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	215168	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview it was determined that the facility failed to notify a Resident's Representative of a change in condition. This was found to be evident for 2 (Resident #18 and #11) out of 2 Residents reviewed for notification during a complaint survey. The findings include: 1) A gastrostomy tube (G-tube) is a feeding tube inserted through the abdomen directly into the stomach to provide nutrition, liquids, and medications. G-tubes are placed through a surgical procedure and are used for conditions where a person cannot get adequate nutrition by mouth. The surveyor reviewed Complaint #365422, by Resident #18's Representative which stated that the resident's G-tube feeding was changed from infusion via pump to bolus and they were not informed. On 10/7/24 at 9:00AM a review of Resident #18's clinical record revealed a physician's order dated 07/23/24 for Osmolite 1.5 at 60 ml/hour x 16 hours/day. The order was discontinued on 10/28/2024 at 8:16 AM and replaced with a new order for Osmolite 1.5 to be given via bolus 240 ml four times a day. Further review of the clinical record revealed the Dietitian on 10/28/24 changed the feeding order to bolus because the resident likes to get up and be out of his/her room during the day. The clinical record failed to reveal that the Resident's Representative (RP) was notified. During an interview 0/8/25 at 8:11AM the LPN Unit Manager #7 reviewed the record and confirmed the surveyor's findings. Unit Manager #7 stated that the RP should have been informed at the time when the feeding order was changed by the Dietitian. In an interview on 10/08/25 at 8:27 AM the DON reviewed the clinical record, confirmed the findings and stated that the expectation was for the nurses to ensure the RPs are notified whenever physician orders are changed or whenever there is a change in the resident's condition. 2) During a review of complaint #2588746 conducted on 10/07/2025 at 9:02 AM, it was reported that Resident #11's Representative was not notified of a wound that worsened. A pressure ulcer is a localized injury to the skin and underlying tissue, often over a bony prominence, caused by prolonged pressure. They are staged from 1 to 4 based on depth, with special categories for deep tissue injuries and unstageable ulcers. Stage 1: Intact skin with a localized area of non-blanchable redness. For darker skin tones, the area may not blanch but can differ in color from the surrounding skin. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 2: Partial-thickness loss of the dermis, presenting as a shallow, open ulcer with a red or pink wound bed, or as an intact or ruptured serum-filled blister. Stage 3: Full-thickness tissue loss where subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. The wound may have undermining (tissue loss under the skin) or tunneling (a pathway under the skin). Stage 4: Full-thickness tissue loss with exposed or palpable bone, tendon, or muscle. Slough or eschar (dead tissue) may be visible, and undermining or tunneling can be present. Unstageable: Full-thickness tissue loss where the wound base is completely covered by slough (yellow, tan, gray, green, or brown) or eschar (tan, brown, or black). The true depth cannot be determined until the dead tissue is removed. Suspected Deep Tissue Injury (DTI): A localized area of purple or maroon discolored intact skin or a blood-filled blister. This is caused by damage to the underlying soft tissue and may be preceded by pain, firmness, or a boggy feel. A review of Resident 11's wound care notes was conducted on 10/07/25 at 9:17 AM. A note dated 06/26/25 showed that the Resident had a Stage 4 pressure ulcer located on the coccyx (The coccyx is the last bone at the bottom (base) of your spine). The pressure ulcer measurements had a length: 3.70 cm, width 7.00 cm, L x W: 25.90 cm2, and depth: 0.40 cm. Undermining: from 11 o'clock to 2 o'clock, 2.1 cm. During a continued review of Resident #11's wound care notes it was revealed that on 06/30/25 the coccyx pressure ulcer measurements had worsened. The measurements showed that the length increased to 7.20 cm, the width increased to 9.20 cm, L x W increased to 66.24 cm2, and depth remained at 0.40 cm. Undermining: from 11 o'clock to 2 o'clock, 2.1 cm. During a review of Resident #11's medical records conducted on 10/07/25 at 9:44 AM, this Surveyor was unable to locate documentation of a change in condition and notification to the Resident Representative of the worsened Coccyx pressure ulcer. During an interview conducted on 10/07/25 at 10:12 AM, the Director of Nursing (DON) advised that she investigate and return. The DON returned and confirmed that a change in condition and notification to Resident #11's Representative of the worsened coccyx pressure ulcer was not done. This Surveyor expressed concern of the deficient practice.