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	215187	A. Building B. Wing	03/06/2025

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Sterling Care Bethesda	5721 Grosvenor Lane Bethesda, MD 20814

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51490 Based on observations, staff and resident interviews, and record reviews, it was determined that the facility failed to treat a resident with dignity by not: 1) ensuring that Resident #429's foley drainage bag was covered; and 2) promoting an environment that enhances the quality of life. This was evident for 2 (Resident #429 and Resident #97) of 17 residents reviewed during the survey. The findings include: A foley drainage bag, or urinary drainage bag, is a medical device used to collect urine from a catheterized resident. The drainage bag is usually worn on the leg or attached to a bed. 1) During observation rounds on 2/27/25 at 10:12 am, Resident #429 was noted to have a foley catheter bag attached to his/her bed. The foley drainage bag was uncovered and contained yellow liquid. The bag was attached to the side of the bed facing the door. Resident #429's door was open, and the foley drainage bag was visible from the hallway. On 2/27/24 at 1:58 pm, the surveyor interviewed the Nursing Home Administrator (NHA). He stated that the expectation was that all foley catheters have a foley bag cover in place and he would make sure the resident had a privacy bag. 51899 2) During observation rounds on 2/27/2025 at 9:00 am, the surveyor observed Resident #97 lying in bed on his/her left side. The residents' bed was located closest to the entrance to the room. During this observation the resident was noted with a dressing to his/her lower extremities dated 2/26/25 (7-3pm shift). The dressings were exposed to the hallway where it could be seen by other residents and visitors. On 2/27/25 at 9:15 AM, this observation was relayed to RN Staff #6. He stated that someone would take care of it. 03/3/25 at 10:25 AM, during observation rounds Resident #97 was noted again lying in bed on his/her left side with his/her lower extremity dressing exposed to the hallway. The GNA (Geriatric Nursing Assistant) staff # 27 was made aware and she put a sheet over the resident lower extremities. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the resident on 3/3/25 at 10:40am, s/he stated that the staff never cover his/her feet and everyone can see them. 3/3/25 at 12:30 PM, this surveyor spoke with the Director of Nursing (DON) and the Administrator regarding the resident concern, they both stated the issue would be resolved. 3/4/25 at 10am during a follow up interview with the DON she stated that she spoke with the resident and all GNA's and the Charge Nurse on the unit have been in-serviced regarding the resident concern and she is certain the issue will be resolved.

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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. 51788 Based on resident record reviews and staff interviews, it was determined that the facility failed to provide residents and/or the resident's representative with an opportunity to formulate an advanced directive. This was evident for 3 (Residents #169, #85, and #173) out of 9 residents reviewed during the survey. The findings include: On 02/28/25 at 09:46 AM, Resident #169's medical record was reviewed. The medical record review revealed that Resident #169 did not have an advanced directive in place. On 02/28/25 at 10:18 AM, Resident #85's medical record was reviewed. The medical record review revealed that Resident #85 did not have an advanced directive in place. On 02/28/25 at 10:33 AM, Resident #173's medical record was reviewed. The medical record review revealed that Resident #173 did not have an advanced directive in place. On 02/28/25 at 10:38 AM, the Director of Social Services #3 was interviewed. During the interview, the Director of Social Services #3 stated that Residents #169, #85, and #173 do not have an advanced directive in place. Also, the Director of Social Services #3 stated that there were no progress notes indicating that Residents #169, #85, and #173 and/or the resident's representative were presented with an opportunity to complete an advance directive.

