STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215168	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Layhill Nursing and Rehabilitation Center	3227 Bel Pre Road Silver Spring, MD 20906

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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 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. 16218 Based on medical record review and interview, it was determined that the facility failed to notify a resident's representative of changes in the resident's treatment. This was found to be evident for 1 out of (Resident #23) one resident reviewed for notification of change. The findings include: During an interview with the resident's Health Care Power of Attorney (HCPOA) on 9/11/24 at 1:22 PM concerns were revealed regarding the HCPOA not being informed about the resident's care. On 9/17/24, review of Resident #23's medical record revealed the resident was admitted in June 2024 after a hospitalization . Review of the 6/11/24 Minimum Data Set (MDS) assessment revealed the resident was rarely or never understood, had functional limitations in range of motion on both sides for upper extremities (arms) and impairment on one side for lower extremities (legs). The resident was dependent on staff for activities of daily living and for eating. The resident was receiving occupational, speech and physical therapy. On 9/17/24, further review of the medical record revealed two cerifications that the resident lacked adequate decision making capacity. On 9/17/24 at 4:02 PM, further review of the medical record revealed a new medication was started on 6/26/24, Metoprolol 12.5 mg two times a day for high blood pressure. No documentation was found to indicate the HCPOA was notified of the start of this new medication. Further review of the medical record revealed the attending physician changed on 7/1/24. A Medical Discharge Summary progress note was completed by Physician #56 on 7/1/24. No documentation was found to indicate the HCPOA was notified that the attending physician was changing. On 9/17/24 at approximately 3:10 PM, the Director of Nursing reported that, when there is a change in the primary care provider to a different primary care provider for the health organization who is responsible for initial short term skilled care at the facility, the healthcare organization should contact the other provider. She also reported the prior primary care provider should inform the family of the change. (continued on next page)

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	On 9/18/24 at approximately noon, surveyor reviewed the concerns with the DON regarding the lack of documentation to indicate the HCPOA was notified of the medication change or the change in the primary care provider.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48470 Based on records review and interviews, it was determined that the facility failed to prevent further potential abuse while an investigation was in progress as evidenced by an inaccurate immediate assessment of the alleged victim. This was evident in 1 (Resident #232) of 5 residents reviewed for abuse. The findings include: Resident #232 resided in the facility for 20 days. An allegation of abuse on behalf of the resident was reported, related to a facility reported incident (FRI) with intake number MD00208964. A review of the investigation packet for the FRI was conducted on 9/20/24 at 9:09 AM. The review revealed the different steps the facility took to prevent further potential abuse of an alleged victim including a pain assessment conducted by the Director of Nursing (DON). The pain assessment with an effective date of 8/20/24 at 4:57 PM indicated the following: Pain presence: No pain in the last 5 days Pain frequency: Rarely or not at all Pain Interference with Therapy activities: Does not apply- have not received rehab in past 5 days Pain management: On a scheduled pain medication Comments: Resident denies any pain at this time A review of Resident #232's electronic Medication Administration Record (eMAR) on 9/20/24 at 9:32 AM, revealed that s/he was on and received an as needed pain medication at least once every day, each time with a pain score ranging from 4/10 to 10/10, since it was prescribed from over 5 days from when the pain assessment was conducted by the DON. On the same day at 10:06 PM, the Director of Rehab (Staff #27) was interviewed about Resident #232. Staff #27 reported that the resident was receiving rehabilitation services when s/he was in the facility. Staff #27 provided documentation that confirmed Resident #232 was on their case load for 4 weeks from 8/10/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/24 at 10:59 AM, the DON and the Nursing Home Administrator (NHA) was interviewed regarding the concerns with the pain assessment. The DON reported that she documented that the resident had no pain in the last five days because she focused on the resident's shoulder. When asked about her documentation regarding the resident not receiving therapy in the past 5 days, both staff agreed that the documentation was inaccurate. Also, the pain management was documented inaccurately as the resident was only on an as needed medication regimen, and in the comment section of the assessment, the DON did not indicate that she was only referring to the resident's shoulder. The concern was discussed that an immediate assessment of an alleged victim was done inaccurately to prevent further potential abuse. Both the NHA and DON acknowledged the concern.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 48168 Based on record review and interview, it was determined that the facility failed to ensure that essential information was provided to emergency department staff when a resident went to the hospital. This was evident for 1 resident (Resident #10) of 2 residents reviewed for hospitalization during the recertification survey. The findings include: On 9/10/24 at 12:37 PM, a review of Resident #10's medical record revealed a physician's order for an emergency room transfer for abdominal pain on 9/04/24. Further record review revealed a transfer form completed by Licensed Practical Nurse (LPN #34) dated 9/04/24, that contained clinical information regarding the resident's status. On 9/12/24 at 9:50 AM, Resident #10 was observed in bed but did not respond to the surveyor's spoken greeting. A sign on the wall above the resident's bed indicated that the resident had a device for ASL [American Sign Language] Interpreter. The device was not present in the room, and the resident refused further interaction at that time. On 9/12/24 at 11:10 AM, a review of Resident #10's clinical record revealed