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	05/06/2026

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

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interviews, record review, reviews of other pertinent documentation, and staff interviews, it was determined that the facility failed to treat a resident who complained of severe pain resulting in harm to the resident. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey.The findings include:In an interview with Resident #1 and a family member on 05/04/26 at 11:07 am, Resident #1 complained of pain in the groin area. Resident #1 moaned in pain with any movement while seated during the interview. Resident #1's family member stated that Resident #1 is in constant pain and that the medications the staff are providing are not working.A review of Resident #1's clinical record on 05/04/2026 at 11:30 am revealed that on 11/25/25, Resident #1's physician gave orders to the nursing staff to administer the pain medication Tylenol, Oral Tablet, 325 mg, give 2 tablets by mouth, every 4 hours as needed for pain.A review of Resident #1's clinical record revealed a monthly progress note date 04/07/26 at 5:47 pm from Resident #1's attending physician (staff member #5) that Resident is requiring Morphine Sulfate ER (Extended Release) for their diagnosis of chronic pain. Resident #1's attending physician also indicated that Resident #1 has tried several other medications, including NSAIDS, OTCs, and topical pain relievers without any improvement. Resident #1's attending physician also indicated that he did not suspect any abuse or addiction and that he will constantly re-evaluate the need for this medication at each visit. The 04/07/26, 5:47 pm progress note indicated Resident #1 had declined an assessment of their groin area.In an interview with the Resident #1's attending physician on 05/04/26 at 12:17 pm, Resident #1's attending physician stated that he was just contacted by the nursing staff 10 minutes ago about Resident #1's pain management and that currently Resident #1 had no complaints of pain. Resident #1's attending physician stated that the nursing staff were applying an ointment to the resident's genitals approximately a month ago. Resident #1's attending physician stated that Resident #1 was admitted to the hospital in December 2025 and has chronic infections (cellulitis) of the genitals. Resident #1 also has a history of genitalcellulitis. Resident #1's physician stated that he just gave orders to the nursing staff that included: to wash resident #1's groin area three times a day with soap and water, administer an antibiotic orally daily for 7 days, and to apply a topical ointment to Resident #1's genitalia for 7 days.A review of the facility Pain Management Policy on 05/04/26 revealed that all residents will receive individualized pain management using both pharmacological and non-pharmacological interventions. Pain will be assessed, treated, monitored and documented consistently. Assessment requirements included the nursing staff will perform a pain assessment upon admission, quarterly, and with significant change and post-intervention. The staff will use standardized pain scales appropriate to a resident's cognitive status. The nursing staff will assess location, intensity, duration, quality, and impact on function. Administer medications per provider orders, including PRN (as needed). Residents receiving PRN pain medications will document effectiveness and side effects. Pain management will be care planned and incorporated into the interdisciplinary care plan. The nursing staff are to document a pain assessment, interventions, response and follow-up including refusal, adverse reactions and provider communication.Further review of Resident #1's clinical record revealed a nursing progress note (written by RN#3) dated 05/02/25 at 3:25 pm that indicated Resident #1 was complaining of severe chronic pain in the groin / (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 0697 Level of Harm - Actual harm Residents Affected - Few	genital area with a pain of 10/10 on pain scale (1-10). On assessment Resident #1's genitals noted to be swollen, tender to touch. RN#3 documented the medication podofilox 0.5% gel had been applied as per physician order. Podofilox 0.5% gel is a prescription topical medicine used to treat external genital and perianal warts caused by Human papillomavirus (HPV). The medication works by destroying wart tissue. Common reactions include burning, stinging, inflammation, itching, pain, and skin redness. RN#3 documented that Resident #1's pain was reassessed and his pain was still noted to be 10/10 after application of topical gel. RN#3's nursing progress note indicated the facility nursing supervisor was notified who reached out to Resident #1's provider/physician. A new verbal telephone order was received on 