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	02/18/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews, it was determined that the facility failed to ensure food and equipment was prepared in a manner that maintains professional standards of food service safety and sanitation. This was found to be evident for 2 (Cook #1 and Dietary Aide #2) out of 4 kitchen staff and 1 commercial dishwasher observed during the recertification and complaint survey. This practice had the potential to affect all Residents who consumed food prepared by the facility's kitchen. ????????? The findings include: A beard net is a lightweight, disposable, and breathable mesh covering-typically made from nylon or polypropylene-designed for food service workers to cover facial hair and prevent hair from falling into food. It ensures compliance with FDA Food Code standards to prevent contamination, featuring an elastic band for a secure, universal fit.During observations conducted 02/09/2026 at 8:28 AM of the initial tour in the facility's kitchen, the Surveyor observed [NAME] #1 and Dietary Aide #2 without wearing a beard net. Wet nesting is the unsafe practice of stacking, nesting, or storing dishes, pots, and pans while they are still wet, which prevents proper air circulation. This creates a dark, moist, low-air environment that fosters rapid bacterial growth and mold, creating a significant health violation in foodservice settings. FDA guidelines mandate that all wares should be air dried. Using towels to dry dishes is never permitted. During the continued initial tour, the Surveyor and [NAME] observed wet nesting in between the silver metal pans that were stacked on the metal rack inside the kitchen and plastic cups stacked on a tray by the steam table.Commercial dishwashers generally reach between 150 degrees Fahrenheit (F) and 180 degrees (F) to sanitize, depending on the type. High-temp machines require a final rinse of 180 degrees (F) for heat sanitation, while low-temp machines operate at lower temperatures, typically at least 120 degrees (F) relying on chemicals instead.During a follow up tour of the kitchen conducted on 02/12/2026 at 11:00 AM, the Surveyor observed Dietary Aide #2 run the commercial dishwasher located in the dish room. The Surveyor observed the wash and rinse cycle and discovered that the rinse temperature was 160 degrees Fahrenheit. The Surveyor asked the Dietary Aide to run the dishwasher again; the rinse cycle temperature again read 160 degrees Fahrenheit. The Surveyor asked the District Dietary Manager to run the commercial dishwasher. The dishwasher was ran 2 times with the same results for the rinse cycle temperature of 160 degrees Fahrenheit. The District Dietary Manager reported that the dishwasher was a high temperature dishwasher which required a rinse cycle 180 degrees (F). The District Dietary Manager reported that he would contact the facility's dishwasher repair vendor Ecolab immediately for repair. A review of the dishwasher temperature log from February 1, 2026 through February 12, 2026, showed the temperatures for wash and rinse were documented at 180 degrees (F). During an interview conducted on 02/12/2026 at 12:00 PM, the District Dietary Manager reported that Ecolab was scheduled to come to the facility today (02/12/2026). The District Dietary Manager also reported that the commercial dishwasher was converted to chemical instead of high temp. On 02/12/2026 at 12:10 PM, the Surveyor observed the commercial dishwasher now running on a chemical cycle for wash and rinse. The wash and rinse temperatures were maintained at 140 degrees (F).

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on interviews and record review it was determined that that facility failed to ensure Resident personal funds were fully accessible. This was found to be evident for 54 out of 54 Residents who have Resident Fund Accounts. The findings include: During an interview conducted on 02/09/2026 at 8:30 AM, Resident #11 reported that his/her money from the Resident Fund Account is not always available during the week and never available on the weekends or holidays. The Resident was unable to provide a time period or date when he/she could not access their personal funds. During an interview conducted on 02/12/2026 at 1:32 PM, the Business Office Manager (BOM) reported that Resident funds are available at the front desk from Monday - Friday from 7:45 AM to 6:00 PM or 7:00 PM when she leaves for the day. On weekends and holidays Resident funds are available at the front desk from the hours of 7:45 am to 5:00 pm. The BOM stated that during the week she maintained a balance of $200 a day at the front desk and on the weekends and holidays she gave the front desk $50.00 for the entire weekend or holiday. The BOM explained that she made sure that all Residents received their money on Fridays to ensure the Residents would not have a need to get money from the front desk on weekends and holidays. The BOM reported that those Residents who wanted funds on the weekends would receive $5-$10, however