a hospital discharge summary that documented Resident #10 was deaf. A review of the transfer form, dated 9/04/24 and completed by Staff #34, revealed that the section regarding the resident's communication needs was blank. There was no indication on the document that the resident was deaf or used any communication devices. On 9/17/24 at 11:47 AM, Licensed Practical Nurse (LPN #34) was interviewed and when she was asked to review Resident #10's transfer form documentation, she confirmed that there was no information regarding the resident's deafness or need for communication device on the transfer form. On 9/17/24 at 1:03 PM, an interview with the Director of Nursing (DON) was conducted. She was informed that Resident #10's transfer form, dated 9/04/24, lacked any information regarding the resident's need for a communication device or ASL interpreter. She was asked to provide any additional evidence that the hospital staff were informed of the resident's communication needs, but none was provided by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to develop and implement a comprehensive, resident centered care plan for a resident receiving psychotropic medications. This was evident for 1 (#78) of 5 residents reviewed for unnecessary medications, and 1 #(78) of 5 residents reviewed for unnecessary medications. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the residents care The findings include: 1) On 9/18/24 at 12:04 PM, a review of Resident #78's medical record documented the resident was admitted to the facility at the end of June 2024 and had a diagnosis which included depression. Review of Resident #78's September 2024 Medication Administration Record (MAR) revealed an 8/20/24 order for Escitalopram Oxalate (Lexapro) (antidepressant) (psychotropic medication) by mouth one time a day for Depression that was documented as given every day from 9/1/24 to 9/13/24. Review of Resident #78's care plans revealed a care plan with the focus, the resident has behaviors related to depressive disorder, initiated on 8/13/24, with the goal, the resident' s behaviors will not cause them or other resident' s distress thru the review period, that had 3 interventions, administer, medications as ordered, physician review of medications as needed, and remove resident from environment. The care plan was not comprehensive, and resident centered, with no indication in the care plan of theresident's behaviors for which a psychotropic medication had been prescribed. In addition, the care plan failed to have measurable goals and interventions, including non-pharmaceutical interventions, to assist the resident with his/her behaviors. The Director of Nurses (DON) was made aware of the above concerns on 9/18/24 and offered no comments at that time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 16218 Based on medical record review and interview, it was determined that the facility failed to have an effective system in place to ensure interdisciplinary care plan meetings were occurring after assessments; and failed to ensure care plans were being reviewed and revised as needed. This was found to be evident for 8 (Resident #30; #23; #95; #78, #55. #84, #10, #100) out of 17 residents reviewed during the survey The findings include: 1) Review of Resident #30s medical record revealed the resident had resided at the facility for several years and whose diagnoses included, but were not limited to, high blood pressure, kidney disease, major depressive disorder and dementia. Review of the Minimum Data Set assessment, with a reference date of 6/5/24, revealed the resident has a BIMS (Brief Interview for Mental Status) of 4 indicating severe cognitive impairment. On 9/13/24 at 11:09 AM, the unit nurse manager #12 reported care plan meetings are scheduled and family and residents are invited, and that therapy, dietary, social work and nursing also attend. When asked how the physicians or nurse practitioners are involved in the care plans, the unit manager reported if the family has concerns they would ask the physician to call the family and then referred the surveyor to the Multidisciplinary Care Conference note. The unit nurse manager confirmed that whenever there is a care conference this note will be used. Further review of the Multidisciplinary Care Conference note template revealed an area for summaries from nursing, dietary, recreation, social work, pharmacy, restorative/PT/OT, and the physician. There is also a section at the end for (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident/Family expectation/Concerns and Care Level Review. Further review of the medical record revealed a Multidisciplinary Care Conference note for a meeting held on 10/31/23. Review of this note revealed the participants included a registered nurse, social worker, resident and the health care agent. Although in the attendance section Registered Nurse is checked, no documentation was found in the note to identify the name of the nurse that attended. The areas of the note for input/summaries from nursing, dietary, recreation (Activities), pharmacy, restorative and physician were all noted to be blank. On 9/16/24, review of Resident #30's medical record failed to reveal documentation to indicate a care plan meeting has occurred since the 10/31/23 meeting. This information was reviewed with the SSD #19 during an interview on 9/16/24 at 10:01 AM. The SSD reported she attempted a care plan meeting but there should be a note that the Health Care Agent (HCA) declined. Further review of the medical record revealed a Discharge Planning Progress note, signed by SSD #19 on 6/19/24, which indicated that the HCA declined a transfer and included the following: SW notified resident that a care plan meeting would be initiated to support a possible transfer and provide more information from the IDT team. Further review of the medical record failed to reveal documentation to indicate that a care plan meeting was scheduled as indicated in the 6/19/24 note. 2) Review of Resident #23's medical record revealed the resident was originally admitted to the facility in June 2024. Review of the 6/11/24 Minimum Data Set (MDS) assessment revealed the resident had functional limitations in range of motion on both sides for upper extremities (arms) and impairment on one side for lower extremities (legs). The resident was dependent on staff for activities of daily living. The resident was receiving occupational, speech and physical therapy in June. