STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49148 Based on observation, record review, and interview with residents and staff it was determined that the facility failed to maintain and enhance the dignity of residents. This was evident for 1 (Resident #81) out of 3 residents reviewed for dignity during the annual survey. The findings include: A Hoyer lift is a mechanical lifting device that allows a person to be lifted and transferred to the bed or chair with a minimum of physical effort. On 5/14/2024 at 1:37 PM, during a tour of the first floor B Unit, the Surveyor noted Resident #81 in the doorway of his/her room, sitting in a wheelchair with a Hoyer pad underneath him, and his head down. The resident's call bell was alarming. The Surveyor conducted an interview with the resident and discovered that he/she had been sitting there for over 40 minutes waiting for someone to assist him/her back to bed. The resident stated that a Geriatric Nursing Assistant (GNA) left him/her there to locate a Hoyer lift to transfer him/her back to bed. Resident #81 mentioned that he/she had not been happy lately and was very upset because finding a Hoyer lift is always an issue here, so I just have to sit here and wait. According to Resident #81, the nursing staff fails to respond to call bells timely leaving the residents waiting for long periods of time before someone comes to check on them. The resident stated that one day he/she had to wait until 2 PM before someone could assist him/her with morning care and getting out of the bed to the chair for the day. The resident informed the Surveyor that he/she can't even go to activities if he/she wanted to because the nursing staff can never find a Hoyer lift to assist them out of bed. On 5/14/2024 at 1:45 PM, the Surveyor observed the Director of Nursing (DON) and Administrative Support assist the resident back to bed. The Surveyor informed the DON of the residents' concerns. On 5/30/2024 during an interview with the Director of Nursing (DON), the Surveyor made the DON aware of the concerns with the call bell system constantly alarming for long periods of time. The DON confirmed the issue. (Cross reference F558)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 44440 Based on observations and interviews it was determined that the facility failed to provide residents with reasonable accommodations of needs. This was found evident of 5 (Resident #18, #11, #66, #81 & #2) out of 62 residents reviewed. The finding include: 1a) On 5/15/24 at 8:18 AM, the surveyor, along with Geriatric Nursing Assistant (GNA) Staff # 43, observed Resident #18 laying in bed. The surveyor asked Resident #18 where his/her call light was in case he/she needed to call for assistance. Resident #18 stated he/she did not know. At this time Staff #43 picks up the call light cord from behind Resident #18's bed and clips it to Resident 18's bed. Staff #43 confirmed that the call light was out of reach and should have been placed back in bed after it was removed. On 5/15/24 at 12:15 AM, the surveyor reviewed a progress note written on 2/24/24 by Licensed Practical Nurse (LPN) Staff #46. The note stated Resident #18 was a new admission adjusting well. It further stated Resident #18 demonstrates appropriate use of the call bell this day. On 5/16/24 at 9:59 AM, the surveyor informed the Director of Nursing (DON) of the observation and confirmed the Resident should have a call light in reach. 1b) On 5/29/24 at 9:09 AM, the surveyor observed GNA Staff #44 inside Resident #11's room. On further observation it was noted that Resident #11 was being lifted via a sling and a Hoyer lift. Resident #11 was observed being up in the air over his/her bed. Staff #44 was the only other person in the room with Resident #11. The surveyor was just outside the door and Staff #44 informed the surveyor that another staff member had just left to assist someone else and she was told he would return to help her. She further stated she was aware there must be two staff while moving someone in a Hoyer lift and confirmed that was why she was waiting to move Resident #11. On 5/29/24 at 9:14 AM, the surveyor observed Staff #44 lower Resident #11 back down to his/her bed and inform the resident that she would return when she found another staff member. On 5/29/24 at 9:19 AM, the surveyor interviews Resident #11. During this interview Resident #11 confirms two staff members were helping to get him/her up but one had to leave. On 5/29/24 at 9:19 AM, Staff #44 returned with another staff member to assist with the Hoyer lift. On 5/29/24 at 10:07 AM, the surveyor interviewed the Director of Nursing (DON). The surveyor described the observations of Resident #11 being left up in the sling while waiting for assistance from another GNA. Staff started to assist Resident #11 and was then asked to wait while in the middle of the assistance. The DON confirmed that Resident #11 should not have been left in the middle of assistance. She further stated she would be educating her staff and not have this happen again. 42783 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a) During an observation conducted on 05/13/2024, 05/14/2024, and 05/15/2024 the surveyor observed three beds, cut cardboard boxes and trash located inside of the Chapel near the front entry of the Chapel. A review of the facility's activity calendar conducted on 05/14/2024 at 8:30 AM revealed that Chapel service was scheduled for every Tuesday and Thursday of each week at 2:00 PM. During an interview conducted on 05/14/2024 at 9:45 AM, the Activity's Assistant #31 stated that the beds were stored inside the Chapel on Thursday 05/09/2024. The Activity's Assistant further stated that the Chapel was not accessible to the residents because of the beds located in the Chapel. During an interview conducted on 05/14/2024 at 11:22 AM, the Director of Nursing (DON) confirmed the beds were stored inside of the Chapel and the plan was for all the beds to be removed by Friday 05/17/2024. On 05/20/2024 at 10:19 AM an interview was conducted with the Activity's Assistant #31. The Activity's Assistant confirmed that residents did not have access for Chapel Service on 05/14/2024 due to the storage of beds inside of the Chapel. 