surveyor requested a copy of confirmation for the appointment. On 08/09/24 at 09:57 AM, a copy of the ophthalmologist appointment confirmation was provided to this surveyor and a review of Resident #31's orders were conducted. An order for an Ophthalmologist appointment on 8/27/24 was placed on 8/9/2024 at 9:42 AM.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined the facility failed to maintain facility equipment in good repair and provide a clean homelike environment. This was evident for 2 resident's rooms out of 8 resident rooms reviewed during the survey. The findings include: During observation rounds on 08/06/24 at 9:22 AM in residents' room [ROOM NUMBER] there was a heating and air-conditioning unit not working, with a wet black substance noted on the inside of the unit's grill, the unit's cover was falling off and there was a musty odor permeating throughout the room. During observation rounds on 08/06/24 at 9:25 AM in residents' room [ROOM NUMBER] bathroom, there was approximately a 1-inch layer of dry gray/white substance located on the inside of the air duct vent opening. The bathroom sink was also noted to be detached from the wall. During observation rounds on 08/06/24 at 9:48 AM in residents' room [ROOM NUMBER] there was a heating and air-conditioning unit leaking water onto the floor, there was a musty odor permeating throughout the residents' room, and a large hole approximately 1x1 foot in size noted in the wall adjacent to the heating and air-conditioning unit on the left-hand side. During observation rounds and an interview on 08/06/24 at 10:36 AM with Maintenance Technician staff #4 confirmed observations found by this surveyor and stated that resident's room [ROOM NUMBER] heating and air-conditioning unit would be fixed, the bathroom air duct vent would be cleaned, and the bathroom sink would be repaired. Staff #4 also stated that residents' room [ROOM NUMBER] heating and air-conditioner unit and wall would be fixed. During observation rounds and interview on 08/13/24 at 12:10 PM with Unit Manager staff #35 in residents' room [ROOM NUMBER] the heating and air-conditioning unit was leaking water onto the floor, there was a musty odor permeating throughout the room and the hole in the wall had not been fixed. In residents' room [ROOM NUMBER] there was still a wet black substance noted on the inside of the heating and air-conditioner grill, there still was a musty odor permeating throughout the room and the bathroom air duct vent still had approximately a 1- inch layer of dry gray/white substance located on the inside of the air duct vent opening. Staff #35 confirmed these observations and stated that she would notify the Maintenance Technician right away.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observations, and interviews, the facility failed to provide supervision to a cognitively impaired resident with known elopement risk and exit-seeking behavior from exiting the building unsupervised. This was evident for 1 of 12 residents reviewed for elopement during the survey. This failure resulted in an Immediate Jeopardy for Resident #82. The facility implemented effective and thorough corrective measures following the incident. The facility's plan of correction and actions were verified during the survey; therefore, this deficiency will be cited as past non-compliance. The date of correction was 07.21.22. The facility administrator and director of nursing were provided a copy of the past compliance IJ documentation and both employees signed and dated the documents at 3:15 PM on 08.14.24. The findings include: On 08.08.24 at 10:15 AM the surveyor reviewed MD00181562 which revealed that on 07.21.22 Resident #82 was found approximately 800 feet from the facility at approximately 12:10 AM -12:15 AM at the Royal Farms gas station. Resident #82 was returned to the unit on the second floor by the 11 PM-7 AM nursing supervisor, Registered Nurse (RN) # 28. The resident's wander guard was still in place on the resident's wrist per the facility report, the resident was examined, and the wanderguard was found to be working. Further review of the facility investigations and medical records revealed that on 07.21.22 Resident #82 described as 72 y.o. with a primary diagnosis of dementia with behavioral disturbance, hypertension, and unspecified atrial fibrillation, and a Brief Interview for Mental Status (BIMS) score of 0 on 07.21.22, indicating severe cognitive impairment. The resident was placed on a wander guard because of wandering behavior on 05.22.22, the elopement risk assessment was high on 06.20.22 due to the resident having poor decision-making skills, exit-seeking behavior, wandering, being oblivious to safety needs, and the resident had the ability to exit the facility. Additionally, resident #82's care plan was updated as well. Continued record review revealed that on 07.20.22 resident #82 was seen at approximately 11:35 PM at the second-floor Nurses' station. Also, on 07.20.22 at 11:45 PM, the resident was seen by the soda machine in the hallway on the second-floor clinical area. Geriatric Nursing Assistant (GNA) #27 in her staff interview stated that he/she coached the resident to come