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interviews it was determined that the facility failed to ensure a Resident Fund Account was accurately managed. This was found to be evident for 1 (Resident #14) out of 1 Resident reviewed for resident funds during the complaint survey. The findings include: During a review of complaint #365431 conducted on 10/08/25 at 10:00 AM it was reported that the facility had not managed Resident #14's fund account accurately. During a review of Resident #14's billing record conducted on 10/08/25 at 10:07 AM, it was revealed that the Resident was charged $571 for Beauty Shop/Barber services. During an interview conducted on 10/08/25 at 10:11 AM, the Business Office Management (BOM) explained that the previous BOM failed to pay for Beauty Shop /Barber service charges that the Resident had incurred for 1 year. The BOM stated that she would provide the accounting of the barber services. During a review of the Senior Salon log sheets conducted on 10/08/25 at 10:32 AM, it was revealed that Resident#14's barber chargers totaled $515 and not $571 that was charged to the Resident.During an interview of the BOM conducted on 10/08/25 at 10:49 AM. The BOM confirmed that there were accounting errors and Resident #14 was overcharged.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of the facility's investigative report and staff interview, it was determined the facility failed to report an allegation of abuse to the State Survey Agency, which was the Office of Health Care Quality (OHCQ) within 24 hours of the alleged incident. This was found to be evident for 2 (Resident #19 and #7) out of 7 Residents reviewed for abuse during the complaint survey. The findings include: 1) On 10/6/25 at 9:00AM a review of Resident # 19's clinical record revealed that the resident was admitted to the facility with diagnoses which included Shortness of Breath, Dementia and Osteoarthritis of the Right Shoulder. Further review of Resident #19 clinical record revealed the resident sustained 2 large skin tears on both forearms while being assisted out of his/her chair by Hospitality Aide #12 who was not qualified to provide care to the resident. The sizes of the skin tears were not documented in the clinical record. However, in Complaint #365421 the resident's representative stated that the skin tears measured 2.5 inches by 1.65 inches. Hospitality Aide #12 confirmed in a written statement that the resident sustained skin tears on the forearms when he tried to assist him/her out of the chair. On 10/06/25 at 12:19 PM in an interview the Director of Nursing (DON) stated that the facility employed Hospitality Aides and their duties include greeting residents and filling water pitchers. They could answer call lights, but they are not allowed to touch the residents or provide care. The DON stated that she was unfamiliar with the incident but would review the facility's documentation. Later at 2:00PM PM on 10/6/25 the DON stated that she located a soft file with investigative notes which she provided to the surveyor. A review of the soft file and of Resident #19's clinical record failed to reveal the incident was reported to the Office of Health Care Quality. The DON confirmed the surveyor's findings. 2) During a review of Facility Reported Incident (FRI) #365432 investigation conducted on 10/09/25 at 8:45AM, it was discovered that Resident #7 reported an allegation of abuse to Unit Manager #15 on 05/18/25. However, the facility did not report the allegation of abuse until 05/21/25. During an interview conducted on 10/09/25 at 9:17 AM, the Director of Nursing (DON) explained that Unit Manager #15 failed to report the allegation of abuse to the Administration. The DON reported that on 05/21/25 Resident #7 reported the allegation of abuse to the DON and Administrator, at which time she immediately reported the allegation of abuse to the State Agency OHCQ.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a complaint investigation, record reviews, and staff interviews, it was determined that the facility failed to ensure a complete and accurate written discharge summary was provided to a resident at the time of discharge. This was evident for 1 (Resident #2) of 1 resident reviewed for transfer and discharge process during the complaint survey.The findings include:Total Parenteral Nutrition (TPN) is nutrition provided through an intravenous (IV) line when a resident is unable to eat or absorb nutrients by mouth.Intravenous (IV) means within a vein. This allows the medicine or fluid to enter the bloodstream right away.On 10/08/25 at 10:17 AM, Resident #2's closed medical record was reviewed in relation to complaint #2563521. Resident # 2 was discharged to a group home