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the resident 39's Health Care Power of Attorney (HCPOA) on 9/11/24 at 1:22 PM revealed concerns regarding not being informed about the resident's care. On 9/17/24 at 1:58 PM, review of the medical record failed to reveal a Multidisciplinary Care Conference note that would indicate a care plan meeting had occurred during the resident's admission. On 9/18/24, after requesting documentation from the Director of Nursing of any care plan that may have occurred for the resident, staff provided a note completed by the unit nurse manager titled Care plan meeting dated 9/3/24 that stated: Care plan meeting held with resident 23's [family members]. Resident medications reviewed with no concerns voiced. Plan of care continues. No documentation was found to indicate who attended the 9/3/24 meeting other than the family and the unit nurse manager who wrote the note. No documentation was found to indicate other members of the interdisciplinary team attended the meeting, or provided input. On 9/18/24 at 11:00 AM, the Rehab Director presented the surveyor with the resident's physical therapy discharge summary, dated 8/27/24. The Rehab Director reported the resident had made great progress in therapy and at the time of discharge the resident's gait distance (walking) was 125 feet with hand held assist and could transfer from chair to bed and bed to chair with contact guard. (A transfer with contact guard assist means the care giver places one or two hands onthe resident to help with balance but no other assistance is provided). When asked if the ability to walk and transfer with contact guard was reflected in the resident's care plan, the Rehab Director replied that it might be. When asked if the resident should continue to walk, the Rehab Director reported that, because of cognitive deficits this would not be realistic to maintain but that theortically could have been walking to the dining room. Surveyor clarified that the resident could be doing some walking, to which the Rehab Director responded: yes, [s/he] could with support obviously. The Rehab Director indicated that therapy personnel would be part of a care plan meeting for a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	short term (skilled) admission. No documentation was found to indicate a respresentative from the therapy department attended or provided input for the 9/3/24 care plan meeting. Review of care plan addressing the residents risk for falls revealed a revision date of 9/13/24. The interventions included, but were not limited to, : Resident is a hoyer lift transfer with 2 GNAs. This intervention was created and initiated on 8/14/24. No documentation was found to indicate that, when the revision was completed on 9/13/24 that the person completing the revision was aware that the resident was no longer using a hoyer lift. A hoyer lift is a mechanical lift used for residents who are completely dependent on staff for transfers. A hoyer lift pad is placed under the resident and then attached to the lift. Two staff members will then use the mechanical lift to raise the resident from the bed and transfer to a chair or vice versa. During the 9/18/24 11:00 AM interview, surveyor reviewed with the Rehab Director that the current care plan indicated the resident required a hoyer lift with 2 GNA assist, in place since 8/14/24. The Rehab Director responded that it could have been so at that time. On 9/18/24 at 11:52 AM, the unit nurse manager #12 reported the resident does stand with one person assist and in regard to walking, she reported: if we see [him/her] get up we walk around with [him/her]. The unit nurse manager indicated they did conduct staff training but confirmed it was not documented. Surveyor reviewed the concern that the care plan still stated the resident requireda hoyer lift for transfers, the unit manager indicated she would update this information. 3) On 9/12/24, review of Resident #95's medical record revealed the resident had resided at the facility for a over one year and whose diagnoses included, but were not limited (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to, dementia and lung disease. Review of the 1/24/24 MDS assessment revealed the resident's family was interviewed in regard to Activity Preferences. This assessment revealed it was very important to listen to music the resident liked; and to participate in religious activities. Review of the care plans revealed a plan for 1:1 Activities: [Resident #95 name] prefers or requires 1:1 activities due to being unable or unwilling to participate in other activities. The goal is [Resident] will be satisfied with their 1:1 activities provided thru the review period. The interventions included: provide 1:1 activities in the room or location that is the residents preference as needed and review activities preferences with the resident or resident representative if the resident is unable as needed. These interventions were established in August 2023 and have not been updated or personalized since then; although the goal included a notation by the unit nurse manager that it was revised on 7/29/24. The care plan failed to reflect the January assessment that listening to music and attending religious activites were very important to the resident. Further review of the medical record failed to reveal documentation to indicate a care plan meeting had occurred since December 2023. On 9/12/24 at 10:54 AM the resident's responsible party reported being at the facility frequently. She also confirmed that there have been no recent care plan meetings. 37276 4) On 9/11/24 at 10:57 AM, when asked if the resident attended care plan meetings and participated in his/her care planning, Resident #78 stated that s/he could not recall attending care plan meetings. On 9/13/24 at 12:36 PM, a review of Resident #78's medical record revealed the resident was admitted to the facility at the end of June 2024. Review of Resident #78's MDS assessments revealed assessments which included a 5-day admission assessment with an assessment reference date (ARD) of 7/4/24 and quarterly assessment with an ARD of 8/28/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continued review of the medical record failed to reveal documentation to indicate that a care plan meeting had been conducted following Resident #78's admission assessment with an ARD of 7/4/24, or that an interdisciplinary care plan meeting had been conducted following Resident #78's quarterly assessment with an ARD of 8/28/24. On 9/16/24, at approximately 2:30 PM, Staff #20, Licensed Practical Nurse (LPN), Regional Director Of Clinical Reimbursement, was made aware of the concern that there was no evidence a care conference had been conducted with Resident #78 since his/her admission assessment. ARD 7/4/24 or since the resident's quarterly assessment 8/28/24. Staff #20 confirmed the findings, and