STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Rockville	9701 Veirs Drive Rockville, MD 20850

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record reviews and interviews, it was determined that the facility failed to thoroughly investigate a resident's allegation of abuse. This was evident for 2 (Resident #74 and Resident # 140) of 4 residents reviewed for abuse during the annual recertification and complaint survey. The findings include:1) On 03/02/2026 at 11:12 AM, a review of the initial report form for the facility reported incident #357580 regarding Resident #74 submitted on 04/23/2025, for the injury of unknown origin, the steps listed by the facility immediately to ensure residents are protected did not list resident interviews or assessments. The action items listed were: investigation initiated; family notified; physician notified; medical director notified and ombudsman notified. On 03/02/2026 at 11:14 AM, a review of the facility's investigation for abuse revealed no resident interviews or assessments were located within the facility's investigation file. However, there were 8 documented staff interviews.On 03/03/2026 at 11:15 AM, A review of the follow up investigation report form under the steps taken to investigate the allegation confirmed interviews were only completed with staff. On 03/03/2026 at 12:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) for completion of allegations of abuse investigations. The NHA confirmed that the copy in my possession was the full investigation. When asked why resident interviews were not included, she responded I know its best practice to include both. NHA stated she was under the impression the social worker had done them. When asked how they would assess residents that are non-interviewable, she responded we interview residents that they can speak to and staff.She stated that usually the nurse managers or social workers complete resident interviews. On 03/03/2026 at 1:03 PM an interview with the Director of Nursing (DON) was conducted and she stated they do not interview residents that are nonreviewable, instead they look for signs or symptoms for abuse, and they will reach out to family to ask if they have noticed any changes. When asked how or where the facility would document the screening the DON stated through skin assessments. When questioned about the incomplete investigation the DON stated she was not sure why the assessments were not included in the facility incident investigation. On 03/03/2026 at 1:23 PM, The DON brought in copies of Resident Treatment Administration investigations (TARs) for residents that reside in the same hallway as the Resident and it showed that the residents had ongoing orders to be monitored daily for any change in condition. The monitoring orders on the TAR were not related to the investigation of abuse. On 03/03/2026 at 1:30 PM, The DON provided copies of skin assessments for 4 of 14 non-interviewable residents. 2 resident skin assessments were completed on 04/22/2025 and 2 resident skin assessments were completed on 4/23/2025. The DON was not able to produce any other documentation. 2)On 03/02/2026 at 10:00 AM, a review of the initial report form for the facility reported incident #2709082 regarding Resident #140 submitted on 01/05/2026, for the injury of unknown origin, the steps listed by the facility immediately to ensure residents are protected did not list resident interviews or assessments. The action items listed were: investigation initiated; Head to toe assessment completed; Resident medicated for pain; physician notified; responsible party notified, medical director notified; x-ray ordered; care plan updated. Resident interviews and assessments were not listed as an action item. On 03/02/2026 at 10:05 AM, a review of the facility investigation for abuse revealed no resident interviews or assessments were located within the facility investigation. There were 9 documented (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff interviews included in the facility investigation.On 03/02/2026 at 10:10 AM, a review of the follow up investigation report form under the steps taken to investigate the allegation confirmed that only staff and the Resident were interviewed for the incident. On 03/03/2026 at 12:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) for completion of allegations of abuse investigations. The NHA confirmed that the copy in my possession was the full investigation. When asked why resident interviews were not included, she responded I know its best practice to include both. NHA stated she was under the impression the social worker had done them. When asked how they would interview residents that are non-interviewable, she responded we interview residents that they can speak to and staff.She stated that usually the nurse managers or social workers complete resident interviews. On 03/03/2026 at 12:59 PM, NHA was able to provide a copy of an email where the social worker reported she interviewed three residents in the same hallway on the day of incident. The NHA stated if they are not interview-able then we can't conduct an interview. The NHA could not provide copies of documented interviews with the three residents. 03/03/2026 1:03 PM interview with The Director of Nursing (DON) and she stated they do not interview residents that are nonreviewable, they look for signs or symptoms for abuse, and they will reach out to family to ask if they have noticed any changes. She was not sure why the assessments were not included in the facility incident chart. DON given time to make copies of the assessments. On 03/03/2026 at 1:33 PM, the DON was not able to provide any documentation of completed Resident assessments.