that was rare because she made sure all Residents received the money they would need on Fridays. During a review of the Resident Fund Management Service report conducted on 02/18/2026 at 10:02 AM it was discovered that there are 54 Residents who have a Resident Fund account. During an interview conducted on 02/18/2026 at approximately 10:30 AM, the Director of Nursing (DON) reported that the front desk receptionist hours are from 7:00 AM and 10:00 PM seven days a week including holidays. The DON reported that Residents can access their Resident funds during those hours. The Surveyor expressed concern that the front desk had a total of $50.00 for the entire weekend and holidays for 54 residents who had a Resident Fund Account. The Surveyor also expressed concern that if a Resident was not available to receive their money on Friday the Resident would receive limited funds on the weekends and/ or holidays.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews and record review, it was determined that the facility failed to ensure 1) Residents were free of physical restraints and 2) a physician order was obtained for the use of a physical restraint. This was found to be evident for 1) 4 (Resident #16, #27, #4, & #11) out of 4 Residents reviewed for restraints and 2) 47 (Resident #90, #142, ##107, #146, #86, #137, #129, #81, #145, #70, #75, #68, #144, #91, #109, #99, #10, #147, #66, #119, #12, #84, #133, #124, #92, #56, #9, #47, #52, #37, #55, #41, #39, #59, #128, #105, #113, #11, #49, #13, #98, #102, #62, #25, #53, #104, & #34) out of 47 Residents reviewed for physician orders for physical restraints during the recertification and complaint survey. The findings include: 1)According to Centers of Medicare and Medicaid Services (CMS), positioning a bed directly against a wall prevents a resident from exiting is considered a physical restraint. Such actions limit freedom of movement and, unless clinically justified for a specific medical symptom and properly documented, are prohibited as they violate patient rights regarding autonomy and safety.During an initial tour of the second-floor nursing unit conducted on 02/08/2026 at 8:35 AM it was discovered that Resident #16, #27, #4, & #11 beds were positioned directly against the wall. A CMS-defined care plan is a structured, person-centered document that outlines a patient's specific health issues, goals, and the medical or supportive services needed to manage them. It serves as an actionable, often electronic, instruction manual for care teams, incorporating assessments, treatments, and coordination across providers.A review of Resident #16, #27, #4, & #11 care plans conducted on 02/08/2026 at 2:45 PM did not show a care plan that the Residents requested to have their bed placed against the wall. During an interview conducted on 02/11/2026 at approximately 8:30 AM, the Surveyor expressed concerned with the Director of Nursing (DON) that Residents #16, #27, #4, & #11 beds were positioned directly against the wall which was a physical restraint. The DON reported that she would conduct a facility sweep to ensure the Resident's beds were not positioned against the wall. Those Residents who had a bed positioned against the wall would be immediately removed from the wall. During an interview conducted on 02/12/2026 at 7:00 AM, the DON reported that staff conducted facility sweep and moved Residents beds 18 inches from the wall. The DON reported that as of 02/11/2026 all Resident beds had been moved from against the wall apart from the Residents who refused to have their beds moved. The DON provided the Surveyor with a list of Residents who refused to have their beds removed from the wall.A review of the list showed there were 47 Residents who were now care planned for their refusal to have their beds moved from against the wall. During a review of the Resident #90, #142, ##107, #146, #86, #137, #129, #81, #145, #70, #75, #68, #144, #91, #109, #99, #10, #147, #66, #119, #12, #84, #133, #124, #92, #56, #9, #47, #52, #37, #55, #41, #39, #59, #128, #105, #113, #11, #49, #13, #98, #102, #62, #25, #53, #104, & #34 medical records conducted on 02/11/2026 from 7:33 AM to 8:52 AM, it was discovered that the Residents did not have a physician's order for a physical restraint.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. Based on observations and interviews it was determined that the facility failed to ensure Residents had a comfortable chair in their room. This was found to be evident for 5 (Resident #40, #41, #12, #108, & #11) out of 5 Resident rooms observed during the recertification and complaint survey. The findings include: During random observations conducted on 02/08/2026 from 9:23 AM to 1:37 PM, the Surveyor was unable to locate a chair in Resident #40, #41, #12, #108, & #11 rooms. During interviews conducted on 02/08/2026 from 9:23 AM to 1:37 PM Residents #40, #41, #12, #108, & #11 confirmed that they did not have a chair in their room. During an interview conducted on 02/18/2026 at approximately 8:00 AM, the Director of Nursing (DON) was given the room numbers of each resident that did not have a chair in their room. The DON reported that each resident should have a chair in their room.