STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215212	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Care Hillhaven	3210 Powder Mill Road Adelphi, MD 20783

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 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. 42783 Based on observation, interviews, and record review it was determined that the facility staff failed to ensure the dignity of a resident as evidenced by the resident's left breast exposed. This was found to be evident for 1 (Resident #30) out of 8 residents observed during a tour of the nursing unit. The findings include: During a tour conducted on 05/16/2022 at 10:05 AM, the surveyor observed from the hallway Resident #30's left breast exposed. The surveyor observed Geriatric Nursing Aide (GNA) #2 enter and exit the resident's room. An observation conducted on 05/16/2022 at 10:12 AM in Resident #30's room, the surveyor observed Charge Nurse License Practical Nurse (LPN) #3 enter the resident's room, he/she walked pass Resident #30 with his/her left breast exposed and began to provide care for Resident #30's roommate, Resident #37. During an interview conducted on 05/16/2022 at 10:13 AM, GNA #2 stated that he\she did not see the resident's left breast exposed. The GNA further stated that Resident #30 tended to disrobe, the GNA pulled down the resident's shirt and pulled the sheet over the resident. During an interview conducted on 05/16/2022 at 10:15 AM, Charge Nurse Licensed Practical Nurse (LPN) #3 stated that she did not understand the surveyor's questions, GNA #2 explained to the Charge Nurse that the resident's breast was exposed and asked if he/she noticed the resident's breast was exposed. The Charge Nurse stated she was with the roommate, Resident #37. Record review of Resident # 30's care plan on 05/16/2022 at 10:50 AM, revealed a behavior problem for disrobing related to dementia with an intervention that stated, cover resident for privacy when noted disrobing. During an interview conducted on 05/16/2022 at 11:35 AM, the surveyor advised the Director of Nursing (DON) of the findings. On 05/17/2022 at 9:45 AM the DON provided the surveyor with an in-service conducted on 05/16/2022 for dignity.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30428 Based on the review of a facility reported incident (FRI) and interview with facility staff, it was determined that the facility failed to provide the survey team with a thorough investigation into a facility reported incident. This was evident in the review of 1 of 4 facility reported incidents. The findings include: On 5/19/2022 at 12:06 PM surveyor requested the investigation into an abuse allegation for FRI #MD00137149, regarding lack of call bell assistance and the handling of Resident #310 by a Geriatric Nursing Assistant (GNA) reportedly occurring on 2/21/2019. The Director of Nursing (DON) stated that although she did not work at the facility at that time, she would look for the investigation. Regarding the FRI, surveyor was able to access the electronic medical record (EHR) for Resident #310. This review revealed no nursing notes or progress notes that alluded to the FRI such as concerns related to abuse or neglect. On 5/20/2022 at 8:57 AM Surveyor spoke with the DON, and she reported that they are unable to locate any investigation for the FRI #MD00137149. The concern that they currently did not have proof that an investigation was completed was reviewed at this time. On 5/25/2022 at the time of the survey exit, the facility was still unable to locate an investigation into the FRI occurring around 2/26/2019.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 37586 Based on Medical Record review and interview the facility failed to complete a change of condition form for Resident # 56 who was sent to the hospital in respiratory distress. This was evident for 1 out of 1 person reviewed. The findings include: On 5/16/22 at 9:11 AM an interview was held with Resident #52. Resident was admitted to this facility on 4/27/22 with a history of Major infection, Depression, Parkinson, Alzheimer's/Dementia and Respiratory issues. A medical chart review was conducted on 5/17/22 at 9:41 AM. It was noted in the medical record that the resident was sent out to the hospital on 5/16/22 about 2 PM in the afternoon with shortness of breath. Resident #52 was on Oxygen 2 liters via nasal cannula. The resident was admitted to the hospital. Record review revealed that there was no change of condition noted in the chart. The medical record noted that Family was made aware in writing on 5/18/22 and the Doctor saw Resident #52 on 5/16/22 before she was sent to the hospital. The DON (Director of Nursing) was made aware of this finding on 5/25/22 at 10 AM.