STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215178	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederick Villa Healthcare	711 Academy Road Catonsville, MD 21228

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and interviews with residents and facility staff, it was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment. This was evident for 2 (Resident #15 and Resident #133) of 44 residents reviewed from the complaints and facility reported incidents investigated during the facility's recertification survey. The findings include: 1) On 8/19/25 at 11:16AM. 11:46 AM and 1:52PM during an initial tour of the facility the surveyor noticed the presence of flies and gnats in rooms [ROOM NUMBERS]. Residents in both rooms complained of flies and gnats flying around in their rooms all the time. In room [ROOM NUMBER]B, Resident #15 also said that flies and gnats always fly around their room and bathrooms. Further review of a complaint incident #337246 had that the” Nursing Facility has issue with Pest Control. There are ants, fruit flies, gnats, and mice within the facility”. In an interview with Staff #18 a Maintenance Director on 8/21/25 at 12:19 PM, he was asked if the maintenance department do a kind of daily or routine checks or rounds on the resident’s rooms and he said that they have weekly/ monthly checks which they do through their “TELS System” used by staff to alert maintenance of issues requiring their attention. He stated that they don’t go around checking each resident’s room unless someone brought to their attention that something was broken and needed repair. That resident or anyone can flag him as he walks down the hallway if there was an issue. He was asked if staff or residents had brought to his attention the issue of flies, gnats or mice in residents’ rooms. He said yes that he was going around changing the fly traps on the walls in the hallways. That the fly traps are not allowed in the residents’ rooms or spraying of any kind. The surveyor told Staff #18 that she was in the resident’s room and saw flies and gnats flying around and asked what can be done to get rid of them. Staff #18 said he will talk to the administrator to see what can be done. The Administrator was made aware of the above concerns on 8/21/25 at 12:28 PM and was asked what the facility was doing about it. He stated that they have a pest control company ([NAME] Pest control), that monitors the window screens and fly traps and have done deep cleaning in some rooms. He said that the residents were given plastic containers to stow their foods/fruits which attract flies and have also added fly traps and installed blue lights in the hallways which they monitor and change periodically. He was asked how often the Pest control company comes in and he said he was not sure. He was asked if the company writes a report after each visit and he said yes, so he was asked to bring the report. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/25 at 2:06 PM The administrator [NAME] an invoice dated 7/2/25 from the [NAME] Pest control company showing that the company came and treated some rooms, laundry room and kitchen with roach sand ant sprays. The other invoice dated 8/18/25 showed bimonthly services for mice, and roaches in residents’ rooms and shower rooms. The administrator also brought in a commercial pest control agreement with the same company dated 8/21/25 for further treatment of the fly infestation and other covered pests. On 8/21/25 at 2:30PM The administrator was made aware that this was still a concern because the flies and gnats are still present in the resident’s room and needed more aggressive treatment and that whatever the facility just implemented was done after surveyor’s intervention. He agreed that it was a concern. 2) Review of complaint 337237 concerning Resident #133 on 8/27/25 at 11:09 AM revealed that the room [320] had not been painted in years and where things had been removed off the wall, the old paint was left. Further review of the complaint revealed the bathroom water faucet was corroded and the plaster on the wall in the bathroom and other parts of the walls looked loose and flaky. On 8/27/25 at 11:32 AM observation of room [ROOM NUMBER] revealed a ceiling tile in the corner of room ajar leaving a gap which led up to the ceiling. In addition, the top corners of the wall above the window had been patched, but had not been painted, the faucet of the bathroom sink was corroded, and the light above bed A did not have a pull cord. The current resident stated that there was no light bulb and that the light had not been working for some time. On 8/27/25 at 11:41 AM in an interview with the Nursing Home Administrator (NHA), a dual observation of the interior of room [ROOM NUMBER] and its bathroom was conducted. The surveyor pointed out the above observations. When asked if the findings in these observations would be considered a comfortable, homelike environment, the NHA stated no.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review, review of the facility investigation of intake #337244, review of facility policy on Conduct and Behavior, resident interview, and staff interview it was determined that the facility staff failed to ensure a resident was free of misappropriation of property. This was evident for 1 (Resident #104) out of 75 residents who were part of the survey sample.The findings include:The review of the facility investigation of intake #337244 on 8/26/25 revealed Staff #34 used Resident #104's bank card and bank account information to access money for his own benefit. Staff #34 admitted to withdrawing money at the resident's request. It was confirmed that he withdrew $100 at the request of the resident but he denied making other withdrawals. The police were called, and their investigation revealed 28 transactions starting 1/28/24 to 4/8/24 with Staff #34's name on it for withdraw via the cash app. The facility investigation file included notice of the police having signed a warrant for Staff #34's arrest. This surveyor reviewed the bank transactions from 8/1/23 to 12/31/23. On 8/1/23 there were two withdrawals from the resident's bank account to Staff #34's cash app. The amounts were $170 and $400. Review of Staff #34's employee file on 8/26/25 revealed he was terminated on 10/11/23. The two transactions on 8/1/23 were prior to termination. Resident #104 was interviewed on 8/26/25 at 8:16 AM. This surveyor asked if the resident could explain what happened in April 2024 with staff using the bank card. Resident confirmed it happened and said there have been no more issues or incidents since April 2024. Resident went on to