on [DATE] with an abdominal drain and total parenteral nutrition (TPN). On 10/08/25 at 11:57 AM, a review of Resident #2's Discharge summary, dated [DATE], revealed that the nursing instructions section was incomplete. Information regarding Resident #2's TPN management, abdominal drain care, patient education provided, and a complete list of medications was not documented on the discharge instructions. On 10/08/2025 at 1:27 PM, review of the facility's policy titled Discharge Instructions, effective 01/29/2024, revealed that a licensed nurse will complete all applicable nursing sections of the discharge instructions prior to discharge.In an interview on 10/08/2025 at 1:45 PM, Social Worker #8 stated that each discipline is responsible for completing their assigned sections of the discharge summary and that nursing staff complete the medication and treatment areas.On 10/08/2025 at 2:33 PM, review of Resident #2's physician orders revealed that he/she was receiving TPN and had an abdominal drain in place at the time of discharge.On 10/09/2025 at 9:31 AM, an interview with the Director of Nursing (DON) confirmed that the nursing sections of Resident #2's discharge summary were incomplete and did not reflect the resident's current status at the time of discharge. The DON stated that Resident #2 was discharged to a group home with TPN supplies, an abdominal drain, and actual prescribed medications in hand. The DON further stated that it is the expectation that all disciplines, including nursing, complete appliable areas on the discharge summary form prior to the resident's discharge from the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to review and revise the interdisciplinary care plans to reveal accurate interventions for a resident. This was evident for 1 (Resident #8) of 1 resident reviewed for care planning.The findings include:Resident #8 diagnoses include Dementia, Muscle Weakness (Generalized) and Cognitive Communication Deficit. The resident was admitted to the facility in May 2025 and discharged in October 2025. The surveyor reviewed Complaint #2624448 which was submitted anonymously and stated that the facility failed to provide appropriate care to the resident after a fall.On 10/08/25 at 10:21 AM a review of Resident #8's clinical record revealed that the resident fell on [DATE] at 8:00 PM in his/her room while trying to get something from his/her drawer. A Licensed Nurse completed an assessment which included neuro checks and documented that there were no injuries.A further review revealed a Nurse's Note Post Fall Documentation dated 9/12/2025 at 20:32 labeled Late Entry stated Recommendation: Interventions currently in place to prevent additional falls: bed in low. Upon review of the resident Care Plans, the surveyor observed that Resident #8's Care Plan for falls was initiated on 8/20/25 and revised on 09/12/25. The Care Plan failed to reveal an intervention for a low bed to prevent falls as stated in the nurse's note.During an interview on 10/08/25 at 11:24 AM Unit Manager Staff #3 reviewed the clinical record and confirmed the surveyor's findings. Unit Manager Staff #3 stated that ensuring a resident's bed is in a low position is a standard intervention to prevent falls and the intervention should have been included in Resident #8's plan of care.On 10/08/25 at 12:32 PM during an interview the Director of Nursing also reviewed the clinical record and confirmed the findings. The DON stated that staff is expected to review and update Care plans in a timely manner when new interventions are put in place.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to provide services that met professional standards of practice. This was found to be evident for 1 (Resident #5) out of 1 Resident reviewed for professional standards of practice during the complaint survey. This deficient practice was identified as past non-compliance. The findings include:Antirejection medications, also known as immunosuppressants, are drugs used to prevent the body's immune system from attacking and rejecting a transplanted organ. These medications are essential for ensuring the success of organ transplants and maintaining the health of the transplanted organ. A review of the Facility Reported Incidents (FRIs) #365430 and #365429 investigations was conducted on 10/06/25 at 9:54 AM. The investigation reported that following a discussion with Resident #5's Cardiologist on 4/23/25, it was determined that an error had occurred. It was identified that the therapeutic drug level of anti-rejection medications was low which indicated that the Resident had not taken the medications as prescribed. At the request of the cardiologist the resident was transferred to the hospital for a non-emergent evaluation and treatment. During a review of the Resident #5's medical records conducted on 