2b) During an observation conducted on 05/17/2024 at 11:47 AM the surveyor observed an audio call bell light blinking above Resident #66's entry door for 25 minutes. Resident #66 appeared frustrated and advised the surveyor that he/she had waited since breakfast to receive care and wanted to get up for lunch. The surveyor also observed Resident #81 in a wheelchair in front of his/ her entry door. Resident #81 advised the surveyor that a staff member moved him/her from the lobby and left him/her in the hallway to wait for a staff member to transfer him/her to the bed. The resident appeared frustrated and expressed he/she was tired of waiting and wanted to get back in bed. During an observation conducted on 05/17/2024 at 11:48 AM, the surveyor observed Licensed Practical Nurse (LPN) #19 at the medication cart two resident rooms down from Resident #66's room. During an interview conducted on 05/17/2024 at 11:48 AM, LPN #19 stated she was aware that Resident #66 required care since breakfast, but she could not locate GNA#50. On 05/17/2024 at 11:52 AM the surveyor advised the Director of Nursing (DON) during an interview that Resident #66 call bell light had been illuminated for an extended period. The surveyor also advised the DON that Resident #81 had been dropped off in his/her wheelchair in the hallway in front of his/her resident room and was waiting for staff to transfer him/her to bed. The DON stated that there was a callout, and she would have staff come to assist the residents. The DON further stated that the facility's expectation was for call bells to be answered in a timely manner and that if a GNA was not available the nurse would be expected to address the needs of the resident. The DON called Staff Scheduler /GNA #59 and Central Supplies /GNA #51 to come to the nursing unit to provide care to the residents. 49148 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) A Hoyer lift is a mechanical lifting device that allows a person to be lifted and transferred to the bed or chair with a minimum of physical effort. On 5/14/2024 at 1:37 PM, during a tour of the first floor B Unit, the Surveyor noted Resident #81 in the doorway of his/her room, sitting in a wheelchair with a Hoyer pad underneath him/her, and his/her head down. The resident's call bell was alarming. The Surveyor conducted an interview with the resident and discovered that he/she had been sitting there for over 40 minutes waiting for someone to assist him/her back to bed. The resident stated that a Geriatric Nursing Assistant (GNA) left him/her there to locate a Hoyer lift to transfer him/her back to bed. Resident #81 mentioned that he/she had not been happy lately and was very upset because finding a Hoyer lift is always an issue here, so I just have to sit here and wait. According to Resident #81, the nursing staff fails to respond to call bells timely leaving the residents waiting for long periods of time before someone comes to check on them. The resident stated that one day he/she had to wait until 2 PM before someone could assist him/her with morning care and getting out of the bed to the chair for the day. The resident informed the Surveyor that he/she can't even go to activities if he/she wanted to because the nursing staff can never find a Hoyer lift to assist them out of bed. On 5/14/2024 at 1:45 PM, the Surveyor observed the Director of Nursing (DON) and Administrative Support assist the resident back to bed. The Surveyor informed the DON of the residents' concerns. On 5/16/2024 at 8:05 AM during review of Resident #81's electronic medical record, the Surveyor discovered the resident was unable to walk, dependent on a wheelchair for mobilization, and required the use of a mechanical lift (Hoyer lift) for transfers, with the assistance of 2 staff members. (Cross reference F550) 49815 4) On the initial tour of nursing Unit A on the second floor of the facility, the surveyors observed on 5/14/24 at 10:15 AM, Resident #2 in bed. Resident #2's call light and cord were lying on the floor out of reach from the Resident to request his/her needs and preferences. The surveyors conveyed this observation on 5/14/24 at 10:45 AM to LPN (Licensed Practical Nurse) #1 that Resident #2's call light and cord was on the floor and not accessible for Resident #2 to request his/her needs and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42828 Based on observations and facility staff interview it was determined the facility failed to maintain a safe, clean and comfortable home like environment free of possible hazards. This was evident for 5 residents (# 40, #67, #24, #85, & #542) out of 62 residents observed for home like environment and 4 out of 6 shower and bathing environments observed in the facility. The findings include: During tour of the facility on 05/13/24 at 9:215 AM, surveyors observed: In Resident # 40's room: - Extensive paint damage on all walls (peeled/removed). - One green Geri- chair (a large padded chair with a wheeled base, designed to assist seniors with limited mobility) a the resident's -bedside with tattered arm rests, inner material visible. - A mattress air flow device attached to the foot of the resident's bed, with it's black power cord on the floor, plugged into an electrical wall socket located a the base of the wall opposite the resident's bed; the cord covered a distance of approximately 3 feet, cord approximately 10 feet in length. During tour of the facility on 05/14/24 at 8:15 AM, surveyors observed: In Resident # 67's room: - The door to the room was ajar, white bed linens on the mattress with a large dark stain on the middle section of the mattress, on plastic urinal container on the floor at the bedside; multiple sections of damaged paint on the wall behind the head of the resident's bed measuring approximately 2 to 3 feet in width. - Two meal trays: one rested on top of a flat surface near the entryway of the room which had a meal ticket dated 5/13/24 Dinner, with empty food containers, plate, plate warmers, and empty cups on the tray; the other meal tray located on top of the radiator under the window, had a meal ticket ticket dated 5/14/24 breakfast with an empty plate, plate warmers, empty juice container, crushed soiled papers and food debris. On 5/13/24 at 10:15 AM surveyors conducted a tour of the facility. The concerns identified during the tour were: The shower room on the 4th unit: - Several broken and loose white (2 inches by 2 inches each) wall tiles located on the partition wall between the shower area and the bath area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower rooms on the 2nd unit: - Rust-appearing substance on the upper door hinge; attaching the door top the upper door frame to the top side of the door. - Several broken tiles upon entrance to the shower room located on the left. - One rectangular, rusty metal container with sharp edges (device was approximately 10 inches by 6 inches) hanging on a wall opposite the shower area. - One window drape/shade propped up against the wall next to the window sill, appeared soiled with black and dark gray substance, no drape or shade in place on window. - Dark gray/Black- circular in shape substance, scattered along the entire door frame of the shower room. - A white sheet of paper posted to a wall with dark gray/black- circular in shape substance, on the entire surface of the paper. In Resident # 24's room: - A television mounted on the wall about 10 ft from the ground connected by its power cord (54 inches long) to a surge protector power strip suspended in mid-air (approximately 22 inches from the ground). On 5/21/24 at 10:38 AM surveyors conducted a tour of the facility with the Maintenance Director. The Maintenance Director acknowledged the electric cord in Resident #40's room as a potential hazard and confirmed all of the environmental concerns identified on 5/13/24. The Maintenance Director confirmed the identified concerns will be addressed and added to the department's work list. On 5/22/24 7:43 AM The Director of Nursing (DON) toured with the surveyors, observed the previously identified findings and confirmed that the Maintenance Department was to be consulted. 