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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interviews and record reviews, it was determined that the facility failed to accommodate a dependent resident's needs by not ensuring the resident's motorized wheelchair was in working condition. This was evident for 1(Resident #156) of 1 resident reviewed for reasonable accommodation of needs during the annual survey.The findings include:Resident #156 whose diagnoses include Quadriplegia, Contracture of the lower legs and Contracture of the left elbow and wrist, was admitted to the facility in 2014.On 4/20/26 at 11:10 AM in an interview Resident #156 stated that their customized motorized wheelchair had been broken for several months, and the facility neither repaired nor provided a substitute motorized wheelchair. As a result, the resident was unable to move around in the facility.The surveyor interviewed the Director of Rehab on 4/21/26 at 2:10 PM. She stated that the wheelchair had been broken since last year. On 09/26/25, the vendor submitted invoices totaling $441.34 for the repairs. However, the facility did not pay the invoices, which resulted in the wheelchair remaining inoperable.On 4/22/26 at 8:30 AM, the Director of Nursing (DON) stated that the facility did not repair the wheelchair because the resident's condition had declined, and the resident was no longer capable of operating a motorized wheelchair.A review of the resident's clinical record on 4/22/26 at 1:00 PM revealed Resident #156 was assessed by Rehab on 4/13/26 and deemed on that date to be incapable of using a motorized wheelchair. The clinical records did not reveal that the resident was incapable of using a motorized wheelchair prior to 4/13/26.On 04/22/26 at 2:15 PM, the Director of Rehab stated that she also checked the clinical records and confirmed the surveyor's findings. Further, the surveyor noted Resident #156's motorized wheelchair had been broken since 09/26/25. The clinical record also lacked documentation to indicate that the facility provided a substitute motorized wheelchair during the inoperable period.On 04/27/26 at 7:26 AM, the surveyor notified the DON of the findings.

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 record review and interviews, it was determined that the facility failed to ensure that the Responsible Party (RP) and/or legal guardian was notified of changes in a resident's condition. This was evident for 2 of 3 changes of conditions reviewed for (Resident #6). The findings include: On 4/20/26 at 11:04 AM, the surveyor reviewed Resident #6's medical record. The review revealed that Resident #6 was unable to make medical decisions and had a legal guardian established in 2004. Next the surveyor conducted a phone interview with Resident #6's guardian and established the guardian was involved in Resident #6's care planning. On 4/21/26 at 10:22 AM, the surveyor reviewed Resident #6's change of conditions dated 8/20/25, 11/6/25 and 12/15/25. Only on the 8/20/25 change of condition was Resident #6 guardian documented as notified. On 4/21/26 at 11:44 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed the legal guardian should have been called and updated on the change of conditions. At the time of exit no additional information was provided to explain why Resident #6's legal guardian was not notified of the change of condition on 11/6/25 and 12/15/25.

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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 interviews, it was determined that the facility failed to ensure a safe, clean, comfortable and homelike environment. This was evident for 2 (Chesapeake and Gateway) out of 5 units, rooms (240 and 252) and 1 of 1 driveway observed during the annual survey. The findings include: Adequate lighting means levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform. 1) On 04/20/26 at 7:05 AM, a flickering light was observed in the hallway by the conference room leading to the Chesapeake unit. The hallway was frequented by residents who traveled to other units, the dining room and the activity room. There was another flickering light observed in a common room at the end of the hall on the unit. When the surveyor arrived at the unit, the floor was in poor condition. The floor was scattered with debris and trash, and a sticky residue was present in multiple areas. On 04/20/26 at 7:17 AM, the surveyor found the bathroom in room [ROOM NUMBER] unkempt. The trash can was filled, toilet tissue was on the floor, the toilet had a brown substance smeared around the toilet seat, and the bathroom sink had black and brown stains in it. On 04/20/26 at 7:59 AM, the surveyor observed an uncovered food item that was left by a window sill in room [ROOM NUMBER]. Additionally, there were yellow stains on the floor by bed B. On 04/20/26 at 8:04 AM, Resident #8 stated that the rooms are not kept clean. 2) On 04/20/26 at 8:10 AM, a flickering light was observed above the nursing station on the Gateway unit, which made the hallway appear dim. On 04/20/26 at 8:30 AM, the Administrator acknowledged the concerns. 