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	03/23/2026

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 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure the baseline care plan reflected the resident's current medications at the time of admission. This was evident for 1 (Resident #10) out of 10 residents reviewed during the complaint survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. This allows residents and their representatives to be more informed about the care that they receive.Xarelto is an anticoagulant (blood thinner) medication used to prevent blood clots and lower the risk of stroke.Eliquis is an anticoagulant (blood thinner) medication used to lower the risk of blood clots and stroke in certain heart conditions.On 03/19/2026 at 9:37 AM, review of Resident #10's clinical record revealed that he/she was admitted to the facility on [DATE] with diagnoses including, but not limited to, ST elevation myocardial infarction (STEMI), congestive heart failure, atrial fibrillation, chronic embolism and thrombosis of deep veins, and hypertensive heart disease with heart failure. Review of Resident #10's hospital Discharge summary dated [DATE] revealed a hospital course note that stated the resident was changed from Eliquis to Xarelto and was started on a loading dose of Xarelto 15mg twice daily on 12/7/2025 with a planned transition to Xarelto 20mg daily on 12/29/2025. Review of Resident #10's physician orders revealed anticoagulant medication (Xarelto) was ordered upon admission to the facility.Review of Resident #10's baseline care plan dated 12/10/2025 revealed the plan did not include anticoagulant medication as part of the resident's current medications and did not include a care plan addressing anticoagulant therapy.On 03/23/2026 at 1:02 PM, an interview with the Director of Nursing (DON) confirmed that Resident #10 was taking anticoagulant medication (Xarelto) at the time of admission and that his/her baseline care plan did not include a plan to address anticoagulant therapy. The DON stated that Resident #10's anticoagulant medication should have been included in the baseline care plan.

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 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 medical record review and interview, it was determined that the facility staff failed to develop a comprehensive person-centered care plan for a resident with extensive pressure ulcers. This was evident for 1 (Resident #5) of 2 residents reviewed for pressure ulcers during a complaint survey.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.A pressure ulcer, also known as pressure sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full-thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed).A wound vacuum (wound vac) is a specialized medical device used in negative-pressure wound therapy. It applies gentle, consistent suction to the wound bed which reduces swelling, drains excess fluids, removes debris, and promotes blood flow, often allowing patients to heal faster with fewer dressing changes. On 3/17/26 at 11:45 AM a review of Resident #5's medical record was conducted and revealed Resident #5 was admitted to the facility in November 2025 with diagnoses that included, but were not limited to, paraplegia due to a motor vehicle accident, stage 4 pressure ulcers to the left buttock, sacral region, and left ankle, local infection of the skin and subcutaneous tissue, and unspecified severe protein-calorie malnutrition. Review of Resident #5's medical record revealed a care plan, has pressure ulcer of the sacral area, and on posterior left leg, right heel, and diabetic ulcer on left ankle r/t (related to) impaired mobility with a date created and initiated on 11/18/25. The goal on the care plan was, will be free for signs of infection and improve by next review date. The interventions on the care plan were, carefully dry between toes but do not apply lotion between toes; position resident off affected area; change position every 2 hours and PRN; WOUND/DRESSING: as Order. Observe dressing (SPECIFY FREQ). Change dressing and record observations of site (SPECIFY FREQ). The care plan for Resident #5 who was admitted to the facility with Stage IV pressure ulcers was not comprehensive or resident centered. The care plan did not specify the wound/dressings or state the frequency. The care plan failed to document interventions for how to prevent further worsening of the heels, such as elevating heels and heel boots. There was nothing mentioned about the wound vac that was ordered for the resident to promote wound healing. There was nothing about monitoring for an intact seal, assessing for infection, bleeding, or fluid leakage. There was nothing about the type of mattress the resident should have been lying on.On 3/23/26 at 10:16 AM the pressure ulcer care plan for Resident #5 was reviewed with the Director of Nursing (DON). The DON was asked if she expected other interventions to be on the care plan and she acknowledged that the care plan was not comprehensive for the type of pressure wounds that the resident had when admitted to the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility failed to administer an antibiotic for an infection as prescribed in the discharge instructions