47758 On 05/16/2024 at 09:37 AM, the surveyor observed that the 1B Shower Room had an access panel in the shower room duct taped to the wall that was ajar 1 inch, caulk was stained and lose in the corner of the shower, and the window frame had two .5 inch holes. The screen behind the window was torn. The 1C Bath was observed on 05/16/2024 10:05 AM. The lock was broken, and maintenance had to be called to enter the room. Near the scale there was a soiled corner with missing caulk. This was shown to the Housekeeping Director who stated they would have it cleaned today. The Maintenance Director was shown the concerns regarding the 1B shower room access panel, the caulk, and the holes in the window and the 1C Bath missing caulk on 05/16/2024 at 10:50 AM. He stated they would be repaired as soon as possible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrater was shown the 1B shower room access panel, the caulk, and the holes in the window on 05/16/2024 at 12:22 PM. She was also shown the concerns in the 1C Bath of the soiled corner and the missing caulk. She stated they would be repaired as soon as possible. The surveyor noted that the new lock had been installed on the 1C Bath door. 05/17/2024 at 12:12 PM the surveyor observed that the 1B shower stall caulk had been removed and new caulk applied. The 1C soiled corner had been cleaned but no caulk was replaced. 05/31/2024 at 8:28 AM the 1B Shower window holes had not been repaired or the 1C Bath caulk replaced. The Administrator and the Maintenance Director observed the 1B shower window holes and the 1C caulk on 05/31/2024 at 9:21 AM and stated both would be repaired shortly. 50503 During observation of Resident #85's room on 05/13/24 at 11:21 AM, surveyor observation revealed Resident #85's bathroom ceiling light fixture was filled with insects. During interview with the Housekeeping Director #10 on 05/23/24 at 01:46 PM she was asked about the cleaning schedule for the facility. They stated work is distributed for two wings per person, they clean rooms and bathrooms once per day. Staff #10 also stated housekeeping is responsible for cleaning bathroom counter sinks, windows, and mirrors. Staff #10 also confirmed they are aware of the bugs in light fixtures and that it is a maintenance responsibility and is usually put in the maintenance book. During interview with Resident #542 on 05/21/24 at 10:09 AM, he/she stated that the cleaning of bathrooms does not happen everyday. He/she also pointed out a broken light fixture behind bed, and lights not working over the sink. During observation of Resident #542's room on 05/13/24 at 11:21 AM, the surveyor observed Resident #542's bathroom with a brown stain on the ceiling. During observation of resident rooms on 5/21/24, the surveyor observed resident rooms [ROOM NUMBER] with sink lights not working. During observation of the facility on 05/13/24, the surveyor observed a mold-like, crusted, substance formed around the fire alarm in the ceiling of the hallway. During interview with Maintenance Director (Staff #17) on 05/21/24 at 01:07 PM he was asked about obtaining maintenance requests for the facility. Staff #17 confirmed that maintenance requests books are located at the front desk or nurses' station and on the second floor of the facility. Staff #17 stated he was not sure of any light bulbs out. He confirmed relying on the nurses to put requests in the maintenance log for light out. He stated there are only two of them working so they would have to prioritize what is important. Staff #17 was also asked about a mold-like substance formed around the fire alarm in the ceiling of the hallway. He stated there had been leaks in the facility the year prior, but no one had addressed the wall issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 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. 45733 Based on medical record review and interview, it was determined that the facility staff failed to timely report an allegation of abuse to the State Agency, the Office of Health Care Quality (OHCQ), immediately but not later than 2 hours after the abuse allegation was made. This was evident for 5 (Resident #57, #34, #93, #51, and #19) out of 30 residents reviewed for facility self-report incidents during an annual survey. The findings include: 1). Review, on 05/29/24 at 10:25 AM, of the facility's self-report investigation file revealed that the Assistant Director of Nursing (ADoN) documented on the Facility's Incident Investigation Form in reference to Resident #57 incident the time was on 06/28/23 at 3:00 PM. Based on the allegation of abuse/harm, the facility's self-report (MD00193871) had to be sent to the State agency no later than 2 hours after the incident had occurred or was reported. Further review revealed that staff had sent the facility self-report to the State agency, on 06/28/23 at 5:37 PM, 2 hours and 37 minutes later. During the interview, on 5/30/24 at 09:30 AM, the ADoN and the Regional Administrator Staff #4, confirmed that facility staff was made aware of the abuse allegation, however, the initial self-report was not sent to the State agency until 06/28/23 at 5:37 PM. 2). Record review, on 5/23/24 at 10:25 AM, of the facility's self-report investigation file revealed that the Director of Nursing (DoN) documented on the Facility's Incident Investigation Form that the facility was made aware of the incident in reference to Resident #57 on 12/11/23 at 3PM. The initial facility's self-report (MD00200712) was sent to the State agency on 12/12/23' at 10:50AM, more than 19 hours later. During the interview, on 5/26/24' at 9:56 AM, the DoN confirmed that the initial self-report for this abuse allegation had not been sent within 2 hours after the incident was reported. 