no further comments were offered at that time. Continued review of Resident #78's medical record on 9/18/24 at 12:04 PM, revealed that, on 6/30/24 at 10:41 PM, in an admission/readmission nursing note, the nurse documented that Resident #78 was admitted to the facility following a hospitalization with a chief complaint of a fall which resulted in a hip fracture. Continued review of Resident #78's medical record revealed on 7/10/24 at 2:00 PM, in a SBAR (Situation, Background, Assessment, Recommendation) (a standard way to communicate medical information) Summary for Providers note, the nurse documented Resident #78 had a fall, and the resident was found kneeling at the bedside. Review of Resident #78's care plans revealed a care plan, the resident is at risk for falls r/t (related to) unsteady gate, created on 6/30/24, with the goal, the resident will not have an injury related to a fall through the review period. The care plan had 2 interventions, place common items within reach of the resident and remind the resident to use their call light to ask for assistance with ADLs (activities of daily living), created on 6/30/24, and included 2 interventions, place bed in lowest position while resident is in bed, and therapy referral, created 7/11/24, which was after the resident's fall on 7/10/24. In a SBAR Summary for Providers note, on 7/17/24 at 9:10 PM, the nurse documented that Resident #78 had a fall, and indicated the physician was notified and a urinalysis, and urine culture and sensitivity were ordered. There was no summary of the observation, and no other documentation in SBAR to indicate the circumstances around the resident's fall. Continue review of Resident #78's medical record failed to reveal documentation to indicate that, following the resident's fall on 7/17/24, Resident #78's fall care plan was reviewed for effective interventions and failed to reveal evidence that following the resident's quarterly assessment with an ARD of 8/28/24, Resident #78's care plans were reviewed by the interdisciplinary team and revised based on the changing goals, preferences and needs of the resident and in response to current interventions. On 9/18/24 at 5:11 PM, the Director of Nurses (DON) was made aware of the above concerns on 9/18/24 at 5:11 PM, and the DON offered no further comments at that time. 5). On 9/12/24 at 10:20 AM, a review of the EMR (Electronic Medical Record) revealed Resident #55 resided in the facility for long term care since 2020 and was readmitted to the facility following a brief hospitalization in the beginning of August 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #55's completed MDS assessments revealed a 9/10/23 quarterly assessment, a 12/11/23 quarterly assessment, a 3/10/24 annual assessment, a 6/10/24 quarterly assessment, and an 8/13/24 5-day assessment. Review of Resident #55's most recent 5-day assessment with an assessment reference date (ARD) of 8/13/24 documented Resident #55's BIMS (brief interview for mental status) summary score was 15, indicating the resident was cognitively intact. Further review of Resident #55's medical record revealed, on 10/3/23 at 11:30 AM, in a Multidisciplinary Care Conference note, Social Services indicated Resident #55 had an interdisciplinary team (IDT) care plan meeting on that date. No further documentation was found in Resident #55's medical record to indicate that IDT care plan meetings had been conducted with Resident #55 following his/her completed MDS assessments with an ARD 12/11/23, 3/10/24, 6/10/24 and 8/13/24. On 9/16/24 at 12:25 PM, the above concerns were discussed with Staff #19, Director of Social Services. At that time, Staff #19 indicated that there had been a turnover of social services staff which affected the long-term care conferences, and that it was most likely no care conferences were done during that time. Staff #19 then confirmed that a care plan meeting had not been conducted with Resident #55 following since October 2023 and following each assessment. 45139 6). On 9/10/24 at 7:34 AM, Resident #84, a long-term resident of the facility, was interviewed. During the interview s/he reported that s/he could not recall the last care plan meeting that she attended. On 9/11/24 at 11:36 AM, review of a progress note revealed a care plan meeting on 1/29/24. Further review failed to reveal any additional care plan meetings in 2024. On 09/12/24 at 3:09 PM, a review of assessment documents titled Multidisciplinary care conference, revealed the resident had care plan meetings on 6/2/23, 10/14/22 and 1/29/24. On 09/12/24 at 1:52 PM, during an interview with the Director of Social Services (Staff #19), she reported that care plan meetings should be quarterly. On 09/12/24 03:45 PM, during an interview the Director of Nursing, it was confirmed that Resident #84 had only one care plan in 2024. On 09/19/24, the Director of Nursing provided the care planning policy with an effective date of 11/01/2019. Review of the care plan revealed the quarterly care plan meeting should occur after the quarterly assessment. On 09/20/24 at 10:50 AM, review of concerns with the Administrator and the Director of Nursing provided no additional information to the survey team. 48168 7). On 9/11/24 at 12:31 PM, a review of Resident #10's clinical record revealed a care plan entry that stated SKIN IMPAIRMENT: the resident has a skin impairment, Date Initiated: 07/25/2024, Created on: 07/25/2024, Created by: [Licensed Practical Nurse (LPN #47)]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/16/24 at 2:13 PM, an interview was conducted with the Director of Nursing (DON) who said the resident does not have any skin issues. On 9/17/24 at 11:41 AM, an interview with unit nurse, LPN #34, was conducted and she explained that Resident #10 had an issue with the skin on their leg, but it was healed now. When asked what the process was for revising the care plan, Staff #34 said usually either the unit manager or the social worker updated resident care plans, she said that she did not really know how to do it. On 9/17/24 at 1:01 PM, the DON was interviewed again and confirmed that Resident #10's skin issue remained on the care plan but should have been discontinued as the resident no longer had any skin issues. 8). On 9/16/24 at 10:35 AM, a review of Resident #100 revealed care plan meeting documentation, dated 11/29/23. On 9/16/24 at 10:44 AM, the Director of Social Work (SW #19) was interviewed and asked when Resident #100's last care plan meeting was held. SW #19 said the last care plan meeting was held on 11/29/23 and confirmed that the resident should have had care plan meetings February 2024, May 2024, and August 2024 but did not.