say that they made me go to court, but I told them to drop the charges because I don't believe in sending people to jail.This surveyor interviewed the Administrator on 8/28/25 at 8:59 AM. The Administrator said the Geriatric Nursing Assistant (GNA), Staff #34, used his cash app to transfer funds from the resident's account to his account so he could give cash to the resident. He added that he was unaware until after the GNA was terminated that the GNA was using the resident's ATM card as well as the cash app. He said the cash app was used by the GNA to get the resident money the resident requested. This surveyor asked if this was the usual way for residents to get money. He didn't respond directly to this question. He said that it was between the resident and the GNA. He said that he had no way of knowing if the GNA gave the resident the money withdrawn from the resident's account. He then said the GNA was terminated and was called by him weeks after the termination to assist the resident to get the resident's money back. The surveyor stated that the facility was responsible for the actions of staff while under employment. He said, again, that he was unaware of the GNA assisting the resident to get money until after the termination. This surveyor asked why the GNA was terminated, and he replied that he did not know. This surveyor asked him to find out and to provide me with a policy on staff obtaining money for a resident. A review of the facility policy entitled Conduct and Behavior on 8/28/25 revealed that under section 2B a staff person may not Misuse or abuse of nursing home funds, dishonesty, theft, misrepresentation employment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility reported incidents (Intake #2578127, # 337212 and #337236), record review, and interview, it was determined that the facility failed to ensure that all alleged resident violations were reported in a timely manner, including: abuse, neglect, exploitation or mistreatment. This was evident for 6 (Resident #86, # 143, #71 #101, #2, and #140) of 76 Residents that were part of the survey sample.The findings included: 1) On 08/19/2025 at 9:04 AM, during the initial screening phase of the survey, Resident #86 alleged to the surveyor that “on the last Sunday night shift (8/17/2025) a nurse was very mean and rough with the resident during care and when her attitude was brought to her attention by Resident #86, she just left the room and never came back. When asked if the incident was reported to anyone, Resident #86 stated “no”. The resident’s roommate (Resident #143) confirmed that nurse was rough with her during care pushing Resident #86 roughly towards the bedrail. The nurse was described as “African” by both residents. On 08/19/2025 at approximately 9:10 AM, during the initial screening phase Resident #143 reported to the surveyor that the staff were “mean and they have very bad attitude, they refuse to attend to our needs when we need help. ‘They get mad when we ring the call bell.” On 08/19/2025 at approximately12:28 PM, unit manager (RN #13) was made aware of Residents #86 and #143 above-mentioned concerns. RN #13 stated that he would speak with the residents. On 8/21/2025 at approximately 11:45 am, the Director of Nursing (DON) was notified that the unit manager (RN #13) was made aware of Resident #86 and #143 concerns; however, there was no documented evidence to support that a follow-up investigation was initiated and reported to the Office of Health Care Quality (OHCQ) in a timely manner. On 08/25/2025 at 3:20 PM, the Regional Director of Clinical Operations (RDCO) was notified that Resident #86 and #143’s concern was reported to RN #13 by the surveyor on 8/19/2025 and the Director of Nursing (DON) was notified of the concern on 8/21/2025. However, there was no report was made to OHCQ. The RDCO stated that she will look into it further. On 8/26/25 at 8:20 AM interview with DON, she was asked, when an abuse incident is reported what was the expectation. The DON reported they start an investigation, if a staff member was involved, they would be removed from the unit; for resident- resident we would separate them. Conduct the follow up investigation immediately; assessment of the residents (complete skin sheet or any kind of notes under assessment section). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/2025 at 1:45 PM, in a follow-up interview with RN#13, he stated that he was removed from the unit for a few days and therefore he was unable to complete the investigation. RN #13 stated that he would typically report concerns of abuse to his supervisor immediately but in this case, it was not done. He stated that he planned to continue with the follow-up investigation upon his return the next day. However, he was then pulled off the floor for an unrelated issue and was immediately sent home. He stated that he could not complete the investigation. He was notified by the surveyor that there was a concern in regard to late reporting to OHCQ for allegations of abuse and or neglect. RN #13 provided the surveyor with a one page document titled “Statement form” where an apparent interview was conducted with Resident #86, however, there was no additional documents provided. On 08/27/2025 at approximately 10:14 AM, a review of the documentation provided revealed that the facility conducted an internal investigative form; however, there was no documentation to suggest that the allegation of abuse was filed with OHCQ as required. On 08/28/2025, the DON was once again informed that the facility failed to report the allegations of abuse/neglect for Resident #86 and #143 to OHCQ in a timely manner. 2) On 08/25/2025 at 3:35 PM, in an interview with Resident #71, the resident alleged to the surveyor that the Geriatric Nursing Aides (GNAs) in the facility have bad attitudes, especially when we need to get to the hoyer lift. The resident alleged that on one particular occasion, a GNA made some hurtful statements to Resident #71 while providing personal care about a month ago. The resident alleged that the GNA stated to the resident that he/she was “too fat, his/her thighs are too heavy, and he/she needed to lose weight because he/she was hurting the GNA’s back”. The resident alleged that sometimes they are afraid to call for help.” Resident #71 reported that GNAs were sometimes using their cellphones while providing care to residents. The resident also reported that on a separate incident he/she had an episode of incontinence and a GNA told Resident #71 to wait until the next shift, the resident stated that they waited from 2pm to 6pm before help was provided. The resident’s roommate