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record reviews, interviews and observations, it was determined that the facility (1) failed to provide access to services outside the facility and (2) failed to ensure Residents were provided a dignified existence. This was found to be evident for 2 (Resident #22 and #41) out of 2 Residents observed for resident rights. The findings include: (1) A CT (computed tomography) scan is a quick, painless, non-invasive imaging procedure that uses rotating X-rays to create detailed, cross sectional slices of bones, blood vessels and soft. tissues. Usually lasting only 10 to 15 minutes, these scans are used to diagnose injuries, diseases, or guide treatment. During a review of medical records for Resident #22 on 2/12/2026 at 8:07 AM it was found that the Resident had an appointment with his/her neurosurgeon's office on 5/21/2025, following this appointment the provider ordered for a CT scan of the Resident's head to be completed with the results being sent to the neurologist. During additional review of medical records for Resident #22 a progress note date 5/22/2025 at 12:16 PM was revealed that stated to Order head CT without contrast. Results to be faxed to neurosurgeon. There was also an order dated 5/22/2025 which stated, Schedule CT of head without contrast to follow-up and Fax result to patient's Neurosurgeon. During continued review of medical records for Resident #22 it was discovered that there was no documentation of a CT scan being scheduled or completed for the Resident following this order from 5/22/2025. During an interview with Unit Manager #5 on 2/12/2026 at 3:43 PM she reported that the appointment should've been scheduled as ordered but it was not completed. She advised that the Unit clerk had attempted to make the appointment for the CT but was told their system was down when she called and was supposed to call back to schedule the CT appointment but did not. She advised the resident ended up going to the emergency room in July 2025 and had a CT while there, so she stated she would contact the neurosurgeon's office to ensure they received a copy of the results. During an interview with Unit Clerk #19 on 2/17/2026 at 1:32 PM she reported that she had made the initial phone call to schedule the CT for Resident #22 and was told their system was down. She advised she was supposed to call back to schedule the appointment and confirmed that a second call to schedule the appointment was never made. (2) During an observation conducted on 02/09/2026 at 8:02 AM, the Surveyor observed Licensed Practical Nurse (LPN) #16 knock on Resident #41's entry door and then entered the Resident's room. The LPN entered the Resident's room without gaining permission and without announcing who she was. During an interview conducted on 02/09/2026 at 8:04 AM, LPN #16 was asked what the expectation (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was when entering a Resident's room. The LPN replied you knock and then enter, when asked does she wait for permission to enter and does she announce herself, the LPN stated yes. The LPN stated that when she entered Resident #41's room today she was trying to see who was in the Resident's room. The Surveyor observed the LPN holding a clip board and blood pressure cuff when she entered the Residents room without permission and unannounced.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, it was determined that the facility failed to provide a homelike environment. This was found to be evident for 4 (Residents #53, #22, #62 and #119) out of 27 resident rooms observed for homelike environment during the course of the survey.The findings include: (1) During an observation of the room for Resident #53 on 2/09/2026 at 11:04 AM a large white area where the paint had peeled or had been scraped off was discovered behind the Resident's bed. An additional observation was made of a small dresser used by Resident #53 which revealed the bottom drawer was lopsided, not closing completely and was missing a handle. During an interview with Resident #53 on 2/09/2026 at 11:05 AM he/she reported that he/she had been in the room for years and that the white area behind the bed had been there since coming to the room. Resident #53 advised the dresser had been supplied by the facility and had been missing the handle to the bottom drawer since being transferred into the room. During an interview with the Maintenance Director on 2/18/2026 at 11:26 AM he advised nursing staff notify him by word of mouth and they have an electronic reporting system to notify maintenance of any concerns. He also reported that he and his assistant would complete rounds on random rooms to identify areas needing to be repaired. He advised that he had been working to get rooms in the facility painted but was trying to get help. During an observation with the Maintenance Director on 2/18/2026 at 11:32 AM of the