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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. 48168 Based on observation, interview and record review, it was determined that the facility failed to ensure that residents' communication needs were met. This was evident for 1 complaint (#MD00209021) of 5 complaints reviewed during the recertification survey. This had the potential to affect all deaf residents. The findings include: On 9/10/24 at 12:14 PM Resident #10 was observed in bed with their eyes closed and appeared to be asleep. A sign above the resident's bed indicated to use an interpreter line IVR instructions and included a company name - o, which indicated to call a phone number and say the language and the call would be connected to an interpreter. A second sign on the wall indicated that to communicate using ASL [American Sign Language] to request a tablet from Admissions, go to the interpreter app, choose the video button, hit the call button and the app would search for a live interpreter. The bottom of the sign stated Staff, tablet must be returned to Admissions once patient discharges. No such tablet was observed in the resident's room. On 9/12/24 at 8:03 AM, a review of complaint # MD00209021 revealed multiple concerns regarding Resident #10's care that related to the resident's inability to communicate with staff. On 9/12/24 at 8:07 AM, in an interview with the complainant via deaf relay service, the complainant reported that Resident #10 had multiple needs that were not met due to the lack of communication with the facility staff. On 9/12/24 at 9:50 AM an interview was attempted with Resident #10 who was sitting in bed eating. The surveyor showed the resident their state surveyor identification badge and the resident made a writing gesture in the air. The surveyor pointed to the sign regarding the tablet for a video interpreter, and the resident shook their head to indicate no. There was no paper in the resident's room to write a note. On 9/12/24 at 10:40 AM in another attempt to interview Resident #10, the surveyor provided a pad of paper and pen, and the resident wrote need interpreter and law. The surveyor wrote a note that the surveyor nurse was investigating the communications concerns and other issues. A Licensed Practical Nurse (LPN #8) was in the room and when asked she said that the resident's IVR device was downstairs because it was not working. LPN #8 left the room and came back with a piece of paper, but the resident refused further interview. LPN #8 was interviewed in the hallway and said the IVR tablet was in the admissions office since the device was not charging properly. On 9/12/24 at 11:10 AM, a review of Resident #10's care plan revealed a problem for risk for complications related to impairment of communication. The associated interventions lacked any information regarding the use of a live video interpreter using a tablet device, the use of a white board, or the use of pen and paper to communicate with the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 2:06 PM, an interview with the Director of Nursing (DON) was conducted. The DON said Resident #10 was non-compliant with using the video interpreter device and instead used written notes to communicate. When asked why the communication strategies were not listed on the resident's care plan, the DON did not answer. On 9/18/24 at 11:09 AM, an interview with the Admissions Director (Staff #34) and Assistant Admissions Director (Staff #35) was conducted by telephone. Staff #34 said that when Resident #10 was admitted , the Admissions office gave the resident a facility-owned iPad which had the interpretation software downloaded on it. She explained that the device was placed in the resident's room and instructions were posted on the wall, and the resident was also provided with pen and paper, and a white board. Staff #34 described how the software worked to easily connect to a live ASL video interpreter. When asked why the device was not in the resident's room, Staff #34 said that there was an error logging in and that the software crashed on us. When asked how long the device had been unavailable, Staff #34 said almost a month, and Staff #35 said about a week and a half. When asked if there was any alternative provided by the interpretative service, they both said no. On 9/18/24 at 11:31 AM the surveyor called the company that managed the software to confirm the software problem that Staff #34 had reported. A voice message was left with technical support. On 9/18/24 at 12:39 PM, an email was received from the company in response to the voice message left by the surveyor, and an email reply was sent to ask if the software had not worked in the past week and a half. On 9/18/24 at 12:59 PM an email reply was received from a complany representative which stated There have not been any disruptions to the interpretaive service in that timeframe.