10/06/25 at 10:07 AM, it was discovered that the Resident was transferred and admitted to a local hospital on [DATE]. A review of Resident #5's hospital discharge summary conducted on 10/06/25 at 10:19 AM revealed a discharge medication list. The discharge medication list dated 03/11/25 showed 2 anti-rejection medications: Sirolimus 0.5 mg (milligram) tablet every 24 hours, and Tacrolimus 2 (1) mg capsules every 24 hours. A review of Resident 5's Physician orders and Medication Administration Record (MAR) conducted on 10/06/25 at 10:33 AM for March and April 2025 did not show an order for Sirolimus 0.5 mg tablet every 24 hours and Tacrolimus 2 (1) mg capsules every 24 hours. The review confirmed that the Resident had not received the anti-rejection medications as listed on the discharge medication list on 03/11/25. A medication trough is the lowest concentration of a drug in the bloodstream, measured just before the next dose is administered. This measurement is part of a process called therapeutic drug monitoring and is essential for medications with a narrow therapeutic index, meaning the difference between an effective dose and a toxic dose is very small. To ensure effectiveness the trough level confirms that the drug concentration stays above the minimum effective level throughout the entire dosing interval. If the trough level is too low, the medication may not be working correctly.During an interview conducted on 10/06/25 at 10:49 AM, the Director of Nursing (DON) explained that the facility was made aware that Resident #5 had not been administered the anti-rejection medications by the Resident's Cardiologist during a routine appointment. The Cardiologist had requested labs to be drawn for the trough of Sirolimus and Tacrolimus a few days prior to the routine appointment. The lab results reported that the trough levels were low which prompted the Cardiologist to request the Resident's active medication list. There it was discovered that the Resident did not have an active order for the anti-rejection medications. When asked why the anti-rejection medications weren't ordered and administered for an organ transplant Resident, the DON stated that there were multiple system failures. She stated that the medications were overlooked during the admission process on 03/11/25 and overlooked again during the pharmacy medication regimen review the next day (03/12/25). When asked what the admission process was, the DON explained that a physician or nurse practitioner are required to review the resident's hospital discharge summary to identify the level of care the Resident required which included reviewing the discharge medication list prior to admission. She further explained that once the Resident was admitted the admitting nurse was required to review the hospital discharge summary and place an order for each medication listed on the medication discharge list unless directed differently from the admitting provider. However, everyone overlooked the anti-rejection medications. When asked why anyone didn't question why the Cardiologist requested troughs for medications that Resident #5 were not receiving, the DON responded unfortunately it was another missed opportunity. The DON advised that the facility had implemented new processes that would ensure this deficient practice would not occur again. On 10/06/25 at 1:45 PM a review of the facility's Ad-Hoc Qapi Action Plan /Qapi Meeting Report was conducted. The report dated 05/01/25 identified the following problems: failure to enter medication orders, breakdown in medication reconciliation, communication gaps, unclear role responsibility and training deficiency. The Report showed that the facility's resolution listed mandatory charge nurse training, enhanced admission protocols, supervisory follow up process, pharmacist review process and continuous process evaluation. A continued review of the report included in-service

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, it was determined that the facility failed to ensure that wound dressings were labeled to indicate when the dressing change occurred. This was evident for 2 (Resident #21and #22) of 3 wound dressing observations.The findings include:On 10/07/25 at 7:45 AM a review of Resident #21's clinical record revealed that the resident was being treated for a skin tear to the Left Elbow 3 times a week and prn (as needed). The physician order dated 10/02/25 stated Left Elbow 1.Cleanse with normal saline, pat dry. 2. Apply Xeroform to base of the wound. 3. Secure with Bordered gauze. 4.Change every Mon, Wed, Fri and PRN every day shift every Mon, Wed, Fri. Start Date: 10/03/25On 10/7/25 at 8:05AM the surveyor accompanied by Wound Nurse RN #2 made random observations of residents' wound dressings. The surveyor observed that Resident #21's dressing to the Left Elbow was not initialed and not labeled as to when it was last changed and on what shift. 