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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. 51712 Based on observations and staff interviews, it was determined that the facility failed to provide a clean, safe, homelike environment. This was evident for 8 (Residents #51, #85, #94, #154, #90, #478, #109, and #117) out of 183 residents observed during the survey. The findings include: 1. On 2/27/25 at 8:34 AM, the surveyor observed Resident #90's room. Marring and scraping were noted on the wall behind the resident's bed. There was a large spackled area of approximately 50% of the wall that required painting. 2. On 2/27/25 at 8:37 AM, the surveyor observed Resident #117's room. There was scraping noted on the wall behind the resident's bed. 3. On 2/27/25 at 12:07 PM, the surveyor observed that Resident #478's room was dirty. The floor was dirty with food and trash around the bedside. The resident was unable to reach the trash can because it was too far away. 4. On 2/27/25 at 12:45 PM, during an interview with Resident #109, the resident reported that the faucet in the bathroom was loose and not secure. The resident further stated that the baseboard was separated from the wall. At this time the resident showed the surveyors the faucet in the bathroom that was not secured and the baseboard that was separated from the wall. On 2/27/25 at 2:00 PM, an interview was conducted with the Administrator and DON, and they were made aware of all concerns. Another observation was made on 3/4/25 at 12:30 PM, and the repairs were made to Resident #90, Resident #109, and Resident #117's rooms. Resident #478's room was clean and free of trash. The resident's trash can was also placed closer to the bedside for the resident. On 3/6/25 at 1:45 PM, an interview was conducted with the Administrator, and it was he stated that the facility is in the process of creating a maintenance prevention program. He stated that the program will help to address all areas of concern and ensure that all of the residents' rooms will be inspected, and repairs will be completed. 51788 5. On 2/27/25 at 7:48 AM, during observation rounds, Resident #51's bathroom had a dried rust colored substance around the base of the toilet, a dried brown substance on the toilet seat, and a broken toilet paper holder. 6. On 2/27/25 at 7:56 AM, during observation rounds, Resident #94 had two cups of a clear yellow substance, which had a strong ammonia, urine-like odor, located by the resident's bed on the bedroom floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 7:57 AM, Unit Manager #22 was interviewed. During the interview, Unit Manager #22 was told about the two cups of a clear yellow substance in resident #94's room. After surveyor intervention, Unit Manager #22 immediately discarded the two cups of a clear yellow substance in resident #94's room. 7. On 2/27/25 at 8:04 AM, during observation rounds, Resident #85's bathroom had a dried rust colored substance around the base of the toilet, and ceiling tiles with a dried, light brown substance on them. 8. On 2/27/25 at 8:17 AM, during observation rounds, Resident #154's bathroom had a dried rust colored substance around the base of the toilet and a dried brown substance on the wall near the toilet paper holder. On 02/27/25 at 12:52 PM, the Nursing Home Administrator #1 and the Director of Nursing #2 were interviewed. During the interview, the Nursing Home Administrator #1 and the Director of Nursing #2 were made aware of the observations that were made in Residents' #51, #94, #85 and #154 rooms.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 51788 Based on resident family interviews and facility record reviews, it was determined that the facility failed to prevent residents from being physically abused. This was evident for 1 (Residents #85) out of 20 residents reviewed during the survey. The findings include: On 02/27/25 at 08:04 AM, the surveyor attempted to interview Resident #85. During the interview, the resident was non-verbal when asked questions regarding his/her stay at the facility and questions about the Facility Reported Intake MD00208175. On 02/27/25 at 10:27 AM, the resident ' s medical record was reviewed. The resident medical record review revealed that Resident #85 had a medical diagnosis of Alzheimer ' s Disease and schizophrenia. On 02/28/25 at 10:53 AM, Resident #85's daughter was interviewed. During the interview, Resident #85's daughter stated that Resident #85 was physically assaulted by a facility staff member in July 2024. On 03/03/25 at 09:36 AM, the facility's records were reviewed. The facility record review revealed that the facility's initial Facility Reported Incident and the follow-up Facility Reported Incident (MD00208175) indicated that, on 07/26/24 at 02:45 PM, the Business Office Director #23 and the Admission Director #26 observed Geriatric Nursing Assistant #27 hit Resident #85 with small, gray bag. The facility's follow-up Facility Reported Incident indicated that after the facility conducted an investigation, the facility substantiated the allegations of abuse against Resident #85 and on 7/26/24 Resident #85 was assessed and showed no signs of pain and trauma, skin discoloration or psychological trauma. Also, facility's follow-up Facility Reported Incident indicated that Nursing Assistant #27 was suspended pending the investigation and was terminated after the investigation, and on 8/5/24, the facility submitted a complaint to the Maryland Board of Nursing regarding Geriatric Nursing Assistant #27.