3). Record review, on 5/29/24' at 09:05AM, of the facility's self-report file found that an initial self-report (MD00182503) in reference of Resident #34 was not sent to the State Agency. However, the local police report revealed that the Police was notified on 3-18-22' with a case# pp22031800001656. Further record review revealed that on the facility's self-report investigation form the alleged incident time dated on 03/23/22 at 8 AM which it was 5 days later. From the State Agency intake record indicated the received time was also 5 days late on 03/23/22' at 10:21 AM. During the interview, on 5/30/2024 at 1:00 PM, the DoN confirmed that the facility staff were made aware of this reasonable suspicion of abuse on 3-18-22. However, there was no record of the initial self-report investigation being conducted immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42783 4.) On 05/22/2024 at 1:02 PM a review of the Facility Reported Incident investigation revealed an allegation of abuse. According to the facility's investigation Resident #93 advised his/her Responsible Party (RP) that he/she was hit on the face with a pillow by a Geriatric Nursing Assistant (GNA). On 11/24/2022 Registered Nurse (RN) Supervisor #4 provided the RP a requested grievance form and was advised at that time of the allegation of abuse. However, the facility did not report the allegation of abuse to the OHCQ until 11/30/2022 following receipt of the resident's RP grievance form dated 11/29/2022. Further review of the investigation report revealed a written statement from the alleged perpetrator GNA #9. The GNA stated that following the care provided on 11/19/2022 Resident #93 accused the GNA of hitting him/her on the face with a pillow. The GNA also stated in the report that she mentioned it to the nurse but did not make a formal report. On an interview summary worksheet, Licensed Practical Nurse (LPN) #27 stated that Resident #93 told the LPN on 11/20/2022 that a GNA hit him/her on the face with a pillow the previous day. The LPN further stated that he/she reported the allegation to the RN Supervisor #26. On an interview summary worksheet, RN Supervisor # 26 stated that she was advised by LPN #27 on 11/20/2022 of the allegation of abuse for Resident #93. The RN Supervisor stated that she interviewed the resident who could not recall the incident. The RN Supervisor further stated that she did not report the incident to management because the resident could not recall the incident. During an interview conducted on 05/22/2024 at 11:09 AM, the Director of Nursing (DON) acknowledged the staff were made aware of the allegation of abuse but failed to report to management. The DON further stated that she would conduct an in service to educate her staff on following the facility policy in reporting abuse. During an interview conducted on 05/14/2024 at 8:30 AM, Resident #51 reported to the surveyors that a GNA provided rough care and pulled on his/her enteral feeding tube. On 05/14/2024 at 9:25 AM, the surveyors reported the allegation of abuse to the DON. The DON stated she would begin an investigation and notify OHCQ. A review of a Facility Reported Incident investigation on 05/30/2024 at 7:22 AM revealed an allegation of abuse for Resident #51. The investigation revealed that the Resident reported to the Assistant Director of Nursing (ADON) that GNA #48 provided rough care and pulled on his/her enteral feeding tube on 04/30/2024. The facility did not report the allegation of abuse until 05/14/2024 when the surveyors reported the allegation to the DON. During an interview conducted on 05/30/2024 at 10:49 AM, the ADON confirmed that Resident #51 reported that GNA #48 had an attitude and provided rough care on 04/30/2024. The ADON also stated that she did not report the allegation of abuse because the resident always complains about certain staff. During a follow-up interview conducted on 05/31/2024, The DON stated she would educate the ADON on the facility 's expectations and policy to report abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49815 5.) On 5/30/24 at 9:57 AM the surveyor reviewed the Facility Reported Incident (FRI) dated 3/5/2024 (initial report) and 3/12/2024 (final report). The facility investigation alleged that Resident #19 had an injury of unknown origin. Further review of the Facility Reported Incident by the surveyors revealed that Resident #19 had a comminuted intratrochanteric fracture of the neck of the left femur as indicated on the TridentCare radiology report at 5:45 PM on 3/4/24 which was performed at the facility. Resident #19 was transferred to the hospital on 3/4/24 for the fracture of the left femur as per physician order and required surgical intervention for the fracture of the neck of the left femur. The surveyors reviewed the facility ' s Leadership Policies and Procedures - Organizational Ethics - Abuse, Neglect, Exploitation, or Mistreatment on 5/30/2024 at 12:47 PM. According to the facility policy and procedure dated 11/1/2017 for injury of unknown source this alleged violation is to be reported immediately. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where the state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. On 5/14/24 at 8:01 AM the surveyor attempted to interview Resident #19; Resident #19 responded to the surveyor by opening his/her eyes when his/her name was called and mumbled a word. The surveyor conducted a phone interview with Resident #19's daughter on 5/15/24 at 11:43 AM. Resident #19's daughter conveyed to the surveyor that the Resident went to the hospital for a broken hip and femur on 2 occasions, and the daughter did not know if the Resident had fallen. On 5/30/24 at 1:20 PM the surveyor interviewed the Director of Nursing (DON) and reviewed the facility investigation file of the reported injury of unknown origin. The surveyor confirmed with Director of Nursing (DON) that the facility received the radiology report at 5:45 PM on 3/4/24 and that Resident #19 was transferred to the hospital per physician order on 3/4/24 for the fracture of the neck of the left femur. Upon review of the hospital discharge summary it revealed that Resident #19 required a surgical intervention for intramedullary nailing (surgery to repair a broken bone and keep it stable) of the left femur. At 7:20 AM on 5/31/24 the surveyor conveyed to the Director of Nursing that further review of the investigation file for the Facility Reported Incident for Resident #19 revealed that the injury of unknown origin, serious bodily injury, fracture of left femur was not reported by the facility within 2 hours of the allegation to the State Survey Agency. The facility was notified of the fracture of the left femur at 5:45 PM on 3/4/24 by TridentCare radiology report. Resident #19's physician was notified at 6:25 PM on 3/4/24 of the fracture of the left femur and ordered to transfer Resident #19 to the emergency room (ER) for evaluation. The facility reported the injury of unknown origin, serious bodily injury, fracture of the left femur on 3/5/24 