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42783 Based on observations, interviews, and record reviews it was determined the facility failed to provide treatment of a pressure injury to promote healing. This was found to be evident for 1 (resident #19) of 2 residents observed for pressure injuries. The findings include: Pressure injuries are sores (ulcers) that happen on areas of the skin that are under pressure. The pressure can come from lying in bed, sitting in a wheelchair, or wearing a cast for a long time. Pressure injuries are also called bedsores, pressure sores, or decubitus ulcers. The severity of the pressure injury is identified by four stages from the least to the worse. Stage 1 sores are not open wounds. The skin may be painful, but it has no breaks or tears. Stage 2 the skin usually breaks open, wears away, or forms an ulcer, which is usually tender and painful. The sore expands into deeper layers of the skin. It can look like a scrape (abrasion) or a shallow crater in the skin. Sometimes this stage looks like a blister filled with clear fluid. At this stage, some skin may be damaged beyond repair or may die. Stage 3, the sore gets worse and extends into the tissue beneath the skin, forming a small crater. Fat may show in the sore, but not muscle, tendon, or bone. Stage 4, the pressure injury is very deep, reaching into muscle and bone and causing extensive damage. Damage to deeper tissues, tendons, and joints may occur. Offloading is described as lifting or pushing an area of high pressure away from the cause of the pressure. To offload is to distribute the load (the weight) to other areas which are not susceptible to pressure areas. Both the calf and foot can help with the offloading. Heel pressure is redistributed to both the calf, a soft muscle belly which can change shape to fit a supportive device as well as the foot. Examples of offloading is to place a pillow under the calves causing the heels of the feet to float off the bed or a specialty boot that will redistribute the weight off the heels. On 05/17/2022 at 11:55 AM review of Resident #19's wound care physician note revealed the resident had a stage 3 pressure injury on the left heel. The assessment plan was to continue to offload. On 05/17/2022 at 12:10 PM review of Resident #19's physician order stated to float heels when in bed. During multiple observations conducted on 05/16/2022, 05/17/2022 and 05/18/2022, the surveyor observed Resident #19 in bed without his/her heels offloaded. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/18/2022 at 11:44 AM the surveyor and Charge Nurse #3 observed Resident # 19 in bed with his/her knees bent and both feet planted directly on the bed. The Charge Nurse #3 stated he/she was assigned to the resident and confirmed the resident heels were not floated. The Charge Nurse stated he/she floated the resident heels on a pillow, but the resident moved a lot and would not keep the pillow under the resident legs. The Charge Nurse further stated the pillow was found on the floor by a GNA who placed the pillow in the resident's closet. The Charge Nurse stated he/she was unaware of which GNA placed the pillow in the closet. During an interview conducted on 05/18/2022 at 11:46 AM, the Unit Manager (UM) #16 stated that the resident moved a lot. The Unit Manager further stated residents that don't keep their feet on a pillow to offload the facility will discontinue the order to float heels. On 05/18/2022 11:50 AM an interview conducted with the Director of Nursing (DON) revealed the facility's policy is to notify the physician if the resident is not compliant and implement alternative devices such as a boot, rehab etc . The surveyor advised the DON of the observations conducted. On 05/19/2022 at 9:12 AM the DON provided the surveyor with an in-service conducted for floating of the heels for nursing staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42828 Based on medical record review and staff interview, it was determined that the facility staff failed to consistently monitor and identify the location of a resident's resident guard (wander guard device). This was evident for 1 of 2 residents (Resident #51) reviewed for accidents. A care plan is a guide that addresses the needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. A Resident Guard (Wander Guard) is a wearable device worn to help protect residents against elopement. It is designed to detect when a resident is near a protected exit and alert staff. The findings include: On 5/17/2022 1:00 PM a review of Resident #51's medical record revealed that Resident #51 was diagnosed with panic disorder, cerebellar ataxia, dystonia, hereditary ataxia, and generalized muscle weakness. Further review of Resident #51's medical record revealed an Elopement Risk assessment dated [DATE] which noted that Resident #51 displayed exit seeking behaviors. On 5/17/2022 1:10 PM a review of the resident's physician orders revealed an order for a {resident guard bracelet} to reduce risk of elopement. Daily function check, every day shift. Further review of Resident #51's medical record revealed a care plan identifying Resident #51 as an elopement risk and wanderer. On the care plan it states, WANDER ALERT: Wander guard device applied to left wrist to decrease elopement risk. During a tour of the unit on 5/18/2022 11:45 AM surveyors observed Resident #51 sitting in a wheelchair located on the hallway outside of his/her room without a wander guard on his/her person or applied to his/her wheelchair. 