room for Resident #53 he agreed the wall needed to be painted and the dresser needed to be repaired. He reported that he was not notified of the wall, lopsided drawer or the missing handle to the drawer. He was able to fix the drawer so it would slide back in appropriately and advised he would get a new handle for the drawer. He added he would add the room to the list of rooms needing painted. (2) During an observation of inside the room for Residents #22 and #62 on 2/09/2026 at 12:51 PM it was discovered to have a large area above and to the right of the Residents doorway had been painted over with a white color that did not match the room's coloration. Additional observations of the wall near the doorway revealed several black streaks running along the lower wall and additional patches of white paint along with white paint drips were noted on the mid and upper wall. During an interview with the Maintenance Director on 2/18/2026 at 11:26 AM he advised nursing staff notify him by word of mouth and they have an electronic reporting system to notify maintenance of any concerns. He also reported that he and his assistant would complete rounds on random rooms to identify areas needing to be repaired. He advised that he had been working to get rooms in the facility painted but was trying to get help. During an observation with the Maintenance Director on 2/18/2026 at 11:30 AM of the room for Residents #22 and #62 he agreed the walls needed to be painted. He advised he would add the room to the list of rooms that needed to be painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3) During an observation conducted on 02/09/26 at 12:11 PM, the Surveyor observed Resident #119's bed against the wall. The wall had large areas of paint that had peeled. During an interview the Resident stated that the wall had been like that for some time. During a tour with the Maintenance Director conducted on 02/09/26 at 1:47 PM the Surveyor and the Maintenance Director observed Resident #119's wall that had peeling paint on the wall next to the resident's bed. During an interview conducted on 02/09/26 at 1:49 PM, the Maintenance Director reported that the Maintenance Assistant and himself conduct rounds on randomly selected rooms and if they identify areas for repair either the assistant or himself will make the repair to the area of concern. The Maintenance Director reported that he was unaware of the peeling paint in Resident #119's room and stated that he would repair the wall. The Maintenance Director further stated that the facility had a formal reporting system but because both him and his assistant are on the floor regularly, the staff and residents report maintenance concerns to them in person.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review it was determined that the facility failed to ensure Resident care plans were developed. This was found to be evident for 2 (Resident #2 & #12) out of 27 Resident care plans reviewed during the recertification and complaint survey. The findings include: 1) During an interview conducted on 02/09/2026 at 2:36 PM, Resident #2 reported that he/she had experienced childhood trauma. The Resident stated that the trauma has messed my head up. A review of Resident #2's trauma screening conducted on 02/17/2026 at 12:59 PM showed that the resident screened positive for trauma. According to Centers for Medicare & Medicaid Services (CMS) guidelines, a care plan is a comprehensive, person-centered document that outlines a patient's medical, functional, and psychosocial needs, along with specific goals, treatments, and services. It serves as an actionable guide for managing chronic conditions and coordinating care across providers. A review of Resident 2's care plan conducted on 02/17/2026 at 1:03 PM did not show a care plan for trauma.During an interview conducted on 02/17/2026 at 1:57 PM, the Director of Nursing (DON) reported that the Social Service Director (SSD) should have triggered a care plan for trauma. The DON returned and confirmed that the Resident was not care planned for trauma. The DON stated that she would investigate it further and have the care plan updated to include trauma. 2) The Centers for Medicare & Medicaid Services (CMS) defines palliative care as patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. It involves addressing physical, intellectual, emotional, social, and spiritual needs throughout the continuum of a serious illness and can be provided alongside curative treatment.During a review of Resident #12's medical record conducted on 02/17/2026 at 9:26 AM, the Surveyor discovered an order for a Palliative care consultation on 11/26/25. During a review of Resident #12's care plan conducted on 02/17/2026 at 10:37 AM, it was discovered that the Resident did not have a care plan for Palliative Care. During an interview conducted on 02/17/2026 at 10:41 AM, the Director of Nursing (DON) confirmed that Resident #12 was on Palliative Care however did not have a care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record reviews, observations and interviews, it was determined the facility staff failed to revise care plans to meet the needs of the residents. This was evident for 2 (Residents # 15 and #13) of 2 residents reviewed for care plan revisions during the recertification survey.The findings include:A Care Plan is used in nursing facilities to summarize a resident's health conditions and care needs. It is used to ensure resident's needs are met and consistent care is provided to the resident based on those needs. 