3) On 04/20/26 at 9:41 AM, during initial rounds, Resident #65 stated they used their motorized wheelchair independently to leave the facility and enjoy community activities. However, several potholes scattered the facility's driveway, creating a danger for residents who used wheelchairs. They reported the issue to the Administrator and the Ombudsman over a month ago. Further, on 04/20/26 at 11:31 AM, the Ombudsman gave the surveyor a copy of an email dated 03/23/26 to the Administrator, outlining the dangers of the potholes. The surveyor observed several potholes on the long driveway leading to the main road on 04/20/26 and 04/21/26, noting residents struggling to navigate them. In an interview on 04/21/26 at 11:58 AM the Administrator confirmed the complaints and stated that he had obtained invoices from two contractors for the repairs of the potholes. However, he was advised to wait until after the winter, when it will be warmer, to proceed with the repairs. The surveyor observed the facility did not temporarily fill the potholes, thus failing to address the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risks they presented. The residents continued to use the driveway despite the potential danger of the potholes' presence. The facility staff filled in the potholes on 04/21/26 after the surveyor intervened.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record reviews and interviews, it was determined that the facility failed to document the reason for hospital transfer and discharge. This deficient practice was evident for two (Resident #195, Resident #197) residents reviewed for inappropriate discharge during the annual survey.The findings include:1. A review of Resident #195's medical records on 04/22/2026, revealed the resident was admitted to the facility in January 2026. Further review indicated the resident was transferred to the emergency department on 02/20/2026, however, there was no physician note documenting the reason for the transfer. Additional review showed the resident was discharged from the facility on 02/21/2026; however, the medical record lacked physician documentation summarizing the resident's clinical course and care provided. On 04/23/2026 at 9:42 AM, during an interview, the Director of Nursing (DON) #2 explained the facility's transfer and discharge process. She stated; for planned discharges, the physician documents a discharge summary note; however, for residents who are transferred to the hospital and do not return to the facility, the physician does not complete a discharge summary note.On 04/27/2026, the DON #2 followed up with the surveyor and repeated that the physician does not complete a transfer note or discharge note for residents transferred to the hospital for further evaluation and treatment. The DON #2 provided a physician discharge summary note dated 04/27/2026 for Resident #195. 2. On 04/20/2026 at approximately 8:00 AM, the surveyor observed that Resident #197 was not present in their room during the initial unit tour. Review of the medical record failed to include documentation of the resident's whereabouts. Upon inquiry, the Registered Nurse (RN) #25 stated that the resident had been transferred to the hospital earlier that day. A progress note entered at 10:19 AM documented the resident's transfer to the emergency department. A follow-up note at 12:30 PM indicated staff contacted the hospital and were informed the resident had been admitted due to a change in mental status.On 04/27/2026, a review of Resident #197's medical record revealed the resident was discharged from the facility on 04/20/2026; however, records lacked physician documentation supporting the basis for discharge. At the time of exit, the DON #2 was unable to provide a physician discharge summary.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews, and interviews, it was determined that the facility failed to provide the resident's responsible party (RP) with a written bed hold notice upon hospital transfer. This deficient practice was evident for one (Resident #195) of two residents reviewed for discharge process during the annual survey.The findings include:A review of Resident #195's medical records on 04/22/2026, revealed the resident was transferred to the emergency department on 02/20/2026. Further review indicated the resident's RP was notified of the transfer and verbalized understanding of the bed hold policy; however, the records failed to show evidence that a written copy of the bed hold notice was provided.During an interview on 04/23/26 at 7:54 AM, the Assistant Director of Nursing (ADON) #19 stated that when a resident has a change in medical condition requiring a transfer to the hospital, the assigned nurse completes a bed hold notice and transfer notice at that time. If the RP is not present at the time of transfer, a copy is sent to them. The surveyor requested documentation to confirm that Resident #195's RP was provided with a written bed hold notice.On 04/23/2026, the facility failed to provide evidence that a written bed hold notice was provided to the resident's RP. At 9:42 AM, the surveyor informed the DON of this concern, and she acknowledged the information.