from the hospital. This was evident for 1 (Resident #6) of 10 residents reviewed during a complaint survey.The findings include:On 3/18/26 at 8:38 AM a review of Resident #6's medical record was conducted and revealed Resident #6 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side. Review of the 1/5/26 hospital discharge summary documented that Resident #6 was diagnosed with a urinary tract infection while in the hospital and was started on an antibiotic. The discharge summary also had a list of medications that were prescribed to Resident #6 upon discharge. Resident #6 was to continue Amoxicillin 500 mg. 3 times a day for 5 additional days.Review of Resident #6's January 2026 Medication Administration Record (MAR) failed to produce evidence that the Amoxicillin was administered to Resident #6 upon admission to the facility.On 3/19/26 at 12:07 PM the Director of Nursing (DON) was interviewed about the missed antibiotic. The DON stated that she reviewed the discharge summary and that the resident received the antibiotic in the hospital. The DON was shown the discharge summary where it documented the Amoxicillin was to continue for an additional 5 days.On 3/20/26 at 9:48 AM Staff #7 was interviewed and reviewed the January 2026 MAR along with the discharge summary. Staff #7 stated our process is when we get a new admission we do a second day chart check to make sure we got everything. I believe it was missed.On 3/20/26 at 1:30 PM the concern was discussed with the DON. The DON confirmed the error and stated they were already looking at their admission process.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure residents remained free from significant medication errors. This was evident for 1 (Resident #10) out of 10 residents reviewed during the complaint survey. The findings include:Xarelto is an anticoagulant (blood thinner) used to prevent blood clots and lower the risk of stroke.Eliquis is an anticoagulant (blood thinner) used to lower the risk of blood clots and stroke in certain heart conditions.On 03/19/2026 at 9:37 AM, Resident #10's clinical record was reviewed to reveal the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, ST elevation myocardial infarction (STEMI), congestive heart failure, atrial fibrillation, chronic embolism and thrombosis of deep veins, and hypertensive heart disease with heart failure. Review of Resident #10's hospital Discharge summary dated [DATE] revealed a hospital course note that stated the resident was changed from Eliquis to Xarelto and was started on a loading dose of Xarelto 15mg twice daily on 12/7/2025 with a planned transition to Xarelto 20mg daily on 12/29/2025. Review of Resident #10's December 2025 physican orders revealed Xarelto was ordered upon admission. The record also revealed multiple Eliquis orders were entered and discontinued on 12/10/2025, 12/11/2025 and 12/15/2025.On 03/19/2026 at 12:07 PM, an interview with the Director Of Nursing (DON) revealed that Resident #10's Eliquis order was stopped and restarted to change the indication from DVT (deep vein thrombosis) to A-fib (atrial fibrillation).On 03/19/2026 at 3:12 PM, an interview with Licensed Practical Nurse (LPN) Supervisor #17 revealed that he was the supervisor when Resident #10 was admitted and that Eliquis orders dated 12/10/2025, 12/11/2025 and 12/15/2025 were created by the pharmacy. LPN Supervisor #17 confirmed the orders were verified after contacting the provider but could not explain the why the Eliquis orders were created for Resident #10.Review of Resident #10's December 2025 medication administration record (MAR) revealed that Resident #10 received Eliquis 5mg on 12/16/2025 during the 9:00 AM medication administration while also receiving Xarelto 15mg as ordered. The administration of both anticoagulant medications increased Resident #10's risk for bleeding.On 03/20/2026 at 9:12 AM, an interview with Registered Nurse (RN) #7 revealed that he was the Unit Manager when Resident #10 was admitted in December 2025 and was responsible for reviewing resident orders. RN #7 stated that Resident #10 was supposed to be on Xarelto per hospital discharge orders and identified that Eliquis orders were entered in error on 12/10/25, 12/11/25 and 12/15/25. RN #7 contacted the provider to verify the correct Xarelto order and discontinued the Eliquis order each time. RN #7 could not explain why the Eliquis orders for Resident #10 continued to appear on the MAR.On 03/20/2026 at 11:22 AM, an interview with LPN #18 revealed that she administered Eliquis 5mg to Resident #10 on 12/16/2025 during the 9:00 AM medication administration along with Xarelto, as evidenced by documentation in the MAR. On 3/20/2026 at 2:15 PM, an interview with the DON confirmed that Resident #10 should have remained on Xarelto per hospital discharge orders and not Eliquis. The DON stated that she would follow up to determine why Eliquis was ordered.On 3/23/2026 at 10:17 AM, during a follow up interview, the DON reviewed Resident #10's December 2025 MAR and confirmed that on 12/16/2025, the resident received both Xarelto and Eliquis during the 9 AM medication administration.The findings were discussed with the Director of Nursing, Administrator and the Regional Director of Clinical Operations at the time of exit conference.