05/02/26 at 4:09 pm that instructed the nursing staff to apply Lidocaine External Cream, 4% cream, to Resident #1's genitals, topically, one time a day. Lidocaine External Cream is used on different parts of the body to cause numbness or loss of feeling for patients having certain medical procedures. Lidocaine skin patch is used to relieve nerve pain caused by herpes zoster or shingles (postherpetic neuralgia). Lidocaine belongs to the family of medicines called local anesthetics. This medicine prevents pain by blocking the signals at the nerve endings in the skin.In an interview with RN#3 on 05/05/26 at 1:10 pm, RN#3 stated that he recalled taking care of Resident #1 on 05/02/26. RN#3 stated that Resident #1 was complaining of 10/10 pain on 05/02/26. RN#3 stated that he administered Resident #1's morning dose of Morphine 15 mg orally during the morning as ordered. RN#3 stated that he applied the Podofilox 0.5% gel to Resident #1's genitalia . RN#3 stated that Resident #1's genitalia was observed on 05/02/26 and noted to be swollen and without any open areas. RN#3 stated Resident #1's physician was notified who ordered the Lidocaine gel to be applied. RN#3 confirmed that a dose of Lidocaine gel was not administered on 05/02/26 because it had not been delivered from the pharmacy. RN#3 stated that he administered a dose of Tylenol to Resident #1 at 2 pm on 05/02/26. A review of Resident #1's May 2026 medication administration record (MAR) on 05/05/26 at 1:30 pm failed to reveal any documentation Resident #1 was administered a PRN dose of Tylenol for pain between 05/01/26 thru 05/04/26 at 11 am. In an interview with the facility dispensing pharmacist on 05/05/26 at 11:47 am, the dispensing pharmacist confirmed a physician's order that Resident #1 was receiving regular Morphine 15 mg, orally, twice a day and not extended release (long acting) Morphine. The dispensing pharmacist confirmed the use for the Podofilox 0.5% gel was for use to the affected areas (warts) only and that the medication was not a pain-relieving medication.In an interview with the facility director of nurses (DON) on 05/04/26 at 12 noon, the DON stated that the expectation for managing a resident's pain includes the nursing staff completing a pain assessment, using a 0 - 10 pain scale, documenting a pain scale number every shift, documenting non-pharmacological interventions used to help a resident's pain, if the resident is receiving a PRN pain medication, a pre and post administration assessment will be documented using the pain scale.In an interview with the facility Regional Clinical Nurse Educator on 05/04/26 at 1:20 PM, Employee #5 stated the expectation for the nursing staff is to document a change in condition progress note, conduct a new pain assessment, document if resident is being assessed with a verbal or non-verbal pain scale by documenting a 0 - 10 scale (0 = no pain, 10 = the worst pain). The nurse surveyor indicated that the nursing staff were just signing off a pain assessment that was completed every shift but there was no documentation of a pain scale being utilized. The Nurse Educator reviewed Resident #1's medication administration record and confirmed that the nursing had not been documenting a numerical pain scale. The Nurse Educator stated that when the physician's order to perform a pain evaluation every shift was placed into the system on 11/25/25, the nurse did not include the supplemental documentation tab in the computer. The Nurse Educator indicated this would only allow the nursing staff to sign off the physician order for the pain assessment but there would be no documentation of Resident #1's verbal or non-verbal response to the pain assessment question.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a clinical record and all pertinent documentation, and staff interviews, it was determined that the facility failed to obtain the staff needed to escort a resident to an outside physician's office visit. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey. The findings include: In an interview with Resident #1 and a family member on 05/04/26 at 11:07 am, Resident #1 complained of pain in his groin area. Resident moaned in pain with any movement while seated during the interview. Resident #1's family member stated that Resident #1 is in constant pain and that the medications the staff are providing are not working.A review of Resident #1's clinical record on 05/04/2026 at 11:30 am revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that are not limited to: dementia with behavioral disturbance, a stroke with right sided weakness, Immunodeficiency disease, chronic pain syndrome, papillomavirus, expressive aphasia, and genital herpes. On 03/17/26, Resident #1's physician gave an order for Resident #1 be seen by one of the local infectious disease physicians in the community. An appointment of 05/04/26 