2) Resident #22's clinical record revealed a physician order dated 08/01/25 which stated Right Lateral Knee: 1. Cleanse with wound cleanser, pat dry. 2. Cut Gentell Blue to the size of the wound. 3. Apply Gentel Blue directly [NAME] the wound bed and fill cavity-**It can be rolled or layered and packed into the wound. 4.Cover with silicone bordered super absorbent dressing. 5. Change Monday, Wednesday, Friday and PRN every day shift every Mon, Wed, Fri. Start Date: 08/04/25The surveyor observed that Resident #22's dressing to the Right Knee was not initialed and not labeled as to when it was last changed and on what shift. During the observation, in an interview, Wound Nurse RN #2 who accompanied the surveyor confirmed the findings. Wound Nurse #2 stated that the standard practice for dressing changes was for the Licensed Nurses to initial, date and label the dressings to indicate when the dressing change occurred. Wound Nurse RN #2 was unable to tell the surveyor who changed the dressings and on what shift. On 10/07/25 at 8:18 AM the Nurse Educator in an interview was informed of the surveyor's concerns, and she indicated that she would educate the nurses.On 10/7/25 at 8:42 AM in an interview, the Director of Nursing (DON) was notified of the surveyor's concerns. The DON stated that she was aware of the findings and that Inservice training on dressing changes had already started on 10/6/25. She gave the surveyor a copy of the Inservice document.

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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. Based on medical record reviews and staff interviews, it was determined that the facility failed to provide treatment and services necessary to prevent pressure ulcer. This was evident for 1 (Resident #16) out of 1 resident reviewed for facility acquired pressure ulcer during the complaint survey process. The findings include:An in-house acquired pressure ulcer is a skin or tissue injury that develops while a resident is in the nursing facility, which was not present at the time of admission. These pressure ulcers occur due to prolonged pressure, friction, shear, or other risk factors and indicate a failure to implement preventive measures or provide timely interventionsDuring record review on 10/08/25 at 7:30 AM, it was revealed that Resident #16 was admitted from the hospital to the facility on 2/27/2025 with medical diagnoses of morbid (severe) obesity due to excess calories and type 2 diabetes mellitus without complications and had no pressure ulcers at the time of admission.On 10/08/25 at 8:00AM review of Resident #16's admission assessment record revealed a Braden Scale assessment for predicting pressure sore risk. The Braden Scale is an evidence-based tool that predicts the risk of developing a hospital or facility-acquired pressure ulcer/injury. The scale uses scores ranging from 6 to 23, with lower scores indicating higher risk for developing an acquired ulcer/injury. Resident #16 scored 15 on the Braden Scale, indicating mild risk, while a score of 19-23 is considered no risk for developing a pressure sore.On 10/08/25 at 8:20 AM, review of the medical record revealed that on 3/10/2025, Resident #16 developed an unstageable pressure ulcer to the sacral area while in the facility, measuring 2.40 cm in length x 0.80 cm in width x 0.20 cm in depth, with a calculated area of 1.92 cm^2 and 100% slough, according to the wound physician's notes. Further review revealed that no change in condition assessment was completed, and the resident's family representative was notified of the change. On 10/08/25 at 10:30 AM, medical record review revealed that the wound assessment report dated 3/24/25 indicated the Resident #16's wound remains unstageable, measured 2.60 cm in length x 1.90 cm in width x 0.20 cm in depth, with a calculated wound area of 4.94 cm^2.During interview with the Director of Nursing (DON) on 10/08/25 at 11:20AM, she stated Resident #16 was admitted with left buttock incontinent associated dermatitis, right abdominal fold and a blister on the right tight. She confirmed that the resident acquired in-house unstageable pressure ulcer at the sacrum on 3/10/25. On 10/08/25 at 11:25 AM, the Director of Nursing (DON) confirmed that no change in condition assessment was completed for the in-house acquired pressure ulcer. When asked if the family was notified of the change, she stated, 'I do not see family or resident notification.' The DON further stated that the facility's expectation is for nurses to complete a change in condition assessment and to notify residents or their representatives of any change in condition. On 10/08/25 at 11:35 AM, the surveyor made the DON aware of the above concerns, and she acknowledged receipt.