05/18/22 12:00 PM surveyors interviewed the assigned Unit Manager, Staff #16, who stated, daily checks are performed, by nursing staff, to identify and monitor residents who are identified as an elopement risk and wear a wander guard device. On 5/19/2022 at 7:40 AM surveyors conducted a tour of the hallway where Resident #51's room was located, and Resident #51 was found laying in bed without a wander guard applied to his/her person or to his/her wheelchair. On 5/19/2022 at 8:15 AM Surveyors interviewed Resident #51's assigned Licensed Practical Nurse (LPN), Staff #3, about the location of Resident #51's wander guard. Staff #3 stated, the wander guard is placed on the resident's wheelchair because the resident has exit seeking behaviors and s/he removed it off his/her wrist multiple times in the past. Staff #3 was present in room with Resident # 51 and no wander guard was found. On 5/19/2022 at 9 AM Staff # 16 was present with surveyors during a subsequent inspection of Resident # 51's room. The wander guard was not found by Staff #16. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/2022 at 1:15 PM the identified concerns were reviewed with the Director of Nursing (DON) and the Administrator throughout the survey and again during the exit.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42783 Based on observation, interviews, and record review it was determined the facility failed to ensurethat a resident was fed in a timely manner. This was found or evident for 1 (Resident #53) out of 8 residents observed during a nursing unit tour. The findings include: According to the National Institute of Health (NIH), the Activities of Daily Living (ADLs) is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. On 05/16/2022 at 9:42 AM a tour of the 100 Nursing Unit was conducted. The surveyor observed Resident #53 in bed and awake. The resident's breakfast tray sat on the tray table next to the resident's bed. The breakfast tray food appeared untouched, thickened liquid containers had not been opened and the silverware was clean and wrapped up in a napkin. During an interview conducted on 05/16/2022 at 10:45 AM, the Unit Manager # 8 confirmed that Resident #53 required to be fed by a staff member and had not been fed breakfast. The Unit Manager stated, breakfast is delivered to the nursing unit daily at 8:00 AM. During an interview conducted on 05/16/2022 at 11:05 AM the Unit Manager #8 stated that GNA # 11 was assigned to the resident and failed to feed him/her. The Unit Manager stated that GNA #11 would be educated. Record review of Resident #53's care plan conducted on 05/16/2022 at 11:33 AM revealed that the resident had an Activities of Daily Living goal for self-care performance deficit related to dementia, limited mobility, and musculoskeletal impairment. The intervention stated that Resident #53 was to be provided with extensive assistance for hygiene, eating, dressing & bed mobility. An interview was conducted on 05/16/2022 at 11:47 AM with the Director of Nursing (DON). The surveyor advised the DON of the findings. On 05/17/2022 at 10:17 AM the DON provided the Surveyor with an corrective action form for GNA #11 for the timeliness to feed Resident #53. The DON also provided the surveyor with an in-service conducted on 05/16/2022 for resident feeding.

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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. 42828 Based on observation, record review and staff interview, it was determined that the facility staff failed to ensure that: 1) Resident nasal cannula (oxygen tubing) was accurately labeled. This was evident for 4 out of 4 residents (#20, #38, #11,and #50); and 2) Resident urinary catheter was accurately labeled. This was evident for 1 out of 2 (Resident #50) residents reviewed during the investigative portion of the survey. The findings include: Nasal cannula, (oxygen tubing) is a small, flexible tube that contains two open prongs intended to sit just inside of the nostrils. The other end of the tubing attaches to an oxygen source and delivers a steady stream of medical-grade oxygen to the nose. 1. Observations made on 5/17/2022 at 7:40 AM, revealed Resident #20 lying in bed wearing an oxygen tube without a label on the oxygen tubing. On 5/19/2022 at 7:47 AM Licensed Practical Nurse (LPN), staff #16, assigned to care for Resident #20, was present with the surveyor in the resident's room and was unable to find the label for Resident #20's oxygen tubing. On 5/19/2022 at 8:45 AM the Unit Manager, Staff #3, assigned to the unit was notified of the surveyor's findings. On 5/20/2022 at 9:50 AM a review of Resident # 20's medical record revealed an order to change oxygen tubing and clean filter weekly every night shift every Thursday and date and initial tubing. 