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	05/01/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and resident and staff interview, it was determined that the facility failed to include a copy of the written notification of transfer or discharge in the resident's medical record. This was evident for 1 (#4) of 3 residents reviewed for complaints. The findings include: On 4/27/26 at 10:08 AM, a review of complaint # 2808503 alleged the facility provided Resident #4 a verbal notice that s/he was to discharge from the facility on 3/18/26, however the facility failed to provide the resident with a written notice of discharge on [DATE] at 10:35 AM a review of Resident #4's medical record documented that the resident was admitted to the facility in the beginning of February 2026 following an acute hospitalization and discharged from the facility towards the end of March 2026. Continued review of the medical record failed to reveal evidence that the facility provided a written notification of discharge to Resident #4 prior to his/her discharge. On 4/29/26 at 1:52 PM, during an interview, Social Service Assistant (SSA) #1 stated that prior to his/her discharge, Resident #4 was made aware his/her rehabilitation goals at the facility had been met, therefore the insurance company denied further payment for the resident to stay at the facility after 3/17/28. After that date, Resident #4 would be discharged or would need to pay for his/her stay at the facility. At that time, SSA #1 indicated the resident was provided a copy of the letter of denial from the insurance company but had not been provided a written notification of discharge from the facility. On 5/1/26 at 12:45 PM, the Nursing Home Administrator (NHA) was made aware that no documentation found in the medical record to indicate a written notice of discharge, which included the reason for the action, the effective date, the location to which they were being discharged , and appeal rights had been provided to Resident #4 prior to his/her discharge. At that time the NHA acknowledged the concerns and indicated that when s/he was made aware of the impending discharge, Resident #4 had not agreed to leave, and would have been given a discharge notification if she did not agree to pay. No further documentation was provided to the surveyor by the time of exit from the survey on 5/1/26 at approximately 7:45 PM. On 5/4/26 at 10:46 AM, the surveyor received an email from the NHA stating that a notice of discharge that was given to Resident #4 on 3/18/26 based on a denial from her insurance company was attached to the email. Review of the email attachment revealed a Notice of Transfer or Discharge for Resident #4 with a discharge date of 3/18/26. The discharge notice, which was not signed by the resident, had not been found in the resident's medical record during the survey.

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

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview it was determined the facility failed to have a qualified full-time staff person to carry out food and nutrition services in the facility. This has the potential to affect all residents in the facility. The findings include:Review of anonymous complaint # 2963054 on 4/28/26 at approximately 1:00 PM revealed concerns including but not limited to menus, scheduled meal times, and alternate food items. During an interview on 4/29/26 at 11:29 AM the Administrator revealed that Staff #11 the Food Service Manager (FSM) was not in the facility, was out on extended medical leave since 1/29/26 and the facility was utilizing their dietician. He further revealed that the dietician was in the facility once per week. When asked who was overseeing the meal services and day to day operations of the kitchen he stated, myself and a remote dietician. He confirmed that he was not certified in food service management. He was asked to provide a schedule for the staff overseeing the day-to-day food service operations of the facility during the FSM's long term absence. The schedule revealed Staff #12 a Registered Dietician (RD) was onsite once per week for 8 hours and Staff #13 a FSM from a sister facility was onsite 1 time per week for 8 hours. The facility failed to have a qualified full-time staff person to oversee the food and nutrition services for the residents as required. These concerns were reviewed with the Administrator and the Director of Nursing on 5/1/26 at approximately 7:00 PM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on record review and interviews it was determined the facility staff failed to conduct regular inspections of resident beds. This has the potential to affect all residents in the facility. The findings include:Review of anonymous complaint #2963504 on 4/28/26 at 1:00 PM revealed a concern regarding bed inspections. The surveyor was informed by the Administrator that the Director of Maintenance was not in the facility at that time. The facility's bed inspection logs were requested for review. On 4/29/26 at 11:29 AM, after several additional requests for the logs, the Administrator was asked if routine inspection of the beds was actually conducted. He indicated yes but we haven't kept very good records. During an interview on 4/29/26 at 11:50 AM the Director of Nursing (DON) and Administrator provided copies of maintenance logs dated from 1/2025 - 4/8/2026. Review of the logs at that time revealed concerns identified by staff related to a variety of areas and equipment in need of repair. However, the logs did not reflect routine inspection of the facility's beds as required. The Administrator indicated that when maintenance makes the bed repairs they also check to make sure the motors work. He confirmed that maintenance was not conducting routine inspections of the beds. Upon request of the facility policy and procedure for routine bed inspections the DON provided a policy and procedure for equipment and utilities management program which included a checklist for a 12-point monthly inspection of the beds. These concerns were reviewed with the Administrator and the Director of Nursing on 5/1/26 at approximately 7:00 PM.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility staff failed to maintain a safe functional and sanitary environment. This was evident for 8 of 8 resident hallways observed on both floors of the facility. The findings include:During a tour of the facility on 5/1/26 from 2:13 PM - 3:15 PM observation in the hallways of the A, B, C and D wings on both floors of the facility revealed:Broken, damaged, sagging and missing ceiling tiles. Missing covers over ceiling access panels. Areas of the plaster/drywall ceilings that were damaged or patched but not painted or otherwise sealed. [NAME] and black stains on plaster/drywall and tile ceilings. Dirty/stained/damaged ceiling fixtures including but not limited to vents, light fixtures and speaker covers. Square ceiling air handler units were located at intervals in several hallways. The units were low profile, with a vent like central air intake panel and louver type air outflow vents along the perimeter on all four edges. The air intake panel in every air handler was covered with thick brown/gray dust like substance. A black substance ranging from clusters of fine speckles to solid lines and patches was observed on the outflow louvers as well as other fixtures and the ceiling surrounding the air handler units. This was also evident for the air handler units located in the Solarium on the 2nd floor B wing. On the A Wing of the first floor, the surveyor observed a dried black substance on the wall and the fire exit door. The substance appeared to have seeped/flowed in a liquid form from the top of the wall along the ceiling to below the level of the handrail. The area extended from above the fire exit door approximately 7 feet, toward room [ROOM NUMBER]. Numerous pea sized dried black drip points were located on the underside of the door frame as well as the emergency exit light. The black substance smudged when rubbed. The above concerns were reviewed with Staff #9 the Maintenance Assistant on 5/1/26 at 5:21 PM. He was shown the black streaks on the wall, fire exit door and a speaker cover at the end of the hallway on First Floor A wing. He indicated the black substance was old oil and sediment that leaked from the HVAC system when a pipe burst in January 2026.He was shown discolored and damaged ceilings and ceiling tiles as well as the concerns related to the ceiling air handling units. He indicated that the brown and black discoloration on the ceilings was due to water damage, he acknowledged the missing and damaged tiles as well as the numerous areas that had been patched and spackled but not finished. He indicated that the air handler units needed to be cleaned and was not sure what the black substance on the blower louvers and surrounding ceilings and fixtures was. The above concerns were reviewed with the Administrator and Director of Nursing on 5/1/26 at approximately 7:00 PM. The DON observed a ceiling air handler unit with the surveyor and indicated that they would need to be cleaned.