1. During a review of the care plan for Resident #15 on 2/11/2026 at 10:04 AM it was discovered that the Resident had a care plan with a focus that was added on 1/14/2024 and it stated the Resident wears a left hand splint and left elbow splint. The plan identified the goal as The resident will maintain their range of motion as much as possible throughout review period and the interventions included Periodic review by licensed nurse.During an observation of Resident #15 on 2/11/2026 at 12:07 PM it was noted that the resident was not wearing a splint on his/her left hand or elbow.During an observation with GNA #18 on 2/12/2026 at 9:20 AM she confirmed that Resident #15 was not wearing a splint and advised that he/she did not have a splint to wear.During additional record review on 2/12/2026 at 1:37 PM it was discovered that there was a previous order for Resident #15 which stated, Splint order - Patient to wear left hand splint and left elbow splint for 5 hours during the day. This order was discontinued on 6/11/2024.During an interview with Unit Manager #9 on 2/12/2026 at 2:38 PM she confirmed that Resident #15 did not have a splint that he/she should be wearing. She advised the resident had used splints in the past but did not use them any longer. She provided a list of Residents that required splints to be worn and Resident #15 was not on that list.During an interview with the Director of Nursing (DON) on 2/12/2026 at 2:48 PM she reported that the expectations are for the care plan to be updated quarterly or if something changes with the Resident's care. She advised that since Resident #15 was no longer using a splint as a part of his/her care, the care plan should have been updated to discontinue the plan for the left hand and elbow splint to be used. She advised anything in the care plan not matching orders should be removed.During a review of the facility's policy Care Planning on 2/18/2026 at 8:48 AM it was discovered that the Care plans will be updated on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment.2. During a review of the care plan for Resident #13 on 2/17/2026 at 9:13 AM it was discovered that the Resident had a care plan with a focus that was added on 4/15/2025 and it stated the the resident has a midline venous access site.During a review of the orders for Resident #13 on 2/17/2026 at 9:26 PM it was discovered that the resident had a midline and it was discontinued on 4/23/2025.During an interview with the Director of Nursing (DON) on 2/17/2026 at 1:12 PM she reported that the expectations are for the care plan to be updated quarterly or if something changes. She advised that since Resident #13 no longer had a midline the care plan should have been updated to discontinue the midline as a part of the resident's care.During a review of the facility's policy Care Planning on 2/18/2026 at 8:48 AM it was discovered that the Care plans will be updated on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record reviews and interviews it was determined that the facility failed to ensure nursing standards of practice were met. This finding was evident for 1 (Resident #9) of 1 resident reviewed for standards of practice during the recertification survey.The findings include:During an interview with Resident #9 on 2/09/2026 at 1:01 PM he/she reported having diarrhea every day for the last two weeks but advised he/she didn't feel the facility was doing anything about it. Clostridioides difficile (C. diff) is a bacterium causing severe, sometimes fatal, diarrhea and colon inflammation (colitis), often triggered by recent antibiotic use that disrupts normal gut flora. It frequently affects people in hospitals or nursing homes. Symptoms include watery diarrhea, fever, and abdominal pain. It is treated with specific antibiotics and, in recurring cases, fecal transplants. During a review of medical records for Resident #9 on 2/17/2026 at 1:14 PM it was discovered that an order for his/her stool to be tested for C. diff had been placed on 2/10/2026 at 3:47 PM and it was signed off as completed on the Treatment Administration Record on 2/11/2026 at 10:55 PM.During a continued review of medical records for Resident #9 it was revealed that there were no lab results for the order to test stool for C. diff.During a review of the Laboratory Orders and Results binder on 2/17/2026 at 1:48 PM it was discovered that the C. diff order was not signed off as being picked up by the lab but was labeled as no stool.During an interview with Licensed Practical Nurse (LPN) #8 on 2/17/2026 at 1:56 PM she confirmed that she