back onto the unit. Per GNA #27 the resident continued to follow the GNA until right before the nurses' station. Resident #82 stopped at the nurses' station and started talking to himself. GNA #27 stated that he/she left the resident at the nurses' station to answer the call lights in the hallway. Per the facility report the police were called at 12 midnight. Resident #82 received a head-to-toe assessment by the night shift RN supervisor, #28 and the 11 PM-7 AM licensed practical nurse (LPN) #29 on 07.21.22 after 12:30 AM. No physical or psychological injuries or trauma were noted by nursing staff on 07.21.22 during the time. At the time of the elopement, there was no wanderguard alarm on the kitchen exit door on 07.20.22. According to the facility investigation, the resident exited through the kitchen exit door which was left open after a contractor cleaning the stove hoods left the door open. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08.09.24 at 11:00 AM the surveyor initiated an interview with the assistant director of nursing (ADON). The ADON stated that the wander guard bracelet was in place as of 05.17.22 related to the resident's history of wandering and exit-seeking prior to the resident eloping. The resident's care plan for the wanderguard was initiated on 05.17.22 as well. The ADON stated that contracted workers were cleaning the kitchen hoods shortly before the elopement and the staff believed that the contractors left the kitchen door unlocked. The kitchen exterior door had a fire safety door with a push handle in July 2022 therefore, the resident pushed the handle and was able to exit outside of the building without an alarm sounding. The wander guard alarm box was not in place at the time of the elopement. The kitchen is located on the second floor as well as Resident #82's assigned room both in July 2022 and at the time of the survey. On 08.13.24 at 2:49 PM the surveyor watched the ADON test the wanderguard on the left wrist of the resident #82. The wander guard worked when the resident was pushed in the wheelchair towards the kitchen door and the wander guard did beep appropriately. On 08.13.24 at 3:15 PM, the administrator and DON explained that the resident was ambulatory in 2022 but now his/her physical strength has declined and is only able to ambulate for short distances. Additionally, the ADON stated that on 07.22.22 the 11 PM -7 AM supervisor received a phone call from the manager at the local Royal Farms gas station stating the resident was there. The 11 PM-7 AM nursing supervisor picked up the resident and brought him back to the nursing home per the ADON 's statement. The 11 PM-7 AM nursing supervisor is no longer an employee of the facility. Also, the ADON stated that she could provide a copy of the root cause analysis and quality assurance performance improvement (QAPI) project that was conducted. The QAPI project notebook was reviewed by surveyor and the staffing assignments were matched against the staff interviews included in the facility report. The detailed list of initiatives and staff in-services were reviewed by the surveyor as well and were initiated on 07.21.22 and provided instructions to the staff regarding elopement risks, reporting of elopement as the prevention of elopement of residents. The facility initiated a sign-in and out sheet process for staff to sign when entering and exiting the kitchen door. On 08.14.24 at 08:27 AM the surveyor spoke with GNA # 27 via telephone, who stated that on 07.21.22 she was informed that Resident # 82 had eloped to the nearby gas station. GNA # 27 stated that elopement occurred approximately 30 minutes after she/he had observed Resident #82, who was fully dressed sitting beside the soda machine on 07.20.22 at 11:45 PM. No further episodes of elopement have occurred related to elopement since 2022. The facility failed to provide ongoing supervision, to address a resident who was known to have exit-seeking/elopement behaviors resulting in Resident #82 eloping from the facility. On 08.13.24 at 3:15 PM the administrator and DON explained the post elopement interventions undertaken by the facility and root cause analysis. The ADON and DON provided the surveyor with a copy of the investigation, the immediate actions taken post the elopement, and the interventions taken to prevent any further elopements: 1. The resident #82's wander guard bracelet was checked and found functional upon his return to the facility on 07.21.22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. A thorough physical examination and psychological assessment performed by the registered nurse and the social worker on 07.21.22 found the resident with physical injuries and was still cognitively impaired with a BIMS of 0. 3. Immediately after the incident occurred all doors were checked in the facility by the RN supervisor for 3-11 PM and the nurses on the 11 PM-7 AM shift on 07.21.22. 4. The ADON who was covering for the DON (who was on vacation) was notified at 12:28 P.M on 07.21.22. 5. The ADON performed an audit of the elopement risk book, elopement assessments, wander guards to ensure placement and function, wander guard orders and elopement care plans to ensure the documents were updated on 07.21.22. 