at 5:25 PM to the State Survey Agency. The Director of Nursing stated to the surveyor that she thought that she had 24 hours to report the initial report of an injury of unknown origin that resulted in serious bodily injury to the State survey Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 44440 Based on record review, and interviews, it was determined that the facility failed to: 1) thoroughly investigate alleged violations of abuse, and 2) prevent further potential of abuse while an investigation was in process. This was found evident of 6 (Resident #91, #108, #2, #19, #93, & #21) of 30 residents investigated for Facility Reported Incidents(FRI). The findings include: 1a) On 5/14/24 at 10:33 AM, the surveyor reviewed Resident #91's medical record. The review revealed that Resident #91 was admitted to the facility in late 2022 and had a past medical history that included, but not limited to, bilateral primary osteoarthritis of knee, adult failure to thrive, unspecified protein-calorie malnutrition, signs involving cognitive functions and awareness, difficulty in walking, and muscle weakness (generalized). Further review revealed Resident #91 was assessed with a Brief Interview for Mental Status (BIMS) assessment and received a score of 15, the highest score, indicating he/she was cognitively intact. On 5/14/24 at 11:12 AM, the surveyor reviewed the investigation report the facility conducted for an alleged allegation of abuse Resident #91's daughter reported to the facility. The review revealed that after the facility conducted interviews with staff and completed a head to toe assessment of Resident #91 the facility was not able to substantiate the allegation. Further the Geriatric Nursing Assistant (GNA) Staff #39, the alleged perpetrator, was placed on suspension pending the outcome of the investigation. However within the investigation file, there were no interviews taken from other residents that Staff #39 was assigned, to verify there were no other concerts from other residents about the GNA's care. On 5/21/24 at 11:14 AM, the surveyor conducted a phone interview with the previous Director of Nursing (DON), who took part in the investigation. During the interview, Staff #40 confirmed that no other residents were interviewed to validate there was no other concerns by other residents regarding the care Staff #39 provided. On 5/21/24 at 1:42 PM, the surveyor conducted an interview with the current DON. During the interview the surveyor informed the DON about the concern that the investigation into Resident #91 allegation was not a thoroughly investigation and lacked interviews from other residents to help confirm there were no other concerns about Staff #39. 1b) On 5/14/24 at 7:33 AM, the surveyor reviewed an investigation the facility conducted regarding an allegation of abuse of Geriatric Nursing Assistant (GNA) Staff # 38 to Resident #108. The review of the investigation was completed by the previous Director of Nursing (DON) Staff # 40 and the Nursing Home Administrator (NHA) (at the time of the survey out on leave). After the investigation, the facility was not able to substantiate the allegation of abuse. Summaries of all interviews were in the report. However, there were no interviews taken from other residents that Staff #38 was assigned, to verify there were no other residents that had concerns. Further there were no written statements from the staff, just summaries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 8:32 AM, the surveyor conducted a phone interview with the previous Business Office Manager Staff #41. In the investigation a statement was summaries by Staff #41. During the interview Staff #41 stated her office was located in the hallway where residents resided. She stated if she heard any type of disturbance, she would evaluate the situation but also reported she would not have stepped outside her job's scope of practice. When asked if she recalled an incident in which she gave a statement about Resident #108 and an allegation of abuse, she reported she could not recall and further stated if she had signed a written statement, she would stand behind the statement, but she could not recall writing or giving a formal statement. On 5/21/24 at 9:46 AM, the surveyor conducted a phone interview with the Nursing Home Administrator (NHA) (currently on leave). During the interview the NHA stated he and the DON conducted the investigations together. The surveyor asked about interviews regarding the investigation into Resident #108's alleged abuse. He could not recall interviewing other residents who also were cared for by Staff #38 but stated the Director of Nursing (DON) at the time may have done them. He further stated he and the previous DON interviewed Staff #41 and took her statement. He confirmed he practice was to summarize the interview and no formal statements were obtained in the investigation. On 5/21/24 at 11:14 AM, the surveyor conducted a phone interview with the previous Director of Nursing (DON) Staff #40, who took part in the investigation. During the interview, Staff #40 confirmed that no other residents were interviewed to validate there was no other concerns by other residents who were cared for by Staff #38. She also stated she worked together on completing investigations with the NHA and human resource staff. She further stated she was responsible for interviewing clinical staff and the NHA or Human Resource staff would conduct interviews with non-clinical staff. She recalled taking a statement from Staff #41 and confirmed both the NHA and herself often wrote summaries of interviews instead of the questions asked and the response. On 5/21/24 at 1:42 PM, the surveyor conducted an interview with the current DON. During the interview the surveyor informed the DON about the concern that the investigation into Resident #108's allegation was not a thorough investigation and lacked interviews from other residents to help confirm there were no other concerns about Staff #38 and validated statements from other staff. 