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, it was determined that the facility failed to accurately document a Minimum Data Set (MDS) assessment in a Resident's medical record. This was found evident of 2 (Resident #23 & #6) of 51 residents reviewed in the survey. The findings include:1) During the surveyors review of Resident #23's MDS assessment on 04/23/2026 at 9:06 AM, no documentation was found of a fall with major injury on the MDS assessments for section J1900 Number of Falls Since Admission/Reentry. On 04/23/2026 at 9:44 AM, the MDS coordinator confirmed that the Fall with Major Injury was not documented in the MDS and a correction would be submitted right away. The Director of Nursing and the Administrator acknowledged the concern on 4/23/2026 at 9:45 AM, stating the correction would be made. 2) On 4/20/26 at 11:04 AM, the surveyor reviewed Resident #6's medical record. The review revealed that Resident #6 had an Minimum Data Set (MDS) assessment (section N Medications) completed on 1/27/26 and documented that Resident #6 had 7 days of insulin injection during the time frame listed. On 4/21/26 at 10:22 AM, the surveyor reviewed Resident #6's orders. The review revealed that Resident #6 did not have insulin ordered during this time period. On 4/21/26 at 12:24 PM, the surveyor conducted an interview with the Minimum Data Set Coordinator (MDS) #5. During the interview the MDS #5 confirmed that Resident #6 was not on insulin and the assessment dated [DATE] was coded incorrectly. He further stated that he would modify and correct the assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, it was determined that facility staff failed to ensure a resident's responsible party (RP) received a written summary of the resident's baseline care plan. This deficient practice was evident for one resident (Resident #123) reviewed for baseline care plans during the annual survey.The findings include:A review of Resident #123's medical records on 04/21/2026 at 8:02 AM, revealed the resident was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy and cognitive communication deficient. The resident's family member was identified as the RP. Further review of the medical records failed to show evidence that the facility provided the RP with a written summary of the resident's baseline care plan.On 04/21/2026 at 10:04 AM, during an interview, the Social Worker (SW) #14, stated for residents who lack cognitive capacity, baseline care plans are conducted with the resident's RP and that these meetings are documented in residents' records. The surveyor informed the social worker that a review of the resident's electronic and paper medical records failed to show evidence that a baseline care plan was conducted with the RP and that the RP received a written summary of the baseline care plan. The surveyor requested documentation indicating the baseline care plan meeting was completed with the RP and that a written summary was provided. On 04/22/2026 at 9:55 AM, the SW#14 acknowledged that he failed to document a progress note indicating that a baseline care plan meeting was conducted with the resident's RP and failed to maintain evidence that a written summary of the baseline care plan was provided to the RP.

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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 interviews and record review, the facility failed to develop and implement a comprehensive care plan to meet the needs of a Resident. This was evident for 1 (Resident #6) out of 1 resident reviewed for hospice care during the survey.The findings include:On 4/21/26 at 9:48 AM, the surveyor reviewed Resident #6's medical record. The review revealed that Resident #6 had an order for hospice services dated 10/28/25.On further review the surveyor noted Resident #6 had a facility care plan that stated, Resident #6 received hospice services with an interventions to have hospice services provide visits to assist with care needs and additionally for the facility to work cooperatively with the hospice team to ensure Resident #6 ?s spiritual, emotional, intellectual, physical and social needs were met. On 4/21/26 at 12:50 PM, the surveyor requested all hospice service documentation. Next the surveyor reviewed a joint care plan from the hospice provider and the facility dated 10/24/25. The care plan outlined that both hospice providers and the facility would be responsible for symptom control, medication regimen, skin integrity, bladder/bowel function, personal hygiene, feeding, disease progression, psychosocial support, and spiritual care. However, it was identified that hospice would provide bathing 2 times per week and the facility 5 times. And for feeding, again, it was written that hospice would provide 2 times per week and the facility 5 times. On 2/22/26 at 10:19 AM, the surveyor conducted an interview with Social Service Assistant (SSA) #14. During the interview the SSA#14 stated that the previous Social Service Director may have been more familiar with Resident #6's hospice care but he could validate that he saw the hospice nurse in the facility once a week and was not sure about other supportive hospice staff.On 3/23/26 at 10:17 AM, the surveyor conducted a phone interview with a nurse from the hospice service, Staff #24. During the interview Staff #24 stated the Resident did not receive Geriatric Nursing Assistant (GNA) services of bathing and feeding. She stated that the care plan created was not accurate for the care Resident #6 received. At the time of exit, the facility was made aware that the cares written in the joint hospice and facility care plan were not implemented or corrected if not appropriate for Resident #6.