Resident#7) confirmed the above-mentioned concerns. Resident #71 stated that a manager was notified about the concerns and asked that the GNA did not return to the resident’s room; however, the GNA returned to the resident’s room once after the complaint was made to the manager. On 08/25/2025 at approximately 3:45 PM, the Regional Director of Clinical Operations (RDCO) was informed by Resident #71 of the concerns shared with the surveyor. The RDCO stated that the issues would be addressed. On 08/26/2025 at 9:13 AM, in a follow-up interview with the RDCO, she was asked if the complaints were reported to OHCQ and she stated they were not reported. She stated that the staff were educated on reportable events. She stated that the concern was investigated and the GNA stated that she was not talking to Resident #71 about their weight, she was talking to someone on the cellphone. The RDCO stated that the GNA was educated on customer service and cellphone policy by the administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/2025 at 9:48 AM, a review of a facility’s internal document revealed that Resident #71 made an official complaint to the facility that on 6/5/2025 at 11pm- 7am shift, the assigned GNA (GNA #47) was rude and told Resident #71 that the resident needed to lose some weight. A signed human resource statement revealed that “GNA #47 changed her work status to PRN (as needed). GNA #47 has not worked at the facility since July 28, 2025 and she is not currently schedule to pick up any shifts for this month (august) or the next (September).” A review of another internal document revealed that on 8/22/2025 Resident #71 reported to the facility that on about 7 -3pm shift, a GNA refused to provide personal hygiene care and the GNA told the resident to wait until next shift. Resident reported that he/she was not changed until 6 pm that evening. This incident was reported by the resident to the Nursing Home Administrator (NHA). On 08/26/2025 at 10:55 AM, in an interview with the NHA, the NHA was notified that the facility failed to report the allegation of abuse/neglect to OHCQ as required and he acknowledged the surveyor’s concerns. The NHA reported that the incidents were not reported to him as a case of abuse. NHA stated he saw the resident in the hallway, and it was expressed more as a customer service issue and not abuse. The NHA stated that they did go back to check the schedule and found that the GNA was accidentally in her room again after the reported incident. The NHA stated that he spoke to the unit supervisor to ensure the GNA was not sent back or assigned to Resident #71’s room again. He stated that the GNA was also educated not to enter Resident #71’s room again. When asked if there was any documented evidence to support that the unit supervisor and GNA were notified of the resident’s request he stated that it was communicated verbally to both of them. 3) On 08/27/2025 at approximately 10:16 AM, a review of a facility reported intake # 2578127 revealed that Resident #101 reported to the facility that his/her cellphone went missing on Sunday 9/8/2024 at around 1PM from his bed. Further review of the facility’s documentation related to this report revealed that a staff member was notified of the Resident’s alleged missing cellphone on 9/8/2024 at approximately 2:30pm; however, documentation suggests that the alleged incident was reported to the Office of Health Care Quality (OHCQ) on 9/9/2024 at 4:57 PM, which was more than 24 hours after the facility was made aware of the incident. On 08/28/2025 at 10:07 am, in an interview with the Nursing Home Administrator (NHA), the NHA was notified the facility failed to report the alleged incident to OHCQ in a timely manner. He acknowledged the surveyors’ concern, and he stated that he was not notified by Staff until 9/9/2024 at 9:30 AM (the following day) as a result the report to OHCQ was submitted late. 4) On 8/26/2025 at 1:34 PM, a review of facility reported incident 337212 was conducted and revealed Resident #2 alleged that he/she was pushed into bed and forced to lie down by GNA #45. Review of the facility’s investigation revealed that the incident was reported to the Social Worker, Staff #46 on 4/20/2023. The initial self-report was emailed to OHCQ on 4/24/2023, which was not within 2 hours of the alleged abuse. On 8/26/2025 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who stated that an allegation of abuse must be reported to OHCQ within 2 hours of the allegation. However, DON stated she was not employed at the facility during that time. The DON confirmed the findings. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) This surveyor investigated intake #337236 on 8/26/25 and 8/27/25. As part of the investigation, this surveyor asked Resident #140, Are you getting along with your roommate? The resident responded by shaking their head no and pointing towards the roommate (privacy curtain was pulled to allow for privacy). Resident #140 said that the roommate did foul things to them. This surveyor asked if he/she told anyone and they replied that they told one of the board ladies. This surveyor asked if they meant one of the GNA's (Geriatric Nursing Assistant) and the resident shook their head up and down. This surveyor asked when did they tell the GNA and they replied about two months ago. This surveyor told the Director of Nursing (DON) on 8/26/25 at 8:35 AM that the resident alleged the roommate does foul things to the resident. She said she would investigate. This surveyor emailed the state survey agency on 8/27/25 and was informed that no self-report was sent. The Administrator was interviewed on 8/28/25 at 9:10 AM. He was informed of the resident’s allegation and that this surveyor told the DON. He replied that he would find out what happened. The Administrator was interviewed on 8/28/25 at 10:00 AM. He said the social worker followed up and the resident agreed to a room change. This surveyor stated that it was not reported to the state reporting agency, and any allegation needs to be reported. It is up to our office to decide if we are going to investigate. Telling a surveyor or getting an allegation from a surveyor does not constitute notification. He replied he understood.