2) On 5/14/24 at 7:33 AM, the surveyor reviewed an investigation the facility conducted regarding an allegation of abuse of Geriatric Nursing Assistant (GNA) Staff # 38 to Resident #108. The review of the investigation was completed by the previous Director of Nursing (DON) Staff #40 and the Nursing Home Administrator (NHA) (at the time of the survey out on leave). After the investigation the facility was not able to substantiate the allegation of abuse. Further review of the investigation failed to show that Staff #38 was suspended pending the completion of the investigation. On 5/14/24 at 12:16 PM, the surveyor reviewed Geriatric Nursing Assistant (GNA) Staff #38's employee file. No suspension letter was noted in the file or termination letter. On review of Staff #38's payroll clock in and out record it revealed that Staff #38 worked on Tuesday, 1/24/24 until 3:11 PM. This was the day the allegation was reported to the facility and again the following day from 7:07 AM till 11PM. Further review revealed Staff #38 worked the next 4 consecutive shifts from 7AM- 3PM shift. No other shifts were documented after that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 12:47 PM, the current DON confirmed that the Staff #38 no longer worked at the facility and her last day of work was on 1/29/24. The DON stated she was not the DON at the time and stated she found out Staff #38 was terminated related to attendance concerns, and she would ask Human Resources to obtain the termination letter. On 5/21/24 at 9:46 AM, the surveyor conducted a phone interview with the Nursing Home Administrator (NHA) (currently on leave). During the interview the NHA stated during the investigations of abuse the alleged perpetrator should be suspended pending the findings of the investigation. When asked why Staff #38 continued to clock in and work after the allegation was made the NHA stated he was not sure and believed it could have been that the investigation was already completed by the next day. On 5/21/24 at 11:14 AM, the surveyor conducted a phone interview with the previous Director of Nursing (DON) Staff #40, who took part in the investigation. During the interview Staff #40 confirmed that any employee suspected of abuse is suspended until the investigation is complete. When asked why Staff #38 was not suspended, Staff #40 stated, during the investigation the Resident denied the incident happened and we wrapped up our investigation. She further stated that she asked that Staff #38 not work with Resident #108 out of abundance of precaution. The surveyor confirmed that the Staff #38 was allowed to continue to work even after the facility did not obtain statements or interviews from other Residents whom Staff #38 worked with, thus validating there were no other concerns from other Residents. On 5/21/24 at 1:42 PM, the surveyor conducted an interview with the current DON. During the interview the surveyor expressed the concerns that Staff #38 continued to work after an allegation of abuse was made and no statements from other residents that she provided care to were interviewed to validate there were no other concerns. 49815 3) On 5/15/24 at 10:00 AM, the surveyors reviewed the investigation file of the Facility Reported Incident (FRI) dated 5/19/2023. Review of this investigation file revealed that The Comprehensive & Extended Care Facilities Self-Report Form and the Resident Face Sheet were the only documentation included in this file. Further review of this form indicated that it was the initial report submitted by the facility. This initial report form revealed that Resident #2 reported that he/she was missing 25 dollars (two $10 bills and one $5 bill) and that the Administrator was notified and that the facility initiated an investigation. On 5/23/24 at 12:01 PM the surveyors interviewed the Interim Nursing Home Administrator (NHA) and she was not able to provide an investigation of the facility reported incident dated 5/19/23. At the request from the surveyor, the Office of Health Care Quality (OHCQ) provided a copy of the 5-day final report. The surveyor then provided a copy of the 5-day final report to the Interim NHA at her request. During an interview with the Director of Nursing (DON) at 11:00 AM on 5/24/24 she conveyed to the surveyors that Resident #2 was reimbursed with $25 from the Interim NHA on 5/23/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the facility ' s Leadership Policies and Procedures - Organizational Ethics - Abuse, Neglect, Exploitation, or Mistreatment policy on 5/28/24. The policy indicated that the facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and/or funds and are reported immediately. On 5/30/24 at 9:57 AM the surveyor reviewed the Facility Reported Incident dated 3/5/2024 (initial report) and 3/12/2024 (final report). The facility investigation alleged that Resident #19 had an injury of unknown origin, fracture of the neck of the left femur. Further review of the facility investigation by the surveyors revealed that the facility only interviewed staff members and did not interview Resident #19 and/or Resident #19's daughter. Also, the investigation file did not include any documentation that other residents were interviewed during the investigation process. The surveyor interviewed the Director of Nursing on 5/30/24 at 10:28 AM and the DON confirmed that the investigation file that was reviewed by the surveyor was a complete investigation file. The surveyor conveyed to the Director of Nursing that other residents in the facility interviews were missing from the investigation file. The Director of Nursing provided no additional documentation for the investigation file as of exit on 5/31/24. 42783 4) On 05/22/2024 at 1:02 PM a review of the Facility Reported Incident investigation revealed an allegation of abuse. According to the facility's investigation Resident #93 advised his/her Responsible Party (RP) and facility staff that he/she was hit on the face with a pillow by a Geriatric Nursing Assistant (GNA) #9. The review of the facility's investigation file revealed that the facility failed to interview Resident #93 and the residents that GNA #9 provided care. A Minimum Data Set (MDS) assessment is a standardized, federally mandated process for evaluating the health status of residents in nursing homes that are certified by Medicare or Medicaid. The assessment is used to identify a resident's strengths, preferences, and potential problems, and to help nursing home staff identify health concerns. The Brief Interview for Mental Status (BIMS) is a 15-point cognitive screening tool used in long-term care facilities to evaluate memory and orientation in older adults. The BIMS assessment has three sections that test short-term word recall and orientation in time. The final score is calculated by combining the scores from all three sections. The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggests moderate cognitive impairment. 13 to 15 points suggests that cognition is intact. A review of Resident #93's MDS; section C revealed that the resident BIMS was assessed at a 12 out of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 05/22/2024 at 1:33 PM, the DON confirmed that the investigation file was complete. The DON acknowledged that the investigation did not include an interview with Resident #93 and the residents that GNA #9 provided care. The DON further stated that she would provide education to the staff on how to investigate allegations of abuse. 