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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. Based on record review, interviews and review of facility investigation documents, it was determined that the facility failed to keep a resident free from accidents and hazards by failing to provide a qualified caregiver to assist the resident. This was evident in 1 (Resident #19) of 1 resident reviewed for accidents and hazards during the complaint survey.The findings include:A review of Complaint #365421 made by Resident #19's Representative stated that the resident was observed on 10/21/24 with 2 lacerations on both arms, both measured 2.5 inches by 1.65 inches. Further, they were not notified of the injuries and when asked, the facility gave four different versions of the incident.On 10/6/25 at 9:00AM a review of Resident # 19's clinical record revealed that the resident was admitted to the facility with diagnoses which included Shortness of Breath, Dementia and Osteoarthritis of the Right Shoulder.Further review of the clinical record revealed a note dated 10/20/24 at 16:30 by LPN Staff #9 which stated that she was called to the resident's room and observed two large skin tears on both forearms of the resident. The resident was non-English speaking, so the LPN Staff #9 got an interpreter. Through the interpreter, the resident stated that he/she was being assisted by a staff member to get out of the chair to go to the bathroom when the incident occurred. The physician was notified, and the skin tears were treated in keeping with the physician orders. The note continued RP (resident representative) not reachable, message left to call back the facility. The surveyor noted that the documentation failed to reveal the size of the skin tears. On 10/06/25 at 11:22 AM the surveyor interviewed LPN Staff #9 who repeated what was written in her note dated 10/20/24. LPN Staff #9 stated that the staff member who assisted the resident was a Hospitality Aide #12 who was not supposed to provide care or get the resident out of the chair. She informed Hospitality Aide #12 that he should not have touched the resident, obtained a statement from him then reported the incident her supervisor. LPN Staff #9 confirmed that she did not measure the Skin Tears. On 10/06/25 at 12:19 PM in an interview the Director of Nursing (DON) stated that the facility employed Hospitality Aides, and their duties include greeting residents and filling water pitchers. They could answer call lights, but they are not allowed to touch the residents or provide care. The DON stated that she was unfamiliar with the incident but would review the facility's documentation. Later at 2:00 PM on 10/6/25 the DON stated that she located a soft file with investigative notes which she provided to the surveyor. The DON also provided the surveyor with a copy of a job description for Hospitality Aides. The document was entitled Job Description - Personal Care Aide (PCA) revised in December 2022. In the document under Heading - Supportive Tasks the document stated PCAs are not permitted to perform direct patient care, even if supervised A review of the soft file revealed a statement dated 10/20/24 from Hospitality Aide #12 confirming that the resident sustained skin tears when he assisted them to get up from the chair. The file also contained documentation that an Inservice was provided to Hospitality Aides emphasizing boundaries of their responsibilities to ensure patient safety and proper care. The concern that a resident was injured by a staff member who was not qualified to provide care was brought to the attention of the DON. The DON stated that she reviewed the documents and confirmed the surveyor's findings.