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 51899 Based on observation and record review, it was determined that the facility nursing staff failed to follow professional standards of practice when administering medications to (resident #110 and #30). This was evident during observation of medication administration. The findings include: 1) On 3/4/25 at 8:30 AM, the surveyor observed that Resident #110 refused Lidocaine Patch as ordered by the physician during medication administration. Following the medication administration observation, a review of Resident #110's March 2025 medication administration record (MAR) showed that the lidocaine patch for Resident #110 was documented as given and not refused. 2) On 3/4/25 at 8:44 AM, the surveyor observed Nurse #21 preparing 11 tablets in a medicine cup to be administered to Resident #30. Nurse #21 stated that Zinc 220mg was unavailable and could not be given to Resident #30. Following the medication administration observation, a review of Resident #30's March 2025 medication administration record (MAR) showed that Nurse #21 had documented that the resident received the Zinc. The review also contained documentation by nurse #21 that Fluocinonide Ointment was given at 9:00 AM, Protein Liquid was given at 9:00 AM, Refresh Tear drops were given at 9:00 AM, and Ocusoft lid Scrub was given at 9:00 AM. However, the surveyor did not observe Nurse #21 administering any of the these medications. The review failed to show documentation in the MAR by Nurse #21 that Resident #30's medication was unavailable with date, initials, and time. Failure to do this resulted in inaccurate documentation. During an interview on 3/4/25 at 1:25 PM, Nurse #21 confirmed that even though she signed the medications given, Resident #110 refused the Lidocaine Patch and Resident #30's Zinc, Fluocinonide ointment, protein liquid, refresh teardrops, and Ocusoft lid scrub were not given. The Administrator, DON and the ADON were made aware of the findings on 3/4/25 at 2pm. The DON stated the issue was being investigated and Nurse #21 has been placed on suspension until she could be evaluated for possible further training.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42863 Based on resident and staff interviews, medical and administrative record reviews, and observations it was determined that the facility failed to address a resident's request for removal of a feeding tube. This was evident for 1 (#142) out of 4 residents reviewed for nutrition during the survey. The findings include: Tube feeding is a way to provide nutrition when you cannot eat or drink safely by mouth. There are risks associated with residents using feeding tubes for nutrition. These risks include aspiration (accidentally inhaling your stomach contents), accidental dislodgement (tube moving out of place or coming out), bleeding and perforation (hole in the wall of your bowel or intestine), infection near the site, pain, and stomach leakage to name some. Appropriate treatment and services are required to prevent complications of enteral feeding. On 02.27.25 at 09:15 AM while making clinical unit rounds the surveyor observed that Resident #142 had a feeding tube in place. Resident #142 informed the surveyor that the feeding tube was not being used for nutrition currently. The resident stated that the staff flush the tube every shift and push was water through the tube for hydration. Also, the resident stated that he/she had been eating a regular diet with nectar thick drinks since December 2024. The Resident stated that he/she has been waiting for 3 months to have the percutaneous enteral gastric (PEG) feeding tube removed and had informed the facility staff. The surveyor observed that the resident had three containers of water and juice on his/her over the bed tray and the resident stated that staff provide fresh water to him throughout the day for him/her to drink by mouth. On 02.27.25 at 10:42 AM the surveyor informed the administrator and the director of nursing (DON) that resident #142 stated that he/she had been waiting for three months to have his/her feeding tube removed. Additionally, the resident stated that he/she had informed the clinical staff of his preference to have the feeding tube since he had been tolerating a regular diet since December 2024. A review of the electronic medical record on 03.04.25 at 09:15 AM revealed that the resident had received speech therapy for pharyngeal swallowing exercise between the dates of 12.27.24 through 01.22.24 with positive results. Also, the Resident had a modified barium swallow study (MBSS) performed which showed the resident was diagnosed as having decreased evidence of silent regurgitation of thin liquids in December 2024 and recommended a repeat MBSS be performed within two months. The review of the electronic medical record failed to reveal that the third recommended MBSS was scheduled by the facility to determine if the resident would a be safe candidate for the feeding tube removal. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03.04.25 at 1:30 PM the surveyor reviewed the nutritional assessment performed by the staff # 34 on 02.28.25. The nutritional assessment stated that Resident #142 had a history of dysphagia and malnutrition. On 02.28.25 staff #34 documented in the nutritional assessment that the resident reported eating well by mouth, more than 51 %, wanted the feeding tube removed and that the resident was on a hydration program of 480 ml every shift. The system review on the same document indicated under Section C. System Review, #4. Swallow Ability: no impairment. Staff # 34 wrote in the nutritional assessment that the DON and administrator had been notified of the resident's desire to have the feeding tube removed. On 03.06.25 at 1:35PM the surveyor interviewed Resident #142 in his/her room while he/she was finishing his lunch. The resident stated that the