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review and interviews, it was determined that the facility failed to hold care plan meetings with the interdisciplinary team for a resident at the time of the quarterly and annual revision of their care plans, and also failed to invite the resident/responsible party to these meetings. This was evident for 1 (Resident #114) of 8 residents reviewed for care planning during the survey.The findings include:On 04/21/26 at 7:30 AM, the surveyor reviewed Resident #114's clinical record. The review revealed that Resident #114's quarterly MDS assessment was completed on 1/19/26 and an annual assessment was completed on 10/19/25. The clinical record contained no evidence that the interdisciplinary team held a care plan meeting with the resident/responsible party within 7 days or around the time of either the last quarterly or annual MDS assessment. Furthermore, there was no evidence to indicate that the facility staff invited the resident/responsible party to the meetings.On 04/23/2026 at 8:17 AM, Social Worker Designee #14 (SWD) reviewed Resident #114's clinical record during an interview and confirmed the surveyor's findings. SWD #14 stated that he would further review the clinical record and provide the surveyor with copies of the record.On 04/23/2026 at 1:10 PM, SWD #14 gave the surveyor copies of the documentation of the care plan meetings held for Resident #114 for the past 9 months. The documents confirmed the surveyor's findings.On 04/27/2026 at 7:32 AM the Director of Nursing was notified.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interviews and record reviews, it was determined the facility failed to ensure a resident who required assistance with activities of daily living (ADLs) received scheduled showers. This deficient practice was evident for one resident (#133) reviewed for ADL care during the annual survey.The findings include: During an interview on 04/20/2026 at 12:44 PM, Resident #133 stated they are scheduled to receive showers on Tuesday s and Friday and reported they did not receive a scheduled shower on Friday 04/17/2026.On 04/21/2026, a review of the resident's electronic medical record revealed documentation indicating the resident did not receive a shower on 04/17/2026.During an interview at 12:58 PM, the Unit Manager (UM) #8 stated staff are required to document showers in the electronic medical record and in the shower book. Review of the shower book showed a shower on 04/14/2026, but no entry for 04/17/2026. The surveyor informed the UM #8 of the lack of documentation. The UM #8 stated the resident is capable of reporting shower receipt and acknowledged the resident likely did not receive a shower as scheduled.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, medical record review, and interviews, it was determined that the facility staff failed to provide appropriate care measures to prevent complications from a hand contracture. This was evident for 1 (Resident #7) of 2 residents reviewed for mobility. The findings include:A contracture is an abnormal shortening of muscle, tendons, skin, or tissues, causing resistance to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand.On 4/20/26 at 10:07 AM, the surveyor conducted an interview with Resident #7. During the interview, Resident #7 stated that he/she had a splint for his/her left hand but only used it occasionally. Resident #7 further stated that he/she sometimes needed help putting the split on. The surveyor noted that the splint was not on the Resident.On 4/22/26 at 8:16 AM, the surveyor observed that the splint was not on Resident #7 and asked if anyone had offered to put the splint on. Resident #7 answered no.Next, the surveyor reviewed Resident #7's Occupational Therapy (OT) notes from 11/11/25. The note stated that Resident #7's long term goal of wearing the left resting hand splint was for 8 hours per day to decrease the risk of further contracture and discomfort. At the time of Occupational Therapy (OT) discharge, Resident #7 tolerated the splint for 4 hours.On further review, there was no order or Treatment Administration Record (TAR) for Resident #7's left hand splint.On 4/22/26 at 12:50 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview, the surveyor asked how the staff communicated the need for Resident #7's left-hand splint. She stated that she would look into the concern. On 4/22/26 at 2:03 PM, the surveyor interviewed the Functional Maintenance Assistant Staff #26 along with the DON. During the interview, Staff #26 stated that Resident #7 was on the functional maintenance daily schedule. She further stated that she utilizes the schedule to address the splinting needs at the facility. The surveyor reviewed the log provided. It was noted that the functional maintenance date for Resident #7 started on 11/11/25. Every weekend except 2 (1/10/26 & 2/22/26) was left blank in 5 months of logs. The surveyor reviewed the concern that Resident #7 was not offered the splint daily to prevent further contracture as recommended by OT.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, it was determined the facility failed to follow professional standards of practice when administering intermittent intravenous (IV) antibiotic infusions. This was found to be evident in 1 (#200) out of 1 resident observed for intravenous access care. The findings include:On 4/20/2026 at 9:15 AM, Resident #200 told the surveyor that his IV antibiotics were discontinued on Friday but his IV line was still in his left upper arm. Resident #200 showed the surveyor the IV line. The surveyor observed bloody fluid in the IV tube and on the bandage that was dated 4/10/2026.On 04/20/2026 at 9:22 AM, Registered Nurse #3 told the surveyor the IV should have been removed when the antibiotics were finished. When asked how often the dressing should be changed, she responded it should be changed every 7 days, verified that the current dressing had been on for 10 days, and stated she would remove the IV now.The Director of Nursing acknowledged the concern on 04/21/2026 at 11:58 AM.