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on a medical record review, facility investigation review, and staff interviews, it was determined that the facility failed to thoroughly investigate allegations of abuse in a timely manner. This was evident for 5 residents (Resident #86, #143, #71, #131 and #73) of 8 residents reviewed for abuse during this recertification/complaint survey.The findings Included: 1) On 08/19/2025 at 9:04 AM, during the initial screening phase of the survey, Resident #86 reported to the surveyor that “on the recent Sunday night shift (8/17/2025) a nurse was very mean to her during care and when the nurse’s attitude was brought to the nurse’s attention, she just left the room and never came back. When asked if the incident was reported to anyone, Resident #86 stated “no”. The resident’s roommate (Resident #143) confirmed that the nurse was rough with her during care. The nurse was described as “African” by both residents. On 08/19/2025 at approximately 9:10 AM, during the initial screening phase Resident #143 reported to the surveyor that the staff were “mean, and they have very bad attitude, they refuse to attend to our needs when we need help. They get mad when we ring the call bell.” On 08/19/2025 at approximately12:28 PM, unit manager (RN #13) was made aware of Residents #86 and #143 above-mentioned concerns. RN #13 stated that he would talk with the residents. On 08/21/2025 at 11:45 AM, the DON was notified that Residents #86 and #143 had concerns that were reported to RN #13 by the surveyor on 8/19/2025; however, there was no evidence to support that additional steps were taken to report or investigate the resident’s claims, the DON stated that RN #13 was pulled of the unit and sent home for a unrelated incident. The surveyor clarified if the residents’ concerns depended on RN #13 ‘s return to the facility and the DON explained that the investigation can be completed by other staff. On 8/26/25 at 8:20 AM interview with DON, she was asked, what was the expectation if an abuse incident was reported to staff. The DON explained that they would start an investigation, if a staff member was involved, they would be removed; for resident- resident we would separate them. Conduct the follow up investigation immediately assessment the residents (skin sheet or any kind of notes under assessment section). On 08/26/2025 at 1:45 PM, in a follow-up interview with RN#13, he stated that he was removed from the unit for a few days and therefore he was unable to complete the investigation. RN #13 stated that he would typically immediately report allegations of abuse to his supervisor but in this case, it was not done. He stated that he planned to continue with the follow-up investigation upon his return to work the next day; however, he was then pulled off the unit and sent home for an unrelated issue. Therefore, he could not complete the investigation. RN #13 provided the surveyor with a one page document titled “Statement form” where an apparent interview was conducted with Resident #86, however, there was no additional documents provided to the surveyor to support that a thorough investigation was completed in a timely manner for resident #86 and #143 to prevent further alleged abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide documented evidence to support that they conducted investigations related to Resident #86 and #143's allegations. 2) On 08/25/2025 at 3:35 PM, in an interview with Resident #71, the resident alleged to the surveyor that the Geriatric Nursing Aides (GNAs) in the facility “have bad attitudes, especially when we need to get to the hoyer lift.” The resident alleged that on one particular occasion, a GNA made some hurtful statements to Resident #71 while providing personal care about a month ago. The resident alleged that the GNA stated to the resident that he/she was “too fat, his/her thighs are too heavy, and he/she needed to lose weight because you are hurting my back”. The resident alleged that sometimes they are afraid to call for help.” Resident #71 reported that GNAs were sometimes using their cellphones while providing care to residents. The surveyor did not observe any concerns for abuse or neglect during the survey process. A review of the facility’s documentation titled “concern and comments revealed that on 6/5/2025 Resident #71 reported to NHA that a GNA was rude to the resident and told the resident that he/she needed to lose some weight. However, there was no documented evidence to support the fact that the facility conducted a thorough investigation and in a timely manner. The facility provided no documentation to suggest that the resident was assessed by a nurse and or a healthcare provider such as a physician, mental health provider, social worker, etc). There was also no documentation to suggest that the facility conducted resident and staff interviews in a timely manner, reported the incident to the appropriate agency, provide additional abuse training to the alleged perpetrator (GNA#47). On 08/26/2025 at 9:57 AM, the NHA reported that the incidents were not reported to him as a case of abuse. NHA stated he saw the resident in the hallway, and it was expressed more as a customer service issue and not abuse. We did go back to check the schedule and found that the GNA was accidentally in the resident’s room again. The NHA stated that he spoke to the unit supervisor to ensure the GNA was not sent back or assigned to Resident #71’s room again. The GNA was also educated not to enter the residents room again. On 08/26/2025 at 10:55 AM, in an interview with the NHA, the NHA was notified by the surveyor that the facility failed to thoroughly investigate the allegation of abuse and he acknowledged the concern. 3) On 8/20/25 at 12:42 PM, the surveyor reviewed the facility’s investigative packet for Self-Reported Incident, 337232. It was indicated that Resident #131 called 911 on 1/01/24 at 11:40 AM to report being aggressively grabbed by a nurse. The Nursing Home Administrator (NHA) was made aware of the incident on 1/02/25 at 9:45 AM and stated he began an investigation immediately. However, a review of Resident #131's medical records showed that assessments including a skin check, a Braden assessment, pain evaluation, and change in condition were not conducted until after 10:00 PM on 1/02/25, more than 12 hours after the NHA was notified. The NHA validated this delay. 4) A facility-reported incident (ID #337256) stated that a family member of Resident #73 reported a Geriatric Nursing Aide (GNA) was providing aggressive care on 2/04/25. The initial report was submitted on 2/04/25 at 4:00 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, Resident #73's medical records showed that the resident's assessment for pain, Braden score, and change in condition was not completed until 2/05/25. In an interview with the Director of Nursing (DON) on 8/26/25 at 8:20 AM, she confirmed that no assessment was completed on the day the incident was reported and validated that all such incidents should be investigated immediately.