had worked during the shift of 2/11/2026 and that Resident #9 did not have a bowel movement during her shift, so the specimen was not obtained. She advised that she had notified the oncoming shift that the specimen was still needed.An additional record review of the medical records for Resident #9 on 2/17/2026 at 1:59 PM it was discovered that there was daily documentation of the Resident having bowel movements after the order to test stool was placed. The bowel movements were documented as occurring on the night shift of 2/10/2026; the day, evening and night shifts of 2/11/2026; the day, evening and night shifts of 2/12/2026; the day evening and night shifts of 2/13/2026; the day, evening and night shifts of 2/14/2026; the day, evening and night shifts of 2/15/2026 and the day, evening and night shifts of 2/16/2026.During an observation of the Laboratory Orders and Results binder with the Assistant Director of Nursing (ADON) on 2/17/2026 at 2:17 PM she reported the lab technician wrote no stool on the stool order in the Draw Log when they came to pick up the specimens. She confirmed the lab did not pick up a specimen for that order.During an interview with the ADON on 2/17/2026 at 2:19 PM she reported that if no stool was obtained for the lab order it should not have been signed off as completed for Resident #9 and it should have been noted that the order was not done because the resident didn't have a bowel movement. She advised that the order for a stool sample is usually placed for a duration of one to two days and if the order for the specimen runs out due to the Resident not having a stool, we should communicate with the doctor so we can extend the order. She confirmed that this order should have been extended since the stool specimen was not obtained.During an additional medical record review 02/18/2026 7:40 AM it was discovered that a new order for Resident #9 to have stool tested for C. diff was placed on 2/17/2026 at 3:19 PM.

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	215168	A. Building B. Wing	02/18/2026

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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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interview it was determined that the facility failed to ensure Pharmacy Medication Regimen Review (MRR) recommendations were reviewed in a timely manner. This was found to be evident for 1 (Resident #4) out of 5 Residents reviewed for unnecessary medications during the recertification and complaint survey. The findings include: A pharmacy Medication Regimen Review [MRR] is a comprehensive evaluation of all a patient's medications-prescription, OTC [over the counter], and herbal-conducted by a pharmacist to ensure safety, efficacy, and appropriateness. It identifies, prevents, and resolves issues like drug interactions, duplicate therapies, improper dosages, and noncomplianceOn 02/18/2026 at 8:33 AM a review of Resident #4's MRR showed that the physician had not reviewed the pharmacy recommendations within the 30 days per the facility's policy. On 09/20/2025 the pharmacy made a recommendation for a reduction in the dosage from 40 milligram (mg) to 20 mg for Pantoprazole. The physician reviewed, agreed and signed the recommendation on 11/15/2025. A review of the Medication Administration Record (MAR) showed that the dosage was decreased to 20 mg on 11/21/2025 although the pharmacy recommended the decrease in dosage on 09/20/2025. Further review of the Resident #4's MRR showed that on 11/23/2025 the pharmacy made a recommendation that stated Risk: Antidepressants with antiplatelet effects (e.g. Sertraline HCl Oral Tab 50 milligram) may enhance the anticoagulant effect of direct oral anticoagulants (e.g. Eliqius Oral Tablet 5 milligram). The physician reviewed the recommendation and selected the section that stated no change at this time as the benefit outweighs the risk. The physician signed the recommendation on 02/13/26 although the recommendation was made 11/23/2025. During an interview conducted on 02/18/2026 at 8:52 AM, the Director of Nursing (DON) stated that she saw that there was a delay in the physician review and response to the pharmacy recommendations. She further stated that she would speak to the providers on the timeliness of their pharmacy medication review recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, it was determined that the facility failed to have a medication error rate of less than 5% during the medication observation facility task. This was evident for 3 out of 29 medications administered during the observation.The findings include:Dysphagia is a condition that involves difficulty swallowing food, liquids, or medications.On 02/11/2026 at 9:17 AM, this surveyor observed Licensed Practical Nurse (LPN) #15 begin medication administration to Resident #3.On 02/11/2026 at 9:20 AM, while reviewing Resident #3's medical record, LPN #15 stated that the resident has a diagnosis of dysphagia and reported that she routinely crushes medications for residents with this condition. The surveyor