facility staff had not discussed a date/time for the swallowing study. Also, the resident stated that he/she was ready to have the feeding tube removed, it was depressing, frustrating, and he/she had not experienced any episodes of aspiration and was tolerating the regular diet and was taking medications by mouth. On 03.06.25 at 2:40 PM the DON provided the surveyor with a copy of the progress note dated 03.05.25 at 12:10PM which stated that staff # 28, speech therapist documented having a conversation with Veterans Administration (VA) staff # 29, SLP requesting that the MBSS be scheduled at the VA hospital based on the resident tolerating a regular diet and thickened liquids in order to determined if Resident #142 is eligible for the feeding tube removal/percutaneous enteral gastric tube (PEG) removal. Also staff #28 documented that she would follow up with the resident once the MBSS was completed. Additionally, Resident #142 would continue to receive the regular diet with nectar thickened liquids. The DON also provided the surveyor with a copy of an email from staff # 30, VA liaison dated 03.06.25 at 3:17 PM that the MBSS was scheduled for 03.14.25. The deficient practice related to the delay in scheduling of the MBSS for resident #195 was reviewed with the administrator and the DON prior to the exit conference on 03.06.25

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51899 Based on observations, medical record review, and interviews, it was determined that the facility staff failed to maintain a medication error rate of less than 5 percent. This was evident for 6 out of 29 opportunities observed for medication errors. The findings Include: 1) During medication observation on 3/4/25 at 8:05 AM for Resident #61, the surveyor observed LPN (Nurse Practical Nurse) Nurse#21 preparing the resident's insulin injection. Nurse #21 filled an empty insulin syringe with 30 units of insulin injection from a prefilled insulin pen. Nurse #21 went into Resident #61's room to give him/her the insulin injection. The surveyor questioned the nurse about how many units of insulin were to be given to the resident per the attending provider's order, and she reported 24 units of insulin. Due to the surveyor's intervention, nurse #21 discarded 6 units of insulin from the syringe and administered 24 units. 2) Continued observation for Nurse #21 on 3/4/25 at 8:30 AM, the surveyor observed that Resident #110 refused Lidocaine Patch as ordered by the physician during medication administration. After the medication observation was completed, Resident #110's March 2025 medication administration record (MAR) was reviewed. The review showed that the lidocaine patch for Resident #110 was documented as given and not refused. 3) On 3/4/25 at 8:44 AM, the surveyor observed nurse #21 prepare 11 tablets in a medicine cup to be administered to Resident #30. Nurse #21 stated that Zinc 220mg was unavailable and, therefore, could not be given to Resident #30. However, after the medication administration, a review of Resident #30's March 2024 MAR showed that nurse #21 had documented that the resident received the Zinc. The review also contained documentation by nurse #21 that Fluocinonide Ointment was given at 9:00 AM, Protein Liquid was given at 9:00 AM, Refresh Tear drops were given at 9:00 AM, and Ocusoft lid Scrub was given at 9:00 AM. However, the surveyor did not observe Nurse #21 administer any of the medications mentioned. During an interview on 3/4/25 at 1:25 PM, nurse #21 confirmed that even though she signed the medications given, Resident #110 refused the Lidocaine Patch and Resident #30 Zinc, Fluocinonide ointment, protein liquid, refresh teardrops, and Ocusoft lid scrub were not given. Nurse #21 also confirmed that 24 units of insulin were given after surveyor intervention. She stated that she has only been a nurse for one year. The Administrator, DON and the ADON were made aware of the findings on 3/4/25 at 2pm. The DON stated the issue was being investigated and nurse #21 had been placed on suspension until she could be evaluated for possible further training.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 51899 Based on observation, interview with facility staff and medical record review, it was determined that the facility staff failed for a significant medication error for an Insulin Dependent resident. This was evident during the review of 1 of 1 resident (Resident #61) reviewed during survey process. The Findings Include: During medication administration on 3/4/25 at 8:05 AM for Resident #61, the surveyor observed nurse #21 preparing the resident's insulin injection. Nurse#21 filled an empty insulin syringe with 30 units of insulin injection from a prefilled insulin pen. Nurse #21 went into Resident #61's room to give him/her the insulin injection. The surveyor questioned the nurse about how many units of insulin were to be given to the resident per the attending provider's order, and she reported 24 units of insulin. Due to the surveyor's intervention, nurse #21 discarded 6 units of insulin from the syringe and administered 24 units. Review of Resident #61's medication administration record (MAR) March 2025 on 3/4/25 at 10:30AM, revealed an order for a Basaglar Tempo insulin Pen inject 24 units subcutaneously at 9:00am for Diabetes. During an interview on 3/4/25 at 1:25 PM, Nurse #21 also confirmed that 24 units of insulin were given after surveyor intervention. She stated that she has only been a nurse for one year. The Administrator, DON and the ADON were made aware of the findings on 3/4/25 at 2pm. The DON stated the issue was being investigated and nurse #21 has been placed on suspension until she could be evaluated for possible further training.