at 9:30 AM was obtained for Resident #1. On 03/19/26 the facility staff conducted a BIMS test on Resident #1 and determined that Resident #1 had a score of 3/15 which indicated severe cognitive impairment.Further review of Resident #1's clinical record on 05/04/26 at 12 noon revealed that the infectious disease physician appointment for 9:30 am this morning had been cancelled and needed to be rescheduled.In an interview with Staff Person #12 at the infectious disease physician's office on 05/04/26 at 3:48 pm, Staff Person #12 indicated a staff member from the facility called and cancelled Resident #1's appointment at 8:16 am this morning due to the facility of not being able to send a staff member (CNA) with Resident #1. Staff Person #12 was also informed by the facility staff member that Resident #1 could not go to an appointment without a staff member (CNA).In an interview with the facility scheduler (Staff Member #4) on 05/04/26 at 4:13 pm, Staff Member #4 confirmed cancelling Resident #1's infectious disease physician appointment this morning (05/04/26). Staff Member #4 stated that there was not an available nursing aide to go with Resident #1 to the physician appointment.Cross reference to F 697

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on complaint, reviews of clinical records and all pertinent administrative records, and staff interview, it was determined that the facility staff failed to promptly notify the ordering physician or clinical practitioner of a laboratory result. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey.The findings include:During the start of the complaint survey at the facility on 05/04/26 at 11:07 am, the facility administrator escorted Resident #1 and their family member to the facility conference room and introduced them to the nurse surveyor. An interview with Resident #1 then proceeded. During a private interview with Resident #1 and their family member, Resident #1 and their family member brought a complaint against the facility indicating that Resident #1 was complaining of continuous pain in the groin area and the facility staff were not providing quality of care to Resident #1.During a review of Resident #1's clinical record on 05/04/26, Resident #1's attending physician assessed Resident #1 on 04/07/26 at 5:47 PM and noted Resident #1 was complaining of discomfort during urination. Resident #1's attending physician also documented that Resident #1 declined to have a genitourinary examination at that time and that Resident #1 was to be seen by an Infectious Disease Doctor in May 2026 (May 4, 2026, at 9:30 am). Resident #1's attending physician's plan included orders to obtain a urinalysis and a urine culture.Further review of Resident #1's chart revealed the nursing staff obtained a urine sample and sent the specimen to the lab on 04/08/26. On 04/08/26 at 9:53 am, the facility laboratory forwarded the results of Resident #1's urinalysis. The urinalysis report noted abnormal findings. Upon the results being reported to Resident #1's attending physician on 04/08/26 at 9:26 PM, Resident #1's attending physician gave new orders to the nursing staff to administer the antibiotic Ciprofloxacin, 250 mg, orally, twice daily, for 7 days due to Cystitis (bladder infection). Resident #1 received the first dose of Ciprofloxacin on 04/08/26.On 04/11/26 at 10:01 am, the facility laboratory forwarded the results of Resident #1's urine culture. The urine culture report noted abnormal findings that included the antibiotic Ciprofloxacin that was resistant to the organism identified in Resident #1's 04/11/26 urine culture results.Further review of Resident #1's clinical record revealed a nursing progress note dated 04/13/26 at 11:04 am indicating Resident #1's attending physician was made aware of Resident #1's urine culture results. At 2 pm on 04/13/26, Resident #1's attending physician discontinued the antibiotic Ciprofloxacin and initiated the antibiotic Keflex, 500 mg, orally, twice a day for 7 days due to a urinary tract infection. Resident #1 received an additional 4 doses of the antibiotic Ciprofloxacin (4/11 - 9 pm dose, 4/12 - 9 am and 9 pm doses, and 4/13 - 9 am dose) after the facility was notified by the facility laboratory on 04/11/26 at 10:01 am that the organism identified in the urine culture was resistant to the antibiotic Ciprofloxacin. Resident #1 received the first dose of Keflex 500 mg orally on 04/13/16 at 9 pm.Cross reference to F 697