inquired whether there was a physician's order to crush medications for Resident #3. LPN #15 and the surveyor reviewed the resident's orders together, and LPN #15 confirmed that there was no order authorizing medications to be crushed.On 02/11/2026 at 9:35 AM, LPN #15 reported that, despite there being no physician's order to crush medications, she uses her nursing judgment to determine whether to crush medications for Resident #3 due to the resident's diagnosis of dysphagia.On 02/11/2026 at 9:36 AM, this surveyor observed LPN #15 crush the following medications: two tablets of Carbidopa 25 milligrams (mg) / Levodopa 100 mg, one 81 mg enteric-coated (EC) delayed-release Aspirin tablet, and one 50 mg Losartan potassium tablet. LPN #15 then mixed the crushed medications with applesauce for administration.On 02/11/2026 at 9:38 AM, LPN #15 entered Resident #3's room, introduced herself and her purpose, correctly identified the resident, explained the medications to be administered, and then administered the medications.On 02/11/2026 at 10:00 AM, this surveyor conducted an interview with LPN #15 and asked whether enteric-coated medications may be crushed. LPN #15 confirmed that enteric-coated medications should not be crushed. The surveyor then informed LPN #15 that she had just crushed an enteric-coated aspirin tablet. LPN #15 acknowledged this error and stated that it was a mistake.On 02/11/2026 at approximately 12:13 PM, a record review of the facility's Medications Not to Be Crushed list showed that both Aspirin (enteric-coated) and Carbidopa/Levodopa were included on this list.On 02/11/2026 at approximately 1:00 PM, a record review of the facility's General Guidelines for Medication Administration policy indicated that long-acting or enteric-coated dosage forms should not be crushed and that an alternative form of the medication should be sought. The policy also states that the pharmacist should be contacted to review all medications being considered for crushing, regardless of whether a physician's order is present, and that instructions for crushing medications should be included on the resident's orders and Medication Administration Record (MAR) so that all staff administering medications are aware.On 02/12/2026 at 9:35 AM, this surveyor conducted an interview with the Administrator and the Director of Nursing (DON). During the interview, the medication errors identified during the Medication Administration observation were discussed. It was explained that the facility's medication error rate was calculated at 10.34%. It was further explained that the errors were related to LPN #15 crushing medications that should not be crushed and doing so without a physician's order. It was also communicated that Aspirin (enteric-coated) and Carbidopa/Levodopa are listed on the facility's Medications Not to Be Crushed list, and that the facility's Medication Administration policy requires consultation with a pharmacist prior to crushing medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and interviews it was determined that the facility failed to ensure medical records were complete and accurate. This was evident for 2 (Resident #22 and #9) of 2 residents reviewed for medical record documentation during the recertification survey.The findings include:1. PASRR stands for Pre-admission Screening and Resident Review. It is a federal mandate requiring that all applicants to Medicaid-certified nursing facilities be screened for serious mental illness (SMI), intellectual disabilities (ID), or developmental disabilities (DD) prior to admission. The process ensures proper placement, preventing inappropriate nursing home admissions and guaranteeing individuals receive necessary, specialized services in the most appropriate setting.During a review of Residents medical records on 02/09/2026 at 2:08 PM it was discovered that that Resident #22 was admitted on [DATE] and did not have a completed PASRR documented in his/her medical records.During an interview with the Social Work Director on 2/10/2026 at 11:10 AM she reported that Resident #22 should have a completed PASRR and it should be uploaded into his/her medical records. She found the PASRR had been completed on the Qualitrac website on 4/10/2025 and confirmed that it had not been uploaded into the medical records for Resident #22. She advised when Resident #22 was admitted she did not have access to the PASRR initially because the facility identification was not added for her to access the document, so it was not added to the Resident's chart upon his/her admission.During additional review of the medical records for Resident #22 on 2/10/2026 at 11:26 AM it was discovered that the PASSR was added to the Resident's chart on 2/10/2026 at 11:21 AM. During a review of the PASRR for Resident #22 it was confirmed that it was submitted and approved on 4/10/2025.During a review of the facility's Level I PASRR policy on 2/11/2026 at 1:32 PM it was revealed that, When the patient is admitted to the Center the Social Work and Discharge Planner will scan and upload