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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. Based on complaint intake # 337241, medical record review, and staff interview it was determined that the facility failed to ensure the resident's discharge papers were completed. This was evident for 1 Resident (#127) of 4 residents reviewed for discharge during a recertification / complaint survey.The findings includes:Review of an attachment to a complaint intake #337241 on 8/27/2025 at 10:24 AM was reviewed and the complainant stated that on 1/23/2025 the discharge papers for Resident #127 were not completely filled out.On 8/27/2025 at 10:53 Resident # 127's closed medical record was reviewed. The resident was discharged on 1/23/2025. The discharge documentation titled Engage Discharge Planning Tool was reviewed and surveyor noted that the following areas were blank:1. Section B. responsible parties' information2. Section C. Primary physician information3. Section O. Staff Signature and Residents or Responsible Party Signature4. Section R. Medication list5. Section R -Question #7. May attach pharmacy print out of medication regimen in lieu of completion of this section. Yes, No, N/A. There was no medication list, and no check off for yes, no or N/A.On 8/28/2025 at 09:57an interview was conducted with the Unit Manager, Staff # 19 who stated that the discharge paperwork engage discharge planning tool was initiated by the Social worker and the physician, nurse, Rehab, Activities, and Dietician fills out their section. Staff #19 further stated that when a resident is discharged the medication list is not printed out and the new prescribed medications are given to the residents on paper prescription and the discharging nurse would click box that medication list was not printed out. In addition, the resident or responsible party would sign a copy of the discharge paper that would be placed in the hardcopy chart.On 8/28/2025 at 10:30 AM, an interview was conducted with the Social Worker, Staff #6 who stated that each area of the Engage Discharge Planning Tool should be filled out prior to hand off to the resident or the responsible party.At approximately 11:34 AM on 8/28/2025 the Director of Nursing was informed of the discharge documentation that was found in the medical records with blank areas. No other documentation was provided related to Resident #127's discharge. DON agreed that this was a concern.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure a baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP) and documented in the medical record. This was evident for 2 (Resident #126 and #122) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to each resident and/or his/her representative and documented in the medical record. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. Brief Interview of Mental Status (BIMS) is a standardized test used to assess a resident's cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) On 8/20/25 at 11:48 AM review of the medical record revealed Resident #126 was admitted on [DATE]. The 8/25/23 MDS coded the resident as rarely understood, and as such, the BIMS assessment was not even conducted. On 8/20/25 at 1:20 PM in an interview with the Director of Nursing (DON) when asked if a copy of the BLCP was provided to the resident and/or RP she stated yes. During the interview, when asked if that was documented in the medical record, she stated yes. When asked how it was documented, she stated as a progress note. When asked for residents with impaired cognition and/or RP's, who should be signing documents for those residents, the DON stated, It had to be the RP. In a follow up interview with the DON and Regional Director of Clinical Operations (RDCO #1) on 8/25/25 at 12:05 PM, the RDCO stated that the facility's expectation was that staff printed out the BLCP, had the resident or RP physically sign the hard copy, and then that the staff member was supposed to scan the hard, signed copy into the electronic health record (EHR) under the miscellaneous tab. On 8/20/25 at 2:00 PM review of Resident #126's medical record failed to reveal a BLCP in the EHR under the miscellaneous tab. On 8/20/25 at 2:20 PM the surveyor requested a copy of the BLCP for Resident #126 and evidence from the medical record that it was provided to the resident or RP. On 8/21/25 at 8:25 AM the DON provided a copy of the BLCP; however, on the last page (7 of 7) in the Signature of Resident or Representative section, it was signed by the resident. The section stated, I have received the above information and understand the content of this information. I understand any updated information will be communicated with me prior to, or at the care conference, after the comprehensive care plan is developed. In a dual observation, the surveyor flipped to the last page and pointed out that the resident had signed (their signature was typed into the field) the BLCP. The DON stated this was an error because the resident has a BIMS of 0 and he/she should not be signing any documents. Furthermore, she stated that she looked in the medical record and was unable to find any evidence that the RP had received a copy of the resident's BLCP. She stated it should have been documented in the progress notes but it was not.2) Review of the medical record on 8/25/25 at 10:13 AM revealed Resident #122 was admitted on [DATE] with diagnoses including, but not limited to, dementia, Alzheimer's disease, muscle weakness, and need for assistance with personal care. Further review of the medical record revealed the resident's 10/14/24 MDS coded the resident with a BIMS of 2. Additional review failed to reveal a BLCP in the EHR under the miscellaneous section. On 8/25/25 at 11:14 AM, the surveyor requested a copy of Resident #122's BLCP and evidence from the medical record that it was provided to the resident or RP.On 8/25/25 at 12:05 PM the DON provided a copy of Resident #122's BLCP; however, on the last page (6 of 6), in the Signature of Resident or Representative section, it was blank. There was no information that was inputted into the fields. Additionally, in the Signature of Staff Completing the Baseline Care Plan section, it was also empty with no information. A dual observation of the document was conducted and the DON verified and confirmed there was not a signature from the staff or resident/RP on the BLCP. Furthermore, the DON verified and confirmed there was no evidence from the medical record that the resident or RP received a copy of the BLCP including a list of medications. The RDCO and DON stated it was the expectation that staff completed the fields, signature of staff completing plan, title and date on the last page of the BLCP.