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	10/09/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to ensure all medications were ordered as listed on the hospital discharge summary. This was evident for 1 (resident #5) out of 22 residents reviewed for physician services during the complaint survey. The findings include: Antirejection medications, also known as immunosuppressants, are drugs used to prevent the body's immune system from attacking and rejecting a transplanted organ. These medications are essential for ensuring the success of organ transplants and maintaining the health of the transplanted organ. A review of the Facility Reported Incidents (FRIs) #365430 and #365429 investigations was conducted on 10/06/25 at 9:54 AM. The investigation reported that following a discussion with Resident #5's Cardiologist on 4/23/25, it was determined that an error had occurred. It was identified that the therapeutic drug level of anti-rejection medications was low which indicated that the Resident had not taken the medications as prescribed. At the request of the cardiologist the resident was transferred to the hospital for a non-emergent evaluation and treatment. During a review of the Resident #5's medical records conducted on 10/06/25 at 10:07 AM, it was discovered that the Resident was transferred and admitted to a local hospital on [DATE]. A review of Resident #5's hospital discharge summary conducted on 10/06/25 at 10:19 AM revealed a discharge medication list. The discharge medication list dated 03/11/25 showed 2 anti-rejection medications: Sirolimus 0.5 mg (milligram) tablet every 24 hours, and Tacrolimus 2 (1) mg capsules every 24 hours. A review of Resident 5's Physician orders and Medication Administration Record (MAR) conducted on 10/06/25 at 10:33 AM for March and April 2025 did not show an order for Sirolimus 0.5 mg tablet every 24 hours and Tacrolimus 2 (1) mg capsules every 24 hours. The review confirmed that the Resident had not received the anti-rejection medications as listed on the discharge medication list on 03/11/25.During a telephone interview conducted on 10/07/25 at approximately 1:00 PM, Certified Registered Nurse Practitioner (CRNP) #16 explained that when a Resident was to be admitted to the facility she would review the hospital discharge summary to determine the resident's level of care which included reviewing the medication list. The CRNP #16 further explained that she does not change or stop any of the medications listed on the discharge medication list. When asked does she reconcile the Resident's admitting medications, the CRNP #16 responded yes. When asked how the medications were reconciled she stated she used the hospital discharge summary medication list. When asked did she reconcile the medications for Resident #5 the CRNP #16 stated she does not have access to the Medications Administration Record (MAR) only to the Electronic Health Record (EHR), but that she could review the medications listed in the EHR. When asked did she reconcile the medications for Resident #5, the CRNP replied no because the admitting nurse completes that task. This Surveyor reminded the CRNP that she earlier stated that she reconciles the medications, the CRNP replied it is the admitting nurse responsibility. When asked if the CRNP #16 notice that the heart transplant Resident was not on any anti-rejection medication she stated no I was focused on the Resident's heart failure medications. During an interview conducted on 10/07/25 at 1:47 PM, the Director of Nursing (DON) confirmed that the admitting nurse will place the order for each admitting medication however the provider is expected to reconcile the medication list.

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	10/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to ensure that an accurate pharmacy medication regimen review was conducted. This was found to be evident for 1 (Resident #5) out of 1 Resident reviewed for pharmacy medication regimen review during the complaint survey. The findings include: During a review of the Resident #5's medical records conducted on 10/06/25 at 10:07 AM, it was discovered that the Resident was transferred and admitted to a local hospital on [DATE]. A further review of Resident #5's medical record showed that the Resident was re-admitted to the facility on [DATE] following the hospital admission on [DATE]. Antirejection medications, also known as immunosuppressants, are drugs used to prevent the body's immune system from attacking and rejecting a transplanted organ. These medications are essential for ensuring the success of organ transplants and maintaining the health of the transplanted organ. A review of the discharge summary conducted on 10/06/25 at 10:19 AM revealed a discharge medication list. The discharge medication list dated 03/11/25 showed 2 anti-rejection medications: Sirolimus 0.5 mg (milligram) tablet every 24 hours, and Tacrolimus 2 (1) mg capsules every 24 hours. A pharmacy medication regimen review is a comprehensive evaluation by a pharmacist to assess a patient's complete medication list for safety and effectiveness. It identifies potential problems like drug-drug interactions, incorrect dosages, unnecessary drugs, or side effects, aiming to promote positive outcomes and minimize risks. This process involves reviewing the patient's medical records and lab reports and often results in a written report to the physician with recommendations for action. A review of Resident #5's pharmacy New admission Medication Review (aMMR) was conducted on 10/06/25 at 10:30 AM. The aMMR failed to identify 2 anti-rejection medications: Sirolimus 0.5 mg (milligram) tablet every 24 hours, and Tacrolimus 2 (1) mg capsules every 24 hours that were listed on the hospital discharge medications list. During an interview conducted on 10/06/25 at 10:49 AM, the Director of Nursing (DON) explained that when a Resident is admitted , the pharmacy has a responsibility to review the hospital discharge medication list and reconcile the medications. The DON confirmed that the pharmacy completed Resident #5's admission medication review however they overlooked the 2 anti-rejection medications.