49148 5) SBAR note stands for Situation, Background, Assessment, and Recommendation is a form of communication used to help the healthcare team share information about the condition of the patient/resident. On 5/30/2024 at 8:15 AM, the Surveyor reviewed Resident #21's electronic medical record and discovered an SBAR note written by Licensed Practical Nurse (LPN) #52 on 4/09/2023 at 8:50 PM. The note stated that the resident is noted with redness to the left forehead, denies pain, doesn't respond to pain when site is touched, Resident is alert and oriented x2, able to state [his/her] name and time. Resident #21 was unable to recall how and when the redness to the left forehead happened. There was no other documentation of this injury of unknown origin. A review of the Facility Reported Incident (FRI) investigative file on 5/30/2024 at 10:00 AM revealed that the facility began an investigation into an injury of unknown origin on 4/10/2023 and reported it to the Office of Healthcare Quality on 4/13/2023 at 10:38 AM. During continued review of Resident #21 investigative file, the Surveyor confirmed that the facility completed their investigation on 4/14/2023. Further review of the Facility Reported Incident (FRI) investigation revealed the facility failed to conduct a thorough investigation. The facility failed to interview all nursing staff who interacted with the resident on shifts prior to and after the identification of the injury of unknown origin, failed to obtain a statement from LPN #52, who documented the observation of the injury, failed to interview all residents on unit A on the second floor, and failed to obtain LPN #54's, the assigned nurse for Resident #21, signed statement. The Director of Nursing (DON) was unable to provide further information regarding the nature of the FRI investigation because the incident occurred prior to her start in the role of DON at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44440 Based on record review, and interviews it was determined that the facility failed to accurately assess a resident. This was found evident of 1 (Resident #96) out of 62 residents reviewed during an annual and complaint survey. The findings include: On 5/15/24 at 10:47 AM, the surveyor reviewed Resident #96's medical record. The review revealed that Resident #96 was admitted to the facility in late February 2023 and had a past medical history of, but not limited to, difficulty walking, muscle weakness, seizures, and cerebral infarction (stroke). The surveyor further reviewed the hospital admission history and physical dated January 31st 2023. In the assessment and plan section seizures were listed. It further stated seizures resulted from an anterior cerebral artery (aca) stroke. The plan further stated, continue home lamotrigine 150 mg twice daily (a medication prescribed to prevent seizures) and sertraline 75 mg daily (a medication prescribed to treat depression). On 5/22/24 at 12:04 PM, the surveyor reviewed the Medication Administration Record (MAR) for Resident #96. The review revealed that Resident was prescribed and given lamotrigine 150 mg twice a day with a reason listed as seizures. The order was written on 2/18/23. On 5/22/24 at 12:50 PM, the surveyor reviewed Resident #96's admission Minimum Data Set (MDS) assessment completed on 2/22/23. In section I, active diagnoses, seizures are not listed among the other diagnoses. On 5/23/24 at 9:46 AM, the surveyor interviewed the MDS Coordinator Staff #20. During this interview Staff #20 stated conditions and diagnosis are coded by looking at the admitting diagnosis, reviewing the discharge summary, and reviewing the medications ordered. The surveyor asked if the resident had a history of seizures noted on the hospital discharge paperwork and a medication written for seizure on admission why seizures were not coded for this resident on her admission MDS assessment. Staff #20 confirmed it was not coded on the admission assessment however was on the discharge assessment. She further stated it could have been a date entry error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff, it was determined that the facility failed to develop and implement a person-centered care plan for: 1) residents with a history of seizure disorder currently taking medication for the condition, 2) a resident prescribed opioids for pain relief, and 3) a resident's pressure ulcer and a fungal skin infection. This was evident for 4 residents (Residents #60, #65, #96 and #64) out of 62 residents with care plans reviewed during the annual survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments. It outlines what needs to be done to plan, assess, and manage care needs. This helps to evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. 1a.On 5/23/2024 at 1:18 PM, during review of Resident #60's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] with diagnoses of, but not limited to, cognitive communication deficit, multiple sclerosis, hypertension, epilepsy (seizure disorder), cerebral vascular accident (CVA/stroke), and encephalopathy (brain disease). Resident #60 was taking an anticonvulsant medication to treat seizures associated with epilepsy. On 5/24/2024 at 10:35 AM, a review of Resident #60 's electronic medical record revealed an admission MDS assessment dated [DATE] which included epilepsy as an active diagnosis and a quarterly MDS assessment dated [DATE] included epilepsy as an active diagnosis. In addition, a review of Resident #60's care plan, from admission to current, failed to reveal a care plan to address his/her epilepsy disorder, precautions for epilepsy, nor the use and monitoring of an anticonvulsant medication. On 5/24/2024 at 10:45 AM, the Surveyor reviewed an interview conducted with MDS Coordinator #20 on 5/23/2024 at 9:50 AM which revealed that diagnoses are coded based off the discharge summary received from the hospital or another facility they are admitted from. The medications are reviewed and are coded based on the medication the resident is currently taking. According to Staff #20, Resident #60 should have been care planned for epilepsy because he/she was admitted while taking medication for it. 1b. On 5/29/2024 at 10:45 AM during a review of Resident #65's electronic medical record, the Surveyor discovered that the resident was admitted on [DATE] with diagnoses of, but not limited to, chronic pain syndrome, pressure ulcer of sacral region, stage 4 (Primary, Admission), pressure ulcers, cognitive communication deficit, atherosclerosis, rhabdomyolysis, and neuralgia and neuritis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During further review, the Surveyor discovered an order for a schedule IV opiate (narcotic) analgesic to be given twice a day for chronic pain syndrome from 11/10/2022 to 3/15/2023, an updated order from 3/16/2023 to current for a schedule II opiate (narcotic) analgesic PRN (as needed), and an updated order from 3/17/2023 to current for a schedule II opiate (narcotic) analgesic to be given once a day prior to wound care. On 5/30/2024 at 1:26 PM, additional review of Resident #65's electronic medical record revealed a care plan for pain. Care plan started on 10/08/2022 stated that Resident #65 had complaints of generalized chronic pain related to disease process, a short-term goal to develop effective coping strategies to help adapt to pain, and an approach for this goal was to administer medications as ordered with a start date of 10/12/2022. The last review was 11/22/2023, with no revisions. Continued review of Resident #65's care plan failed to reveal a care plan for the use and monitoring of an opiate (narcotic) analgesic for pain relief from admission through current. On 5/31/2024 at 12:00 PM, the Director of Nursing (DON) was made aware that the development and implementation of care plans for residents were a concern. 