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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. 16218 Based on medical record review and interview, it was determined that the facility failed to ensure that feedings via a g-tube were administered as ordered and failed to ensure a plan to try to restore oral eating was established. This was found to be evident for one (Resident #23) out of one resident reviewed for tube feeding. The findings include: Review of Resident #23's medical record revealed the resident was admitted in June 2024 after a hospitalization . The resident's diagnosis included dysphagia which is difficulty swallowing and the resident had a g-tube for the administration of nutrition. The resident was admitted with orders that nothing was to be given by mouth, and a g-tube with orders for bolus feedings of Jevity 1.5 four times a day. A bolus is when a large amount of feeding is given at one time. Further review of the medical record revealed there were two different enteral feed (g-tube) orders in effect from 6/6/24 until they were both discontinued on 7/26/24. The first order, placed on 6/6 at 4:22 AM, was for Jevity 1.5 425 ml bolus four times a day every 6 hours per protocol. Review of the Medication Administration Record (MAR) revealed these feedings were scheduled for midnight, 6:00 AM, noon and 6:00 PM. Review of the MAR revealed a check mark to indicate the 425 ml bolus feed was administered as ordered four times a day from 6/6 until the order was discontined on 7/26, except for one dose on 7/4 at 6 am was noted to be blank. The Jevity 1.5 provides 1.5 calories per ml, thus a 425 ml bolus provides 638 calories per bolus and four bolus per day would provide 2550 calories per day. This first order also included instructions to document the amount of feeding provided every 8 hours. Further review of the medical record failed to reveal documentation of the actual amount of Jevity that was being administered during each bolus feed or every 8 hours as ordered. The second g-tube feeding order was placed on 6/6/24 at 12:51 PM and was for Jevity 1.5 one carton 4 times a day. The order includes a notation that, in addition to the Jevity, the resident would also be receiving ALP (Active Liquid Protein) 30 ml three times a day and that this would provide an additional 300 calories and that the resident would receive a total of 1720 cals per day. Review of the manufacturers website revealed the Jevity 1.5 cartons are 8 ounces. There are only 236 ml per 8 ounces. The website indicated that there were 355 calories per 8 ounce carton, so four bolus per day would provide 1420 calories per day from the Jevity. Review of the MAR revealed documentation that staff administered one carton of the Jevity 1.5 four times a day at 9:00 AM; 1:00 PM, 5:00 PM and 9:00 PM every day from 6/6/24, until the order was discontinued on 7/26/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed a 7/26/24 registered dietitian (Staff #30) note which documented that the resident's weight on 6/7 was 132 lbs and on 7/8 the weight was 125 lbs which was considered a significant weight loss. The resident's estimated caloric need per day were 1710- 2000 calories. The dietitian's summary revealed that the resident appeared to have a significant weight loss over 1 month which was unfavorable and unplanned, the tube feeding was providing 1420 calories per day and the resident was receiving an additional 180 calories from a supplement which totaled 1600 calories per day. Needs do not appear to be met with current rate as evidenced by wt loss. Recommend changing TF regimen Jevity 1.5 1 carton q3hour [every 3 hours], 6 times a day. The new regimen would provide 2130 calories per day. No documentation was found to indicate the weight loss identified on 7/8/24 was addressed by the dietitian prior to 7/26/24. Further review of the medical record revealed a new g-tube order was put in place on 7/26/24 at 2:35 PM for one carton Jevity 1.5 bolus 6x/day. There was a notation that this feeding would provide 2130 cals per day. This order was discontinued on 9/18/24. Review of the MAR revealed staff documented the Jevity bolus feeds were administered 6 times a day as ordered every day from 7/27/24 thru 9/17/24, except for two feedings that were due scheduled to be administered on 9/5/24 at 10:00 AM and 1:00 PM. The area to document these feedings were noted to be blank, there was no documentation to see nurse's note or that these two feedings were held. On 9/17/24 at 1:10 PM, review of the medical record revealed an order, dated 8/28/24 to hold the 10 AM bolus feed. There was also an order for dysphagia advanced texture diet for lunch only on 8/28/24. Further review of the medical record on 9/18/24 revealed the RD #30 had seen the resident on 9/17/24 and entered a note at 5:31 PM. This note acknowledged that the resident was receiving lunch only and tube feeding for all other meals. It documented the current tube feeding as being Jevity 1.5 bolus 6 x/day. The note included the following weights: 6/7: 132 lbs; 8/5: 132 lbs and 9/4: 132 lbs. The recommendation was to continue the diet and tube feeding as ordered. The note failed to include notation that there was a current order to hold the 10 AM feeding. On 9/18/24 10:01 AM, surveyor asked Nurse #59, who was assigned to care for the resident, when the next bolus feed will occur. The nurse reported that the resident was eating at the time, that s/he would get a bolus at 6 AM the next was not until the evening. She then confirmed that she was not administering the 10 AM or the 1 PM bolus feeds. On 9/18/24 at 10:08 AM, the unit nurse manager #12 reported the resident received bolus feeds and proceeded to check the documentation in the computer. She went on to report the resident gets lunch only and bolus of Jevity 1.5 six times a day. When asked if the 10 oclock feeding was held, the unit nurse manager responded: yes for lunch and then she clarified that the resident was getting 5 bolus'. After reviewing the MAR, the unit nurse manager stated: they are signing for it but not giving it and confirmed the order in August to hold the 10 AM feed. On 9/18/24 at 1:54 PM, surveyor reviewed the concern with the DON that the RD assessment from yesterday failed to address the order to hold the 10 AM feeding which meant resident is only receiving 5 bolus feedings per day, not the 6 as indicated in the RD note. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the medical record on 9/23/24, revealed a note completed by RD #24 on 9/18/24 which revealed Noted NP [nurse practitioner] order 8/28 for holding TF @ 10am to help promote oral intakes, per nursing staff holding bolus has benefited [him/her] as [s/he] has been able to eat well and has great appetite for lunch (intakes of 50-100% per nursing charts). I discussed TF regimen w/dtr [daughter] today via phone. Dtr agrees to adjust the amount of bolus provided while taking into consideration current oral intakes. Will also d/w SLP [speech therapist] possibility of evaluation to determine if frequency of meals could be increased. The recommendations included adjusting the tube feeding orders to Jevity 1.5 1 carton 4 x/day and speech therapy for diet eval. A corresponding physician order for the Jevity 1.5 1 carton 4 x/day was found for 9/18/24.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 16218 Based on medical record review and interview, it was determined that the facility failed to provide behavioral health monitoring to ensure a resident's highest practicable mental and psychosocial well being.This was found to be evident for 1 (Resident #30) out of 5 residents reviewed for unnecessary medications. The findings include: Review of Resident #30's medical record revealed the resident had resided at the facility for several years and whose diagnoses included, but was not limited to: high blood pressure, kidney disease, major depressive disorder and dementia. Review of the Minimum Data Set assessment, with a reference date of 6/5/24, revealed the resident had a BIMS (Brief Interview for Mental Status) of 4 indicating severe cognitive impairment. Review of the medical record revealed that the resident was seen about once a month by either the Psychiatrist #37 or the Psychiatric Nurse Practitioner (NP) #36. 1) Review of the Psychiatric NP #36's note, dated 2/7/24, revealed the resident's current psychiatric medications included Seroquel (an antipsychotic) 25 mg two times a day and Zoloft (Sertraline- an antidepressant) 50 mg daily. The Treatment Plan/Recommendation section included: Continue Current Meds. No documentation was found in this note to indicate a GDR of the Zoloft was being considered or planned. Further review of the medical record revealed that the resident was receiving the antidepressant medication, Sertraline 50 mg one time every day from 10/24/23 until 2/29/24. On 2/29/24, the Sertraline 50 mg every day order was discontinued by the primary care physician #26. A new order was put in place on 2/29/24 for Sertraline 25 mg one time a day for 90 days. The medication was not renewed after the 90 days was completed. This tapering down and then discontinuation of a psychoactive medication is referred to as a gradual dose reduction (GDR). Review of the Psychiatrist #37's note, dated 3/25/24, revealed a notation that the resident was currently being treated with Zoloft and that the current dose was 25 mg every day. However, no documentation was found to indicate the 25 mg every day dose was a recently initiated GDR. The Treatment Plan/Recommendations section included: GDR is not recommended at this time as the benefit of the medication outweigh the risks of dosage reduction. Review of the Psychiatric NP #36's notes, dated 5/8/24 and 5/15/24, revealed the resident's current psychiatric medications included Serorquel (an antipsychotic) 25 mg two times a day and Zoloft (Sertraline) 25 mg daily. The Treatment Plan/Recommendation section included: Continue Current Meds. No documentation was found in this note to indicate there was a plan to continue the GDR of the antidepressant. The 2/29/24 order for Sertraline for 90 days was completed at the end of May. No documentation was found to indicate that the resident had received this antidepressant since May 2024. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed a change in condition note that revealed on 6/8/24, the resident was highly agitated and was observed being verbally abusive and throwing items at the resident's roommate. The psychiatrist #37 was notified, there was an order to transfer the resident to the hospital. After the resident refused the transfer, the psychiatrist was notified and there was then an order for IM Haldol (an antipsychotic) and IM Benedryl (an antihistamine) for aggressive behavior. These IM medications were administered on 6/9/24 at 1:50 AM. Review of the Psychiatric NP #36's notes, dated 6/12/24, revealed the following: Chart reviewed; Spoke with staff regarding patient's progress; No new behavioral concerns reported; No agitation, irritability or aggression noted this visit. The Treatment Plan/Recommendation section included: Continue Current Meds. No documentation was found in this note regarding the recent discontinuation of the antidepressant medication or the 6/8/24 episode which resulted in the use of an IM antipsychotic medication. Review of the Psychiatrist #37's notes, dated 6/17/24 and 7/15/24, revealed a notation that the resident was current being treated with Zoloft, Depakote and Seroquel. On 9/23/24 at approximately 9:00 AM, surveyor reviewed the concern with the Director of Nursing that the resident's antidepressant was stopped but no documentation was found to indicate this was a planned GDR. The DON then provided a copy of the 2/29/24 order to discontinue the Zoloft which