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to provide the required level of assistance for a resident to perform their Activities of Daily Living. This was evident for 1 (Resident #122) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:Activities of Daily Living (ADLs) are the basic, essential self-care tasks people need to perform to maintain their health, safety, and well-being, such as bathing, dressing, eating, and toileting.Brief Interview of Mental Status (BIMS) is a standardized test used to assess a resident's cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's health status, functional abilities, and needs. It is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident.Review of complaint 337250 on 8/25/25 9:06 AM revealed the complainant noted that on 10/11/24, he/she arrived to the facility and found Resident #122 in a soiled incontinence brief that the resident had tried to remove the feces by tearing up the brief. Further review of the complaint revealed the complainant noted on 10/13/24 he/she arrived to find the resident in bed with feces on his/her hands, under his/her nails, all inside and on his/her pants, shirt, and bed linens. The complainant noted that the Geriatric Nursing Assistant (GNA) said Resident #122 was directed to the bathroom about 90 minutes ago; however, the complainant indicated that the resident required hands on assistance using the toilet and another staff member was surprised to hear that Resident #122 needed any assistance. Review of the medical record on 8/25/25 at 10:13 AM revealed Resident #122 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia, Alzheimer's disease, muscle weakness, and need for assistance with personal care. Review of Resident #122's medical record on 8/25/25 at 11:07 AM revealed the resident had the following care plan:- Resident #122 has an ADL self-care performance deficit r/t (related to) Alzheimer's. Further review of the medical record revealed the 10/14/24 MDS coded Resident #122 with a BIMS of 2. Furthermore, the 10/17/24 MDS revealed for:- Self-care: the resident's need for assistance with bathing, dressing, using the toilet, or eating, Resident #122 was coded as Needed Some Help - Resident needed partial assistance from another person to complete any activities. - Toilet transfer: the ability to get on and off a toilet or commode, Resident #122 was coded as Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. On 8/28/25 at 11:57 AM the October 2024 Documentation Survey Report was reviewed for Toilet transfer: the ability to get on and off a toilet or commode. The key for which was as follows:09- Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.06- Independent - Resident completes the activity by themself with no assistance from a helper.05- Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.04- Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance. Assistance may be provided throughout or intermittently.03- Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunkor limbs but provides less than half the effort.02- Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.01- Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. The review revealed that Resident #122 was coded each of these numbers from 09 down to 01. The resident was coded 06 which means the resident is Independent on 5 shifts during the month of October 2024; however, Resident #122 is coded in the MDS, which is what guides the level of care they require, as needing some help and supervision or touching assistance. On 8/25/25 at 12:47 PM in an interview with the Rehab Director when asked what was the expectation for a resident coded as Supervision/touching assistance, she stated that meant either eyes or a hand are on the resident. GNA #49 was interviewed on 8/28/25 at 1:19 PM. During the interview when asked how she knows what level of assistance each resident on her assignment needs with toileting and eating she stated, \We get report from

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, resident interview, review of complaint intake #337241 and staff interviews, it was determined that the facility failed to 1) monitor a resident for pain and schedule an appointment for pain management following hospital discharge, and 2) ensure that a resident was given pain medication consistent with professional standards of practice. This was evident for 3 (Resident #107, #127, and #68) out of 76 residents reviewed during the recertification/complaint survey. The findings include: 1) On 08/19/2025 at 9:09 AM in an interview with Resident #107, the resident reported “I have pain from my feet to my thighs and have requested pain medication, but no one has responded yet.” On 08/21/2025 at 9:56 AM a review of Resident #107’s medical record revealed the following: -On 07/21/2025 at 5:42 PM, a Discharge Summary from Hospital documented that Resident #107 was recommended to follow up with his/her pain management clinic and spine specialist after discharge. -On 7/22/2025 at 11:59 PM a physician placed an order to follow up with his/her pain management clinic and spine specialist. -On 07/23/2025 at 12:07 PM a physician ordered a pain management consultation for chronic pain. Further review of Resident #107’s medical record revealed a pain care plan initiated on 07/21/2025. This plan indicated the patient experienced pain in the waist area and lower extremities. The review further showed interventions to monitor for signs and symptoms of pain. An additional review of Resident #107's MAR (medication administration record) for July and August, 2025, showed no evidence of pain being monitored or recorded every shift. 08/26/2025 at 9:00 AM, in an interview with resident #107 stated he/she had not seen their pain and/or spine specialist and was unaware of any scheduled appointments. The resident stated he/she was experiencing pain, that a recent injection had not provided relief, and expressed a desire to see their pain management MD. On 08/26/2025 at 9:30 AM, an interview with Staff #12 (Medical Record Director) stated upon admission from the hospital, nurses are responsible for reviewing the discharge summary for any required follow-up appointments, including pain management. They then provide a copy of the discharge summary to the Medical Record Director for scheduling and notify the resident and/or their responsible party of the appointment date. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/2025 at 9:39 AM during an interview with the Staff #19 (Unit Manager) stated that the Staff #12 schedules appointments based on discharge summaries. Nurses then updated physician orders with appointment details and informed residents. Staff #19 was unaware of any pain management appointment for the resident; stated such an appointment would have been noted in physician orders if scheduled. She verified there was no such order, and the resident was also unaware of any appointment. Staff #19 also stated that nurses record pain monitoring every shift in the treatment administration record. However, she verified there was no evidence of the resident being monitored for pain during July and August 2025. On 08/26/2025 at approximately 1:30 PM a document, titled Appointment and Transport request form for Resident #107, was given to the surveyor by Staff #19. It indicated a follow up from hospital discharge appointment with the pain physician for Resident #107 on September 11th, 2025 at 10:00 AM. Staff #19 confirmed that this appointment was arranged after surveyor intervention. On 08/28/2025 At 3:00 PM the Director of Nursing (DON) was made aware and understood the concerns. 