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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. 51899 Based on observation and staff interviews, it was determined that the facility failed to properly store medications, as evidenced by failing to discard expired medications. This was evident for 1 of 3 medication storage rooms observed during the survey. The findings include: An observation of the Potomac Unit medication storage room on 2/27/25 at 8:00 AM with LPN (Licensed Practical Nurse) #21 present revealed 2 bags of Intravenous drugs with expiration dates of 9/1/24, a COVID self-test kit with an expiration date of 12/20/2023, and an Insulin injection pen with an expiration date of 8/1/24. During an interview on 2/27/25 at 8:45 AM, the assistant director of nursing (ADON) said that she expected the staff to dispose of expired medications. The expired medications were removed at that time by ADON.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51490 Based on observations and resident and staff interview, it was determined that the facility failed to provide food and drink that accommodates the resident intolerances. This was found to be evident for 1 of 1 resident (Resident #100) selected for review. The findings include: On 02/27/25 at 08:29 am during the initial observation of the unit, an interview with Resident #100 revealed that s/he is lactose intolerant and is supposed to get lactose free milk with meals. Review of the menu sheet for this resident showed Lactaid milk - 8oz, however S/he was given 2% milk which was not what was marked on his/her menu sheet. Resident #100 stated that often times the milk is incorrect. On 02/27/25 at 08:32 am GNA (Geriatric Nursing Aide) #20 was made aware of the resident receiving the incorrect milk. On 02/28/25 at 09:11 am a follow-up interview was conducted with Resident #100 and they stated the staff brought no milk this date and the milk choice on the menu sheet was crossed out. This was verified on the menu sheet by the surveyor observation. On 03/05/25 at 01:39 PM an interview with the Dietary Manager was conducted and when asked about the issue of Resident #100 not receiving lactose free milk he stated it may have been a supply issue and he will make sure the resident receives the correct milk in the future.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Bethesda	5721 Grosvenor Lane Bethesda, MD 20814

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 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. 51788 Based on observations and staff interviews, it was determined that the facility failed to provide a sanitary, comfortable environment for residents, staff and public. This was evident for 1 unit out of 5 units observed during the survey. The findings include: On 2/27/25 at 7:48 AM, during observation rounds, there was a strong, ammonia urine-like odor throughout the hallways and residents' rooms on the [NAME] Unit. On 2/27/25 at 7:52 AM, Unit Manager #22 was interviewed. During the interview, Unit Manager #22 stated and agreed to the strong ammonia, urine-like odor throughout the hallways and residents' rooms on the [NAME] Unit. On 02/27/25 at 12:52 PM, the Nursing Home Administrator #1 and the Director of Nursing #2 were interviewed. During the interview, the Nursing Home Administrator #1 and the Director of Nursing #2 were made aware of the strong ammonia, urine-like odor observed throughout the hallways and residents' rooms on the [NAME] Unit. On 3/05/25 at 1:00 PM, during observation rounds, there was still a strong ammonia, urine-like odor throughout the hallways and residents' rooms on the [NAME] Unit. On 2/27/25 at 7:52 AM, Unit Manager #22 was interviewed. During the interview, the Unit Manager #22 stated that the facility was working on the odor and agreed that the hallways still had a strong ammonia, urine-like odor. On 3/05/25 at 1:30 PM, the Nursing Home Administrator #1 was interviewed. During the interview, the Nursing Home Administrator #1 was made aware that a strong ammonia, urine-like odor was still present throughout the hallways and residents' rooms on the [NAME] Unit.