included GDR in the area to document the reason for discontinuation. No other documentation was provided at the time. On 9/23/24 at 10:40 AM, an interview was conducted with the psychiatrist #37, in the presence of the Director of Nursing. When asked if psychiatric providers were involved in GDRs, the Psychiatrist reported the nurse practitioner (NP) sat with the staff to review for GDR. When asked if he expected the NP to document a GDR, psychiatrist #37 responded: yes, of course, she would document the dose of the GDR. Surveyor reviewed the concern that the resident's antidepressant was reduced and then stopped at the end of May, but no documentation was found in the NP notes to address this GDR. 2) Review of the Medication Administration Record (MAR) revealed areas for nursing staff to document resident behaviors on the day, evening and night shifts. Review of the MAR revealed staff could document based on the following coding: 1 - compulsive; 2 - pacing continuously; 3 - Continuously screaming and yelling; 4 - danger to others; 5 - danger to self; 6- false beliefs; 7 - finger painting feces; 8 - spitting; 9 - other. On 9/16/24, review of the documentation for this monitoring for June, July, August and September thru the 16th, 2024 revealed only a check mark for each shift. On 9/16/23 at 3:52 PM interview with Nurse #8 revealed that a check on the behavior monitoring sheets meant that the resident had none of those behaviors. On 9/16/24 at 3:58 PM, interview with the unit nurse manager #12 revealed that, when the nurses see this item on the computer, they have to answer yes or no. The unit nurse manager confirmed that the checks indicated that the resident was not displaying behaviors. After reviewing the September MAR with the unit nurse manager, surveyor asked if that was an accurate assessments of the resident, the unit nurse manager stated: no. When asked where were staff documenting the resident's behaviors, the manager indicated they were supposed to use the MAR. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the MAR revealed there was another section to document other psychiatric symptoms: 1- mood swings; 2 - sad; 3 - continuous crying; 4 - withdrawn; 5 - depressed; 6 - angry; 7 - poor eye contact; 8 - other. Review of the nursing documentation from June, July, August and September thru the 16th, 2024 revealed that staff documented every shift either a 0 or an N, thus indicating the resident was not experiencing these symptoms. Based on review of the behavior monitoring documentation being completed every shift by nursing staff, the resident was not experiencing any behaviors of concern for June, July, August or September. On 9/17/24 review of the physician orders revealed the resident had orders for Seroquel 25 mg twice a day from November 2023 until 6/17/24. Review of the 6/17/24 psychiatrist #37 note revealed documentation to indicate staff was reporting the resident was getting aggressive with the roommate and there was a documented plan to increase the Seroquel dose to 50 mg two times a day. This increase occurred more than a week after the 6/8/24 incident resulting in the order for the IM Haldol and after the 6/12/24 NP visit in which the NP documented that she spoke with staff regarding the resident's progress and there were no new behavioral concerns reported. From 6/17/24 until 7/10/24, the order was for Seroquel 50 mg two times a day. Further review of the physician orders revealed from 7/10/24 until 9/17/24, the order was for Seroquel 100 mg two times a day. On 7/15/24, there was a new order for Risperdal (antipsychotic) 0.5 mg two times a day that was in effect until 9/5/24. Review of the 7/15/24 psychiatrist #37 note revealed documentation to indicate staff was reporting the resident was getting aggressive toward roommate due to paranoia to the point they had to move the resident out of the room. The note documents the start of the Risperdal 0.5mg twice a day for paranoia and stated if the resident does well with Risperdal, would consider tapering off Seroquel. Review of the Psychiatric NP #36's notes, dated 8/7/24, revealed staff reporting episodes of getting aggressive towards roommate and does not want a roommate. The note included a notation of Risperdal 0.5 mg bid (two times a day) and included a plan to Continue Current Meds. Further review of the medical record on 9/17/24 revealed that, on 9/5/24, there was a new order for Risperdal 1 mg two times a day that was currently in effect. No documentation was found to indicate why this antipsychotic medication was increased on 9/5/24. Review of the Psychiatric NP #36's notes, dated 9/11/24, revealed: Chart reviewed; Spoke with staff regarding patient's progress; No new behavioral concerns reported; Per staff [s/he] has been stable and has not exhibited symptoms of depression, mania, anxiety, psychosis or self-injurious behavior. The note did include Risperdone 1 mg bid in the list of current psychiatric medications but failed to address why the dose was double less than a week before this visit. The note included the plan to Continue Current Meds. (continued on next page)

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	215168	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Layhill Nursing and Rehabilitation Center	3227 Bel Pre Road Silver Spring, MD 20906

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 11:31 AM, surveyor reviewed the concern with the Director of Nursing regarding the increase in the antipsychotic medication without adequate indication. Reviewed that the behavior monitoring sheets since June failed to reveal documentation of behaviors to indicate the need for this increase. Surveyor requested any additional documentation they may have regarding this concern. On 9/23/24, review of the medical record revealed a note written by the NP #36 which included the plan to attempt GDR on seroquel to 100 mg at time of sleep.