6. An elopement drill was performed at the facility to ensure all residents were in the facility on 07.21.22. 7. An assessment of the kitchen door was performed again by the administrator and the maintenance director on 07.21.22. 8. The plan of correction was initiated, and staff education was initiated regarding the kitchen staff signing off in the evening that the kitchen door is locked on 07.21.22. 9. On 07.21.22 a statement signed by the Maintenance Director stated that he educated the vendors on the new policy related to ensuring the kitchen doors remain locked while the vendors are working on kitchen projects. The requirement to have a facility maintenance staff member present during the evening hours when the contracted vendors are present. 10. On 07.29.22 the magnetic lock and the wander guard alarm were installed on the exterior kitchen door. 11. Elopement drills to be conducted on 7-3, 3-11, and 11-7 shifts by 07.22.22 and then quarterly. After surveyor review it was determined the facility corrected the deficiency practice by 07.21.22 prior to the start of the survey, therefore the deficiency will be cited as past non-compliance with a correction date of 7. 21.22

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on record review and interviews it was determined that the facility staff failed to ensure the assignment sheets were completed daily on Unit 300 and failed to reserve the posted daily nursing staff data for a minimum of 18 months. This deficient practice was discovered during the survey. The findings include: On 08/07/24 at 11:50 am the surveyor asked Geriatric Nursing Assistant #34 for a copy of the assignment sheets dated 08/02/24 - 08/07/24 all shifts. The surveyor reviewed the staffing sheets which revealed the written copy of the schedule for the dates 08/02/24 11pm-7 am, 08/03/24 & 08/04/24 all shifts, 08/05/24 11pm-7am, and 08/06/24 11pm- 7 am were not available. During an interview with RN Unit Manager #35 on 08/07/24 at 11:54 am the surveyor reported some of the assignment sheets were missing. RN Unit Manager #34 verbalized the staff are expected to complete the assignment sheets daily for all shifts. On 08/14/24 at 2:03 pm during an interview with Assistant Director of Nursing #5 they verbalized the assignment should be completed every shift. After one month they are removed from the book on the unit and stored monthly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview with facility staff, it was determined that the facility failed to store food in accordance with professional standards for food service safety. This was found to be evident during the facility's survey and has the potential to affect all residents eating food prepared in the facility's kitchen. The findings include: During the initial tour of the kitchen conducted on 08/06/2024 at 8:35 AM with the dietary aide staff #13 accompanying the surveyors. Inside of the stand-alone refrigerator was a large bowl of croutons with a date-in of 06/13/24 and a date-out of 06/19/24. The dietary aide staff #13 immediately removed it after confirming that it should have been out of the refrigerator. During a continued tour of the kitchen on the same day at 08:40 AM, inside the walk-in freezer, the following items were observed, a small bag of sugar cookies was opened, 5 large bags of pancakes and 3 bags of French toast. There was no date label on any of the items observed. The dietary aide staff #13 stated that the items should have been dated and she removed the items immediately. All concerns were discussed with the administration team at the time of exit on 08/14/2024 at 05:00 PM.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews with resident and facility staff, it was determined that the facility failed to ensure that repairs were made, as needed, in the resident's room. This was evident for 1 resident (Resident# 32) out of 66 resident's rooms observed during the facility's survey. The findings include: During an observation of Resident #32's room on 08/06/24 at 11:37 AM, surveyors observed a large area of the baseboard (approximately 25 feet) located at the head of the resident's bed was totally separated from the wall with broken pieces of dry walls noted. In addition, observation of the resident's bathroom sink was noted to have a large area of separation along the width of the sink, between the sink and the corresponding wall, that was in need of caulking. During an interview with the resident at that time, he/she stated that some repairs were done but after a flood in the hallway some time ago, the wall located at the head of the bed shifted. The resident also stated that personal shoes and bags were placed in a plastic bag while on the floor. On 08/07/24 at 12:24 PM during a walk through with the Administrator staff #1 the surveyors showed him the observations made in Resident' #32's room and bathroom. He stated that the repairs would be made immediately. A follow-up observation was made to Resident #32's room on 08/14/2024 at 08:10 AM and repairs were observed in progress. All concerns were discussed with the administration team at the time of exit on 08/14/2024 at 05:00 PM.