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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 review, complaint review, and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Resident #5, #4) of 10 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.1a)On 3/17/26 at 11:45 AM a review of Resident #5's medical record was conducted and revealed Resident #5 was admitted to the facility in November 2025 with diagnoses that included, but were not limited to, paraplegia due to a motor vehicle accident, stage 4 pressure ulcers to the left buttock, sacral region, and left ankle, local infection of the skin and subcutaneous tissue, and unspecified severe protein-calorie malnutrition.Review of Resident #5's medical record revealed the resident was seen weekly by the wound care physician/wound care nurse. Initially, the only wound notes in the medical record for wounds were dated 11/21/25, 11/29/25, and 2/12/26.On 3/20/26 at 8:33 AM an interview was conducted with the Wound Care Nurse Practitioner, Staff #21 who stated she has worked at the facility since December 2025. Staff #21 stated that they changed systems in December 2025 which went from wound expert to doc now. Staff #21 stated it did not look like any of the wound expert notes pulled into PCC (electronic medical record system) from doc now. Staff #21 stated that she would let their office manager know so she could send the notes over to the facility. Staff #21 was able to show the surveyor the weekly visits in her computer system.After interview with Staff #21, the Director of Nursing (DON) was interviewed and gave the surveyor the wound care notes that were printed off for dates of service 12/12/25, 12/19/25, and 12/26/25. The DON confirmed the notes were not initially in the medical record.1b) Review of Resident #5's medical record revealed a 2/18/26 change in condition note that documented Resident #5 was sent to the hospital for hypotension and critical labs. The vital sign section of the form documented the respiratory rate was 18 and the oxygen saturation was 97 percent on room air. There was no documentation of trouble breathing on the change in condition form or on the hospital transfer form. However, review of the hospital emergency room documentation dated 2/18/26 documented patient also reports some shortness of breath. The note documented on 2/18/26 at 14:45 the resident was on a non-rebreather mask receiving oxygen at 15 liters a minute. On 3/20/26 at 9:04 AM an interview was conducted with Staff #7 who stated he was the RN that sent the resident to the hospital. Staff #7 stated the resident was having respiratory issues and that the blood work was abnormal and the hematocrit and hemoglobin was low. Staff #7 stated that normally the resident would reject being sent to the hospital for a blood transfusion but this time the resident was having respiratory issues, so the physician wanted the resident sent out. Staff #7 confirmed that he failed to document that the resident had respiratory issues prior to being sent out. On 3/20/26 at 11:28 AM an interview was conducted with the DON about the documentation not reflecting the resident's condition. The DON agreed that the nurses needed to expand on the change in condition form as to what was actually going on with the resident and that they would need to educate the staff.1c) Review of geriatric nursing assistant (GNA) tasks for bowel movements for Resident #5 documented bowel movements were monitored every day that the resident was in the facility in December 2025, January 2026, and February 2026. There were, however, some blank spaces for some of the shifts. It was also noted that Resident #5 had a colostomy and was ordered to have bowel movements monitored every shift for output. A colostomy is a surgical procedure that creates an opening (stoma) in the abdominal wall, bringing a portion of the large intestine to the surface to allow stool to exit the body into an attached, replaceable bag.Review of the December 2025 GNA task record for bowel movements was blank for (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 7:00 AM to 3:00 PM shift on 12/9/25, 12/13/25, and on the 3:00 PM to 11:00 PM shift on 12/20/25, 12/21/25, and 12/28/25. Review of the January 2026 GNA task record for bowel movements was blank for the 7:00 AM to 3:00 PM shift on 1/11/26, and the February 2026 record was blank on the 11:00 PM to 7:00 AM shift on 2/6/26 and 2/9/26. On 3/20/26 at 11:28 AM an interview was conducted with the DON who stated, if it was not signed off it was not done.1d) Review of complaint 2790378 alleged that Resident #5 could not keep any food down. Review of nursing progress notes and change in condition forms did not reveal that Resident #5 had any nausea or vomiting.Review of February 2026 physician's orders for Resident #5 revealed the order Ondansetron 4 mg. to be given every 8 hours as needed for nausea and emesis (vomiting) on 2/16/26 at 1831 (6:31 PM). On 3/19/26 at 8:56 AM Staff #12 was interviewed about Resident #5 and stated that Resident #5 did vomit one morning, and they gave him/her something and he/she was able to eat lunch.On 3/19/26 at 9:25 AM physician #14 was interviewed and stated that Resident #5 did vomit but never told anyone and I did not find out about it until several days later, but I don't remember any of the details about it. There was no documentation in the medical record that Resident #5 had nausea or vomited.On 3/20/26 at 11:28 AM an interview was conducted with the DON. Informed the DON that there was no documentation of Resident #5 having nausea and/or vomiting, however an order was written for Ondansetron (anti-nausea medication). The DON stated that the nurses needed to expand more on their documentation.1e) Review of complaint 2790378 alleged that the facility failed to hold mandated care plan meetings. Review of Resident #5's medical record revealed a letter that invited the family to a care plan meeting on 2/11/26, however there was no documentation in the medical record that validated that the meeting took place.On 3/23/26 at 9:58 AM an interview was conducted with the Regional Social Worker, Staff #25, who was able to provide an attendance record of the meeting. Staff #25 did confirm there were no social work notes in the medical record, and the meeting should have been documented in the assessment section of the medical record that day.2)On 3/23/26 at 11:11 AM a review of Resident #4's medical record was conducted and revealed Resident #4 was admitted to the facility on [DATE]. Review of the medical record failed to produce documentation that a care plan meeting was held with the resident after admission. Review of the miscellaneous section of the electronic medical record (Emr) revealed there was a care plan invitation letter for a care plan meeting for 1/21/26, however there was nothing noted for October 2025 or November 2025.On 3/23/26 at 12:54 PM an interview was conducted with Staff #25, who validated that there was no documentation related to the care plan meeting after admission. Staff #25 stated she could only find the meeting notes from the care plan meeting that took place on 1/21/26. Staff #25 stated that the facility changed the policy after they found the issue of care plan notes that had not been put into the medical record. She stated that the current social worker was out, and they could not find any of the notes.On 3/23/26 the Nursing Home Administrator and the DON were informed of the documentation concerns at the exit conference.