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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. Based on record review and interviews, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards for accuracy. This was found evident in 4 (Resident #138, #6, #4, & #8) of 51 residents reviewed during the survey. The findings include:1) On 4/20/26 at 9:41 AM, the surveyor conducted an interview with Resident #138. During the interview Resident #138 stated that he/she was admitted to the hospital due to a Urinary Tract Infection (UTI). On 4/22/26 at 9:43 AM, the surveyor reviewed Resident #138's medical record. The review revealed that Resident #138 was hospitalized in August of 2025. The discharge summary from that hospital stay recommended that Resident #138 be followed up by Urology. On further review of the medical record, it was noted that there was no urology consultation notes present. On 4/22/26 at 9:45 AM, the surveyor requested the urology consultation notes for Resident #138. On 4/22/26 at 1:41 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that the facility did not have the consultation notes but that she reached out to the provider to obtain them. The surveyor reviewed the concern that if the consultation recommends a change to the plan of care and the facility does not have the consultation results, there was a risk the resident wouldn't get the care that was recommended. On review of the urology consultation note dated 2/11/26 the urology consultant recommended obtaining a kidney and bladder ultrasound. The surveyor requested the results of the ultrasound as they were not in the medical record either. On 4/23/26 at 9:27 AM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated she was still waiting to obtain the ultrasound results. On 4/27/26 at 11:06 AM, the surveyor reviewed Resident #138's ultrasound date 3/2/26 with the DON. The DON confirmed that the ultrasound was not part of Resident #138's medical record. The surveyor reviewed the concern that resident #138's medical record was incomplete and inaccurate. The surveyor reviewed the progress note written on 3/25/26 in which Resident #138's provider referenced that Resident #138 was seen by the previous urology consult team, which was not accurate. It also stated that the sonogram (ultrasound) was completed on 3/2/26 and that no results were in the chart with the notations to follow up with the incorrect urology consult team to obtain the results and for ongoing catheter management. 2) On 4/21/26 at 9:48 AM, the surveyor reviewed Resident #6's medical record. The review revealed that Resident #6 had an order for hospice services dated 10/28/25. On 4/21/26 at 12:50 PM, the surveyor requested all hospice service documentation. Next the surveyor reviewed the hospice documentation and noted on 10/22/25 Resident # 6 was visited by the hospice admissions personnel and a hospice social worker. On 10/24/25 Resident #6 was visited by the hospice nurse. No other notes were documented until 1/6/[25] (sic) (a two-month gap) when a social worker documented a visit followed by a visit by a nurse 1/19/26. The visits noted in February were on 2/2/26 and 2/5/26 and were from the hospice social worker. In March a social worker documented a visit on 3/17/26. No nursing visits were documented in February or (continued on next page)

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	215187	A. Building B. Wing	04/27/2026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March. The next visit documented was by a social worker on 4/17/26 (a month from the last visit) and a nurse's visit after with an eligible April date. On 4/22/26 at 10:19 AM, the surveyor conducted an interview with Social Service Assistant (SSA) #14. During the interview the SSA#14 stated that the previous Social Service Director may have been more familiar with Resident #6's hospice care but could validate that he saw the hospice team in the facility once a week. On 4/23/26 at 10:17 AM, the surveyor conducted a phone interview with a nurse from the hospice service Staff #24. During the interview Staff #24 stated the Resident did not receive Geriatric Nursing Services (GNA) services of bathing and feeding but was seen by a hospice nurse weekly. On 4/27/26 at 11:32 AM, the surveyor reviewed the concerns with the Director of Nursing (DON) that the facility did not maintain all the documentation from the hospice services provided to Resident #6 as well as the concern that there was minimal documentation on the coordination of care from the facility and hospice for those visits. 3) On 04/22/26 at 7:45 AM, the Electronic Health Record (EHR) for Resident #4 and #8 revealed that Certified Medical Assistant, CMA I (#10), marked No for the enhanced barrier precautions task for multiple dates in April 2026. This task was to ensure staff maintained enhanced barrier precautions by wearing a gown and gloves during care activities involving direct resident contact. On 04/22/26 at 8:00 AM, Staff #9 and CMA I #10 confirmed that the task should have been marked Yes. Staff #9 stated that he/she would provide education for CMA I #10. On 04/22/26 at 8:15 AM, the Director of Nursing acknowledged the concern.

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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. Based on observation and interview, it was determined that the facility failed to handle soiled linen safely. This was found to be evident in 1 (Rosemary) out of 5 units observed during the annual survey. The findings include:On 04/22/2026 at 7:54 AM, the surveyor observed a linen cart in the soiled utility room with the lid off and unbagged linen overflowed onto the floor. Licensed Practical Nurse #17 stated the clothes should be bagged and thought the linen is supposed to be picked up once a week but would call for a pick up. On 04/27/2026 at 8:04 AM, the Director of Nursing acknowledged the concern regarding unbagged, soiled linen in the soiled utility room.