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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 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 provide services that met professional standards of practice. This was found to be evident for 1 (Resident #166) out of 1 Resident reviewed for professional standards of practice during the recertification and complaint survey. The findings include: 1)A review of complaint #2607648 submitted to the Office of Health Care Quality (OHCQ) was conducted on 02/27/26 at 8:00 AM. The complainant reported that the facility failed to hold a blood pressure medication and notify the physician when the Resident blood pressure was low. Systolic blood pressure, the top number in a reading (e.g., the 120 in 120/80 mmHg), measures the maximum pressure in your arteries when your heart muscle contracts and pumps blood. It indicates how hard your heart is working to pump blood to the rest of the body with each beat.A review of Resident #166's Medication Administration Record (MAR) conducted on 03/02/26 at 8:19 AM showed the following orders: Amlodipine Besylate Oral Tablet 10 mg (milligram) (Amlodipine Besylate). Give 1 tablet by mouth at bedtime for HTN (hypertension) hold for SBP (Systolic Blood Pressure) less than 110. Metoprolol Succinate ER (Extended Release) Tablet 24 Hour 50 mg. Give 1 tablet by mouth one time a day for HTN hold for SBP less than 110. HR (Heart Rate) less than 60. Further review of the MAR showed that Registered Nurse (RN) #28 administered Metoprolol Succinate ER (Extended Release) Tablet 24 Hour 50 mg on 03/13/25 between 8-10 am. However, the Resident's Systolic Blood Pressure reading was 101 which was less than 110 and should have been held. During a review of Resident #166's Blood Pressure (BP) readings conducted on 03/02/26 at 8:24 AM it was discovered that the Resident's Systolic Blood Pressure reading was below the acceptable parameter of 110. On 03/13/25 the BP was 103/57, on 03/13/25 the BP was 101/58, on 03/14/25 the BP was 102/57, and on 03/16/25 the Resident had two readings 94/51 and 98/56. A review of Resident #166's medical records conducted on 03/02/26 at 8:29 AM did not show that the physician was notified of the Resident's Systolic Blood Pressure reading was less than 110 and the medication was not administered. During an interview conducted on 03/02/26 at approximately 9:10 AM, the Director of Nursing (DON) reported that she reviewed the MAR and confirmed Resident #166 was administered the Blood Pressure medication in error. She also confirmed that the physician was not notified that the Resident's Systolic Blood Pressure was less than 110 and the BP medication was not administered. The DON explained that it is the facility's expectation that the physician is notified when a Resident falls below a parameter and/or a medication cannot be administered.2) During a review of the Maintenance hot waterlogs conducted on 03/02/26 at 11:00 AM, the Surveyor discovered the following: 02/16/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/17/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/21/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/22/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/23/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/24/26 the hot water temperature was recorded at 119 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/25/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.02/26/26 the hot water temperature was recorded at 120 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.2/27/26 the hot water temperature was recorded at 119 F with a line and an arrow (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pointing downward through each box for each resident room in place of the actual temperature. 02/3/26 the hot water temperature was recorded at 121 F with a line and an arrow pointing downward through each box for each resident room in place of the actual temperature.During an interview conducted on 03/02/26 at 11:52 AM, the Maintenance Director acknowledged that the hot waterlogs were not documented completely or accurately. The Maintenance Director stated that he reviewed the logs and was in the process of educating his staff on the importance of capturing the accurate hot water temperature for each room accurately completing the sheet.

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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. Based on record review and interview, it was determined that the facility failed to ensure that a resident received care that met acceptable standards of quality. This was evident for 1 (Resident #6) out of 1 resident reviewed during review of a facility reported incident.The findings include: On 03/02/2026 at 9:43 AM, a record review was conducted of the investigation file related to a facility reported incident. The facility reported incident involved an allegation of abuse and neglect against Geriatric Nursing Assistant (GNA) #16 toward Resident #6, which reportedly occurred on 03/04/2025 and 03/05/2025.During review of the investigation file, an interview with Resident #6's Patient Decision Aide (PDA), conducted on 03/11/2025, was reviewed. The PDA reported that she worked with Resident #6 on 03/04/2025 and 03/05/2025 and confirmed that GNA #16 was also providing care to Resident #6 during that time. From the interview questions, the PDA confirms that she observed GNA #16 slamming cabinet doors in the resident's room, moving quickly while opening and closing doors, and had left a dirty blanket on the Resident's bed.An additional interview contained in the investigation file was conducted on 03/11/2025 with a family member of Resident #6. During the interview, the family member reported observing GNA #16 rapidly opening and closing cabinet doors in Resident #6's room and reported that GNA #16 did not appear compassionate while providing care.Another interview contained in the investigation file was conducted on 03/11/2025 with Resident #6. During the interview, the resident was asked about the care provided by GNA #16. The resident reported that she moves too quickly.On 03/02/2026 at 12:21 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed that GNA #16 is no longer employed at the facility. The DON was informed that review of the facility investigation file did not reveal sufficient evidence to substantiate abuse; however, concerns were identified related to the quality of care provided by GNA #16. It was explained that multiple interviews described GNA #16 moving quickly, slamming cabinet doors in a resident's room, and leaving a dirty blanket on the resident's bed. Additionally, another resident interview described the staff member as moving too quickly while providing care. While these findings did not substantiate abuse, they raised concerns regarding the quality of care provided to residents. The DON acknowledged and confirmed understanding of the concern.