2. Observations made on 5/17/2022 at 7:43 AM revealed that Resident #38 was lying in bed wearing an oxygen tube without a label on the oxygen tubing. On 5/19/2022 at 7:50 AM Staff #16 assigned to care for Resident #38, was present with the surveyor in the resident's room. Staff #16 was unable to find Resident # 38's oxygen tube label. On 5/19/2022 at 8:45 AM the Unit Manager, Staff #3, assigned to the Unit was notified of the surveyor findings. On 5/20/2022 at 9:55 AM a review of Resident # 38's medical record revealed an order to change oxygen tubing and clean filter weekly every night shift every Tuesday, Thursday and date and initial tubing. On 5/20/2022 at 11 AM further review of a document provided by the facility titled, Oxygen Therapy Policy revealed a resident's oxygen tubing is to be labeled with a date and the initials of the staff member who completed the task. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/2022 at 11:45 AM the Director of Nursing was notified of the surveyor's findings. 37586 3) On 5/18/2022 at 10:45 AM, Resident # 11 was observed sitting up on the side of the bed. Resident #11 has a history of Respiratory Failure, Hypoxia, Heart Failure Pulmonary Edema Sleep Apnea, Chronic Kidney disease and other diagnosis. The resident has an order for oxygen 2 liters with humidified water via nasal canula. The order also included: date and initial tubing and water bottle weekly. Resident # 11 did not have the oxygen tubing dated. 4) On 5/16/2022 at 9:39 AM Resident # 50 was observed lying in bed getting his wound dressing changed. The resident has a history of multiple wounds, diabetes mellitus 2, protein calorie malnutrition, hypoxia, obstructive uropathy and other diagnosis. Also, Resident #50 had an order for oxygen 2 liters via nasal canula with humidified water. The order stated to change the tubing and clean the filter weekly every Tuesday: Date and initial tubing. The prefilled humidified water bottle is to be changed on Tuesday and Friday, Date and initial water bottle. Resident also has a urinary catheter for obstructive uropathy. Both the oxygen and urinary catheter did not have a date.

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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** 42783 Based on observations and interviews it was determined that the facility failed to provide a safe, sanitary environment to prevent the development and transmission of a disease and infection as evidenced by: 1) staff did not practice hand hygiene, 2) staff failed to properly handle linen, and 3) staff did not wear face mask appropriately. This was found to be evident for 3 out of 3 staff members observed during a facility tour. The findings include: COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. Wearing a well-fitting mask that covers your nose and mouth will help protect yourself and others. According to the Centers of Disease Control and Prevention (CDC) staff members should never carry clean linen cradled in arms or against body because pathogens may be transferred from the skin to the textiles (linen). 1) On 05/16/2022 at 10:04 AM a tour was conducted on the 100-Nursing Unit. The Surveyor observed Geriatric Nursing Aide (GNA) #2 exit resident room [ROOM NUMBER] and enter resident room [ROOM NUMBER]. The GNA retrieved linen and exited room [ROOM NUMBER] and re-entered room [ROOM NUMBER]. The GNA did not practice hand hygiene upon entry and exit of resident rooms #104 and #105. During an interview conducted on 05/16/2022 at 10:05 AM, GNA #2 stated that the facility's policy required him/her to practice hand hygiene prior to entry and exit of each resident's room. The GNA acknowledged he/she did not practice hand hygiene at entry and exit of resident rooms #104 and #105. 2) On 05/16/2022 at 10:04 AM a tour was conducted on the 100-Nursing Unit. The Surveyor observed Geriatric Nursing Aide (GNA) #2 exit resident room [ROOM NUMBER] and enter resident room [ROOM NUMBER]. The GNA retrieved linen and exited room [ROOM NUMBER], the linen was carried up against the GNA's chest. The GNA re-entered resident room [ROOM NUMBER]. During an interview conducted on 05/16/2022 at 10:15 AM, the GNA #2 stated he/she was aware of the facility's policy and should not have carried the linen against his/her chest. On 05/16/2022 at 11:23 AM an interview was conducted with the Director of Nursing (DON), the DON confirmed the infection control policy required staff to practice hand hygiene when a staff member provided care, anytime when hands are soiled, at entry, and exit of a resident's room. The surveyor advised the DON of the observations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) During a tour of the kitchen on 05/18/22 12:05 PM, the surveyors observed Dietary Aide #14 on the tray line with his/her face mask worn under their nose and mouth. An interview was conducted on 05/18/2022 at 12:06 PM, the Dietary Aide # 14 stated that he/she was aware of the facility's policy and was expected to wear his/her face mask above the nose and mouth. The Surveyors observed the Dietary Aide pull the face mask up above the nose and mouth with a napkin. During an interview conducted on 05/16/2022 at 12:07 PM, the dietary supervisor confirmed that the Dietary Aide was expected to wear the face mask above the nose and mouth. On 05/16/2022 at 1:35 PM an interview was conducted; the Director of Nursing (DON) stated that the facility's infection control policy was to properly wear a face mask at all times. The surveyor advised the DON of the observation.