2) On 8/26/25 at 12:45 PM review of an attachment to a Complaint intake #337241 had that Resident #127 was getting pain medications when their pain level was at zero, and that nonpharmacological measures were not being implemented prior to medication administration. On 8/26/25 at 1:00 PM review of the physician’s order dated 10/31/23 read: “oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug*Give 1 tablet by mouth every 4 hours as needed for pain. Further review did not reveal an order for non-Pharmacological interventions. Review of the resident’s Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of November 2023 through January 2024 on 8/26/25 at 1:16PM did not indicate that nonpharmacological measures were being implemented. Further review revealed that Resident #127 got their pain medication on January 20, 2024, when their pain level was documented as zero, indicating no pain. On 8/27/25 at 9:12 AM In an interview with the Director of Nursing (DON) she was asked if a resident on a PRN (As Needed) pain medication should have a non-Pharmacological interventions put in place, and she said yes. She was asked if they should be getting pain medications when their pain level was at a zero, and she said no. She was made aware that Resident #127 got pain medications when their pain level was at zero with no nonpharmacological interventions implemented. She said she would follow up with more staff training. 3) Review of Resident #68’s clinical records on 8/21/2025 at 10:37 AM revealed the resident was re-admitted to the facility in July 2023 with medical diagnoses that include but not limited to Opioid dependence, uncomplicated, Chronic pain syndrome, non-pressure chronic ulcer of bilateral lower leg, Peripheral vascular disease, chronic embolism and thrombosis of unspecified deep veins of bilateral lower extremity. On 8/21/2025 11:17 AM Review of physician orders revealed the following active orders: - Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) : Give 1 tablet by mouth every 4 hours as needed (PRN) for pain, start date 11/12/2024, and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Tylenol Oral Tablet 325 MG (Acetaminophen): Give 2 tablet by mouth every 4 hours as needed for Pain, start date 4/18/2025 [of note, there are no parameters/pain scale indicated for administration of the above PRN pain meds]. On 8/21/2025 at 11:21 AM, record review revealed that Resident # 68's pain was not managed consistently: A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2025 was completed. Staff documentation revealed that the resident was given: 1) PRN Tylenol 325mg (2 tabs) ordered without parameters for pain management, for a pain score of 6 on 8/18/2025 at 0641 (6:41 AM). 2) PRN Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 4 hours as needed for pain was given on the following dates/times: - On 8/1/2025 at 7:39 (7:39 AM) and at 1749 (5:49 PM) for pain score of 6…. - On 8/3/2025 at 0008 (12:08 AM) for pain score of 6, at 0723 (7:23 AM) for pain score of 7, and at 1925 (7:25 PM) for pain score of 1. - On 8/5/2025 at 0052 (12:08 AM) for pain score of 7, at 1049 (10:49 AM) for pain score of 5, and at 2001 (8:01 PM) for pain score of 6 - On 8/18/2025 at 1703 (5:03 PM) for pain score of 8, etc. More so, there was no documentation of non-pharmacological interventions (NPIs) attempted prior to these PRN pain meds administration. On 8/25/2025 at 9:05 AM, an interview was conducted with Registered Nurse (RN #24) regarding administration of PRN pain medications: RN #24 stated that prior to giving any pain medication, he will assess the resident's pain and choice of pain med to be given will be based on physician orders/ordered parameters. He stated that each PRN pain med order must have a pain scale/parameters for administration: mild pain 0 -4, moderate pain 5-7, and severe pain 7-10. When asked what pain med to give a resident that has both Acetaminophen (Tylenol) and Oxycodone ordered, RN #24 stated that he would give Acetaminophen for mild pain and Oxycodone for moderate to severe pain. He added that he would attempt non-pharmacological interventions (NPIs) such as relaxation technique, distraction, massage etc. prior to administering any PRN pain medication. RN #24 further stated that it was not appropriate to administer Oxycodone 10mg for a pain score of 1. RN #24 stated that he would educate the resident regarding pain management and if the resident insists on the Oxycodone, he (RN 24) would call the Physician and get a one-time order for the Oxycodone and document it. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/2025 at 3:04 PM, in an interview with the Director of Nursing (DON), she stated that PRN pain meds should be given following physician orders and the PRN pain med order should have parameters (at least mild, moderate, severe pain) for administration. Regarding non-pharmacological interventions (NPIs) prior to PRN pain med administration, DON stated that staff were expected to document in their progress notes that they attempted NPIs prior to PRN pain med administration. Surveyor reviewed with the DON Resident #68’s MAR and TAR for August 2025 regarding staff PRN pain med administration (Tylenol and Oxycodone). DON verified that the PRN orders failed to have parameters/pain scale for administration. She validated that the resident’s pain was not consistently managed and it was not appropriate to give Tylenol for a pain score of 6 and Oxycodone for a pain score of 1. However, she stated that she was going to look at the nurses' progress notes to see if they documented the reason for administering the above pain meds and/or NPI's that were attempted. On 8/27/2025 at 7:30 AM, in a follow up interview with the DON, she stated that she could not find any nursing progress notes that indicated that NPI's were attempted prior to administering the above PRN pain meds to Resident #68. She added that there were no notes indicating why the Tylenol was given for a pain score of 6 and the Oxycodone for a pain score of 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215178	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frederick Villa Healthcare	711 Academy Road Catonsville, MD 21228