44440 2) On 5/15/24 at 10:47 AM, the surveyor reviewed Resident #96's medical record. The review revealed that Resident #96 was admitted to the facility in late February 2023. The surveyor further reviewed the hospital admission history and physical dated January 31, 2023. In the assessment and plan section seizures were listed. It further stated seizures resulting from anterior cerebral artery (aca) stroke. The plan stated to continue home lamotrigine 150 mg twice daily (a medication prescribed to prevent seizures) and Sertraline 75 mg daily (a medication prescribed to treat depression). On 5/15/24 at 11:27 AM, the surveyor reviewed a progress note written by Registered Nurse (RN) Staff #42. The note stated Resident #96 was observed having a seizure while up in his/her wheelchair. It further stated after getting the Resident back to bed the resident had another seizure. The physician was notified, medications ordered and an order was given to transfer Resident #96 to the hospital On 5/22/24 at 12:04 PM, the surveyor reviewed the Medication Administration Record (MAR) for Resident #96. The review revealed that the resident was prescribed and given lamotrigine 150 mg twice a day with a reason given; seizures. On 5/22/24 at 11:50 AM, the surveyor reviewed Resident #96's care plans. No seizure care plan was initiated even though the resident had a diagnosis and was actively being treated for seizures. On 5/23/24 at 10:32 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that there was no active care plan for seizure even though the resident was diagnosed with a seizure disorder and was taking seizure preventative medications. 50504 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Review of medical records on 05/28/24 at 8:09AM revealed Resident #64 was admitted to the facility on [DATE] with diagnoses including Polyosteoarthritis, Depression, Dementia, Muscle weakness and Age-related physical debility. On 11/14/22 Resident#64 was seen by the Medical Director who documented in residents' History and Physical (H&P) assessment record, a pressure ulcer on the sacral region. Resident #64's pressure ulcer was treated from 11/12/22 until it was resolved. The wound consultant report dated 11/30/22 revealed that the resident's pressure ulcer was resolved on 11/30/22. A note written by Licensed Nurse #20 on 01/03/23 at 1:10PM stated that a fungal rash was observed on Resident #64's sacrum, abdominal fold and bilateral breast and he/she informed the Medical Director. On 01/03/23 Resident #64 was assessed by the Medical Director and a diagnosis of an Extensive Fungal Rash was documented. An antifungal powder was ordered along with an oral antifungal medication for 7 days to treat the rash. The antifungal powder was applied to Resident #64's affected areas from 01/03/23 to 02/06/23 and Resident #64 was medicated with an oral antifungal medication from 01/04/23 to 01/10/23. On 05/28/24 at 8:09 AM a review of Resident #64's comprehensive care plan revealed that the facility failed to develop /implement a care plan for Resident #64's pressure ulcer and fungal rash. During an interview on 05/29/24 at 11:49 AM the Director of Nursing (DON) informed the surveyors that she would look for the care plans. On 05/29/24 at 1:10 PM surveyors received a care plan from the DON which did not include Resident #64's plan of care for a pressure ulcer ulcer and fungal rash.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Rosa Nursing and Rehabilitation, LLC	3800 Lottsford Vista Road Mitchellville, MD 20721

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44440 Based on record review, and interviews it was determined that the facility failed to accurately dispense and record medications as per scheduled ordered time. This was found evident of 1 (Resident #103) of 5 Residents reviewed for pain management. The finding include: On 5/14/24 at 11:41 AM, the surveyor reviewed Resident #103's medical record. The review revealed that Resident #103 was admitted in early November 2022. Further review revealed that Resident #103 was prescribed a pain medication, oxycodone, on 11/3/22. The order was for oxycodone 5 mg every 6 hours as needed for pain. In review of the progress note dated, 11/7/22, Licensed Practical Nurse (LPN) Staff #30 wrote; Resident continues to complain of pain to his/her right knee. It further stated the Medical Director evaluated Resident #103 and wrote orders for routine oxycodone to be given at 7 AM along with the as needed oxycodone. On 5/15/24 at 7:56 AM, the surveyor reviewed Resident #103's Medication Administration Record (MAR). The review revealed that oxycodone 5 mg was scheduled to be given at 8 AM starting 11/8/22. From 11/8/22-11/30/22 the scheduled oxycodone was documented at given on the scheduled time twice, 12 times the scheduled oxycodone was documented as given with a comment; charted late, once charted as given late, once with a comment other and another medication not available. On 11/17/22 & 11/28/22 the sign off for the scheduled oxycodone was blank. On 5/15/24 at 11:49 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #19. During the interview Staff #19 stated that when she gives pain medications, she charts the administration shortly after giving the medications in the MAR. On 5/16/24 at 9:59 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated that it is the expectation that staff document administration of the medication in the MAR when the medication is given. The surveyor showed the DON the MAR documentation for Resident #103's scheduled oxycodone. The DON agreed that only 2 days the medication was documented as given on schedule and the delayed documentation was done by multiple staff. She further stated she was not the DON at the time and can't speak about the documentation practices at the time.