the PASRR(s) into the patient's electronic medical record no later than five (5) days after the patient is admitted to the Center.2. Clostridioides difficile (C. diff) is a bacterium causing severe, sometimes fatal, diarrhea and colon inflammation (colitis), often triggered by recent antibiotic use that disrupts normal gut flora. It frequently affects people in hospitals or nursing homes. Symptoms include watery diarrhea, fever, and abdominal pain. It is treated with specific antibiotics and, in recurring cases, fecal transplants. During a review of medical records for Resident #9 on 2/17/2026 at 1:14 PM it was discovered that an order for his/her stool to be tested for C. diff had been placed on 2/10/2026 at 3:47 PM and it was signed off as completed on the Treatment Administration Record on 2/11/2026 at 10:55 PM.During a continued review of medical records for Resident #9 it was revealed that there were no lab results for the order that requested stool testing for C. diff.During a review of the Laboratory Orders and Results on 2/17/2026 at 1:48 PM it was discovered that the C. diff order was not signed off as being picked up by the lab but was labeled as no stool.During an interview with Licensed Practical Nurse (LPN) #8 on 2/17/2026 at 1:56 PM she confirmed that she had worked during the shift of 2/11/2026 and that Resident #9 did not have a bowel movement during her shift, so the specimen was not obtained. She advised that she had notified the oncoming shift that the specimen was still needed.During an interview with the Assistant Director of Nursing on 2/17/2026 at 2:19 PM she reported that if no stool was obtained for the lab order it should not have been signed off as completed for Resident #9 and it should have been noted that the order was not done because the resident didn't have a bowel movement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interviews it was determined that the facility failed to ensure staff practiced infection control. This was found to be evident for 2 (Residents #13 and #22) out of 2 Residents observed for infection control during the recertification survey. The findings include:2. During an observation of the hallway for Resident #13 on 2/09/2026 at 10:18 AM Geriatric Nursing Assistant (GNA) #17 was seen exiting the room of Resident #13 and entered into the room of Resident #22. GNA #17 returned from the room of Resident #22 holding a plastic bottle. He took the bottle back into the room of Resident #13.During an interview with GNA #17 on 2/09/2026 at 10:19 AM he reported that GNA #18 was giving a bed bath to Resident #13 and was out of body wash. GNA #18 had asked him to get her more body wash. He reported he had taken the body wash from the room of Resident #22 and took it to GNA #18 to so she could continue with the bed bath for Resident #13.During an interview with GNA #18 on 2/09/26 at 11:01 AM she confirmed that she was giving Resident #13 a bed bath and had run out of body wash so she requested GNA #17 to get her more body wash. She advised that each resident gets their own body wash and that it was not common practice in the facility for staff to take supplies from another resident's room to use for a different resident. During an interview with the Director of Nursing (DON) on 2/10/2026 at 9:07 AM she advised that personal hygiene products should not be taken from a Resident's room and taken to another Resident's room. She reported that GNA #17 should have went to storage to get a new bottle of body wash for Resident #13. She reported taking supplies from one resident and to another resident is an infection control issue.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews it was determined that the facility failed to ensure a Resident's smoke detector was in working condition. This was found to be evident for 1 (Resident #44) out of 9 Resident smoke detectors observed during the recertification and complaint survey. The findings include: During a random observation conducted on 02/08/2026 at 10:28 AM, the Surveyor heard a chirping sound from the 2nd floor nurse's station. The Surveyor followed the sound to Resident #44's room and determined the chirping sound came from the ceiling smoke detector.During an interview conducted on 02/08/2026 at 10:30 AM, Resident #44 reported that the smoke detector had been chirping for an extended period. During the interview the Surveyor observed Licensed Practical Nurse (LPN) #20 with her medication at the entry door of Resident #44's room. During an interview conducted on 02/08/2026 at 10:33 AM, LPN #20 reported that although she was in front of Resident #44's room she did not hear the smoke detector chirping so therefore she had not reported it the maintenance. On 02/08/2026 at 10:35 AM the Surveyor reported that the smoke detector was chirping to the Director of Nursing (DON). The Surveyor observed the DON enter Resident #44's room. The DON returned and advised that the smoke detector's batteries needed to be replaced. The DON called the Maintenance Director, reported the issue, and requested batteries.