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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 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. Based on record review, a facility reported incident (Intake #2578127) and interviews, it was determined that the facility failed to maintain medical records on each resident that were complete and accurately documented. This was evident for 2 (Resident #74 and Resident # 127) out of 76 resident records reviewed during the survey process. The findings included: 1) On 08/27/2025 at approximately 5:00 PM, a review of facility reported incident #2578127 revealed that on 07/29/2025 at 3:24 PM, Resident received a one-time dose of Narcan due to the resident unresponsiveness to call and drowsiness. The nurse contacted the physician, and he ordered a dose of Narcan to be administered to the resident. A review of the 7/29/2025 3:36PM Nursing Progress Note stated: Narcan was administered due to sleeping excessively and resident was alert to person, place and time. Denied pain no discomfort noted. Will continue to monitor. On 08/28/2025 at 2:10 PM, in an interview with the Director of Nursing (DON) she was asked to explain the circumstances surrounding the above-mentioned event. The DON stated that Resident #74 was sent on a leave of absence from the facility due to a family emergency. Upon the resident’s return to the facility the resident’s behavior was significantly different. The resident’s nurse was unsure if the resident took any other medication while out of the facility as a precaution the nurse notified the physician and a one-time dose of Narcan was ordered. The medication was administered and was effective. On 08/28/2025 at 2:32 PM, a review of Resident #74’s Medication Administration Record (MAR) for the month of July 2025 revealed that the medication was not signed off on the MAR to indicate when the one-time dose of Narcan was administered, as required. There was also documented evidence to support that the resident’s behavior was being monitored routinely. On 8/28/2025 at 3: 00 PM the DON was notified that the facility failed to have documented evidence to support that the Narcan administration was documented using professional standard of practice. 2) A review of Resident #127's clinical record revealed that the resident was admitted to the facility with a therapeutic boot. The resident had a consultation with the orthopedist on 11/7/23. The consultation report included a recommendation to continue using the boot to assist with weight bearing as tolerated. The Director of Nursing was interviewed on 8/28/25 at 1:15 PM. She was asked what her expectations for nursing were when they received this consultation. She replied that she would expect nursing to follow the recommendations. Further review of the clinical record revealed that there was no evidence that nursing staff were documenting the use of the boot on the Treatment Administration Record. The Administrator was informed of the findings on 8/28/25 at 1:40 PM. He replied that he understood.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint 337259 and the facility's pest problem logs and interview with facility staff, it was determined that the facility failed to maintain an effective pest control program. This deficient practice had the potential to impact all residents.The findings include:Review of complaint 337259 on 8/25/25 at 12:13 PM revealed that the facility was infested with roaches and rodents.The surveyor requested the facility's pest logs from 2025 on 8/27/25 at 7:42 AM. Review of the Pest Problem Log on 8/27/25 at 9:42 AM revealed the following entries in patient care areas:11/13/24 room [ROOM NUMBER]: roaches, mice11/13/24 room [ROOM NUMBER]: roaches, mice1/21/25 room [ROOM NUMBER]: roaches2/6/25 Medication room [ROOM NUMBER], 2, 3: ants, roaches, mice, mice droppings4/21/25 Rooms 118, 115, 120, 116, 117: roaches4/21/25 Rooms 217-220: roaches, mice4/22/25 Rooms 105, 106, 111, 112: roaches4/23/25 Break room: ants4/25/25 Front area: roaches5/2/25 Rooms: 207-209: water bugs5/2/25 Rooms: 100, 109: mice5/15/25 Rooms 204: spiders5/20/25 Unit 3 nurse's station: ants 5/20/25 room [ROOM NUMBER]: roaches 5/25/25 Rooms 211, 220: ants5/26/25 room [ROOM NUMBER]: bugs5/27/25 room [ROOM NUMBER]: bugs5/29/25 Rooms 211, 220: ants5/31/25 room [ROOM NUMBER]: spiders5/31/25 room [ROOM NUMBER]: ants6/1/25 room [ROOM NUMBER]: spiders6/1/25 room [ROOM NUMBER]: roaches 6/2/25 room [ROOM NUMBER]: spiders6/2/25 Rehab: roaches6/4/25 Rooms 102, 104, 106: ants, roaches6/4/25 room [ROOM NUMBER]-120: ants, roaches6/24/25 Laundry room: roaches7/16/25 Conference room: roaches, mice8/6/25 Rooms 202, 208, 314, 315: roaches, mice8/6/25 room [ROOM NUMBER]: roaches, mice8/6/25 Shower rooms 1, 2, 3: ants, roaches, mice8/8/25 room [ROOM NUMBER]: gnats8/12/25 room [ROOM NUMBER]: flies, gnats8/15/25 room [ROOM NUMBER]: flies On 8/27/25 at 8:21 AM in an interview with the Nursing Home Administrator (NHA) when asked if he has seen roaches and rodents in the facility he stated, Yes, we live in the state of Maryland and so I have seen roaches and rodents in the facility. We do have a pest management company. On 8/27/25 at 9:16 AM in an interview with the NHA, the surveyor shared the concerns that there was a complaint filed regarding the roaches and rodents, that the logs show sightings of roaches and rodents, and that he verified and confirmed that there are roaches and rodents in the facility. During the interview, the NHA stated this building was an old building and being surrounded by woods and water, it was a continuous effort to keep the pests and rodents out of the building. The surveyor shared this issue was a concern and the NHA stated, sure, I understand.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on reviews of a facility reported incident, reviews of administrative records, and staff interviews, it was determined that the facility failed to provide abuse education to geriatric nursing assistant (GNA) upon their hired date. This was evident for 1 (Staff #39) of 5 GNAs abuse education reviewed during a recertification/complaint survey.The findings included:On 8/20/25 at 12:42 PM, the surveyor investigated Facility Reported Incident #337205. The report showed that Resident #119 claimed to have been sexually abused by a GNA of the opposite gender on 4/07/23.A further review of the facility's investigation revealed that they assessed Resident #119 and obtained statements from residents and the staff member. Resident #119 later confessed to the Nursing Home Administrator and a physician that the accusation was false.A review of the education records for Staff #39, who was falsely accused, on 8/20/25 at 1 PM revealed the staff member was hired on 10/03/22. However, the staff members' required training, such as infection control, dementia care, and abuse training, was not completed in a timely manner. The training completion date was documented as 11/30/22.During an interview with the Nursing Home Administrator (NHA) on 8/20/25 at 2:45 PM, he confirmed that Staff #39 was hired on 10/03/22 and began caring for residents shortly after. The NHA confirmed that essential training for newly hired staff should be completed during their orientation. The surveyor shared concerns that Staff #39's training was completed two months after the hire date, and the NHA validated the concern.