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a clinical record and all pertinent documentation, and staff interview, it was determined that the facility failed to follow a physician's order to obtain a timely infectious disease and urology consult. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey. The findings include: 1) In an interview with Resident #1 and a family member on 05/04/26 at 11:07 am, Resident #1 complained of pain in his groin area. Resident moaned in pain with any movement while seated during the interview. Resident #1's family member stated that Resident #1 is in constant pain and that the medications the staff are providing are not working.A review of Resident #1's clinical record on 05/04/2026 at 11:30 am revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that are not limited to: dementia with behavioral disturbance, a stroke with right sided weakness, Immunodeficiency disease, chronic pain syndrome, papillomavirus, expressive aphasia, and genital herpes. On 03/17/26, Resident #1's physician gave an order for Resident #1 be seen by one of the local infectious disease physicians in the community. An appointment of 05/04/26 at 9:30 AM was obtained for Resident #1. On 03/19/26 the facility staff conducted a BIMS test on Resident #1 and determined that Resident #1 had a score of 3/15 which indicated severe cognitive impairment.A review of Resident #1's clinical record on 05/04/26 at 12 noon revealed that the infectious disease physician appointment for 9:30 am this morning had been cancelled and needed to be rescheduled.In an interview with Staff Person #12 at the infectious disease physician's office on 05/04/26 at 3:48 pm, Staff Person #12 indicated a staff member from the facility called and cancelled Resident #1's appointment at 8:16 am this morning due to the facility of not being able to send a staff member (CNA) with Resident #1. Staff Person #12 was also informed by the facility staff member that Resident #1 could not go to an appointment without a staff member (CNA).In an interview with the facility scheduler (Staff Member #4) on 05/04/26 at 4:13 pm, Staff Member #4 confirmed cancelling Resident #1's infectious disease physician appointment this morning (05/04/26). Staff Member #4 stated that there was not an available nursing aide to go with Resident #1 to the physician appointment.2) Review of Resident #1's clinical record on 05/04/26 at 12 noon revealed a physician's order dated 12/02/25 instructing the nursing staff to Schedule a urology consult to follow up regarding the diagnoses of penile cellulitis, and chronic HSV (Herpes simplex virus) infection with condyloma acuminata (commonly known as genital warts).In an interview with the facility scheduler (Staff Member #4) on 05/04/26 at 4:13 pm, Staff Member #4 stated that Resident #1 was seen by a urologist while in the hospital in early November 2025 and that it was decided then that Resident #1's genitourinary issues were not of a urological concern. Staff Member #4 was unable to produce any urology consult progress notes or state why the physician's order for a urologist had not been discontinued by Resident #1's attending physician.Cross reference to F 697

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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. Based on complaint, reviews of a clinical record and all pertinent documents, and interviews with facility staff, it was determined that the nursing staff failed to 1) follow the physician ordered parameters when documenting a resident's lung sounds every shift, and 2) obtain a resident's pacemaker check every shift for proper functioning. This was evident for 1 (Resident #1) of 6 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. In an interview with Resident #1 and a family member on 05/04/26 at 11:07 am, Resident #1 complained of pain in his groin area. Resident #1's family member stated that Resident #1 is in constant pain and that the medications the staff are providing are not working.A review of Resident #1's clinical record on 05/04/26 at 12 noon revealed the following 2 physician orders:1) On 11/25/25 at 12 noon, please document lung sounds once a day 1 = clear 2 =rales 3 = rhonchi4 = wheezing, one time daily for monitoring. 2) On 11/25/25, obtain a Pacemaker Check every shift for proper functioning. A review of Resident #1's April and May 2026 medication administration records (MAR) and treatment administration records (TAR) on 05/04/26 at 12 noon revealed that nursing staff are only signing off (initialing) that both lung checks and a pacemaker check had been completed. The nursing staff are not following the physician parameters for lung sounds nor obtaining a result that Resident #1's pacemaker is still functioning appropriately daily. In an interview with the facility director of nurses (DON) and the regional clinical educator on 05/04/26 at 1:20 pm, the regional clinical educator stated that Resident #1 goes out to the cardiologist's office to have his pacemaker checked. They have the equipment to perform the test there. We do not use the telephone method to check Resident #1's pacemaker function. Resident #1 had his pacemaker last checked in July 2025 and has a current appointment on 05/13/26 to have the pacemaker rechecked.