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	01/14/2026

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

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of staff records and facility staff interviews, it was determined the facility failed to ensure that all nursing staff had competency skill evaluations. This was evident for 5 Geriatric Nursing Assistants (GNA) (GNA #2, GNA #3, GNA #6, GNA #7, GNA#18) of 5 GNA records reviewed. The findings include:A nursing competency is a set of knowledge, skills and abilities (KSAs) needed for an individual to successfully perform various job duties. Centers for Medicare and Medicaid (CMS) guidance clarifies that competency cannot be demonstrated by documenting that staff attended a training or watched a video. A skills checklist must include a return demonstration (practical application) for physical skills.Relias training provides online learning, compliance, and performance management solutions for healthcare, offering accredited online courses and videos for staff development, mandatory compliance, and continuing education (CE).On 01/14/2026 at 12:36 PM, a review of 5 GNA's (GNA #2, GNA #3, GNA #6, GNA #7, GNA#18) employee files showed the facility utilized online training from Relias for the mandated 12 hours of annual training.On 01/14/2026 at 12:54 PM, an interview with the Assistant Director of Nursing (ADON), whose duties included staff education, revealed that she does not conduct annual return demonstration skill competency training with GNA staff. She stated she provides skill competency training when there is an issue with care provided by a GNA brought to her attention. She conducts a training at that time, using a skill checklist if the skill the GNA is providing is not done correctly. When asked about Registered Nurse (RN) or Licensed Practical Nurse (LPN) return demonstration competencies, the ADON stated she would look for the sign in sheets for the in-service. On 01/14/2026 at 2:31 PM, an Interview with Regulation Specialist confirmed there has been no return demonstration skill competencies documented for all nursing staff over last year. She was unable to find any in-service sign-in sheets for return demonstration skills competency training. On 01/14/2026 at 2:40 PM, the concern was brought to the Nursing Home Administrator.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety in the kitchen. This practice had the potential to affect all residents that eat food prepared by the facility's kitchen. The findings include: 1. During a tour of the Kitchen with the Dietary Manager on 1/05/2026 at 8:08 AM it was discovered to have food products that had been opened and undated, unsealed and had expired food products. During observation of the walk-in refrigerator the following items were found:A Vital Cuisine Mighty Shake with a use by date of 12/03/2025 which was removed by the Dietary Manager after finding. Tuna fish was found in a plastic container covered with plastic wrap and was not labeled with a date of opening or expiration date. Two strawberry pies wrapped in plastic that were not labeled with a date of opening or expiration date. A cup of fruit had been made and was not labeled with a date of production or an expiration date.A cup of pureed fruit had been made and was not labeled with a date of production or an expiration date.A stack of sliced pieces of cheese had been removed from the original packaging was wrapped in plastic, not labeled and had no date of opening or expiration date. During an observation of the reach-in refrigerator the following item was found: A package of Block and Barrel Fully Cooked Ham had been opened was labeled with a facility sticker with a use by date of 1/02 which was removed by the Dietary Manager after finding. During an observation of the door to the refrigerator on 1/05/2026 at 8:20 AM it was discovered to have a sign that stated, Everything must be labeled and Dated! During an interview with the Dietary Manager on 1/05/2026 AM at 8:23 AM she reported anything opened should be rewrapped and labeled with an expiration date. During continued observations in the Freezer on 1/05/26 at 8:25 AM there were items found:A box of Ravioli Cheese that had been opened and the bag was not resealed. A box of Oven Ready Par-fried Alaska [NAME] that had been opened and the bag was not resealed. [NAME] Dumpling Squares that had been opened and the bag was not resealed. During an interview with the Dietary Manager on 1/05/2026 at 8:32 AM she confirmed the items should have been sealed after being opened and labeled with an expiration date. During review of the facility Safe Food Handling Policy on 1/09/2026 at 10:38 AM it reported All foods removed from the original packaging are stored in a closed container or tightly wrapped package and labeled with the common name of the item and the date it was opened.During review of the facility Food Safety in Receiving and Storage Policy on 1/09/2026 at 10:42 AM it stated, Refrigerated, ready to eat Time/Temperature Control for Safety Foods (TCS) are properly covered, labeled, dated with a use by date, and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded.2. During observation of the freezer with the Dietary Manager on 1/05/2026 at 8:25 AM it was discovered to have clumps of ice built up on the floor. Continued observation of the freezer's ceiling revealed multiple frozen drops of water hanging from the ceiling. An observation of the boxes of food under the freezer's fan revealed ice cycles hanging from the lid of a box of Anne's Dumpling Squares.During an interview with the Dietary manager on 1/05/2026 at 8:43 AM she advised the ice issues may be due to having a late shipment last week and staff were in and out of the freezer. During a review of the facility Food Safety in Receiving and Storage Policy on 1/09/2026 at 10:42 AM it stated to Store food away from sewer and water lines, drains, and condensation dripping from pipes or ceilings. During an interview with the Nursing Home Administrator on 01/14/2026 at 12:05 PM he reported he reported he thinks the ice buildup may be due to the door being left often while staff were inside the freezer. He advised he would have maintenance look at it.3. During an interview with the Dietary manager on 1/05/56 at 8:08 AM she reported the facility dishwasher had been inoperable due to a clogged drainage pipe since November, so dishes were being handwashed in the facility. During an interview with [NAME] #29 on 1/05/26 at 8:54 AM he reported the water in the dish washing sink doesn't get really hot, our water is (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	set so no one can burn themselves.During an observation with the Dietician on 1/06/26 at 2:26 PM, she was using the kitchen thermometer to obtain readings of the water being used to wash the dishes. The readings showed the water already in the sink with the dishes being washed was 91.3 degrees Fahrenheit and after running a new hot fresh sink of water the temperature reached 104 degrees Fahrenheit.During an observation with the Maintenance Director on 1/08/26 at 9:15 AM using the facility infrared thermometer he obtained temperature readings when [NAME] #29 was observed washing dishes. The temperature of the water with the dishes being washed was 100.4 degrees Fahrenheit. Then he obtained a temperature while the water was running out of the spigot in the kitchen sink and the highest temperature obtained was 108 degrees Fahrenheit. During a review of the facility Emergency Preparedness Plan - Temporary Loss of Dishwasher Due to Drainpipe Clog on 5/09/25 at 10:42 AM it identified the facility will follow the 3-compartment sink policy and follow the Manual Cleaning and Sanitizing with a three-compartment sink instructions.During a review of the facility Manual Cleaning and Sanitizing with a Three-Compartment sink Policy on 5/09/25 at 10:48 AM it reported that in the 1st sink Equipment and utensils are thoroughly washed in the first sink in detergent solution of at least 110 degrees Fahrenheit. Wash water is kept clean and changed frequently.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. citeBased on interview and observation, it was determined that the facility failed to (1) implement measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building's water systems, and (2) ensure proper storage of clean linens. These deficiencies were identified during the Infection Control review conducted as part of the annual survey and have the potential to affect all residents.The findings include:(1)Legionella is a type of bacteria commonly found in water systems that can cause Legionnaires' disease, a serious form of pneumonia, when contaminated water droplets are inhaled.On 01/12/2026 at 2:11 PM, an interview was conducted with the facility's Infection Preventionist (IP), who confirmed that there have been no reported cases of Legionella or other opportunistic waterborne pathogens at the facility.On 01/13/2026 at 9:42 AM, an interview was conducted with the Maintenance Director regarding the facility's water management practices. When asked how the facility prevents waterborne pathogens, including Legionella, he reported that the facility does not utilize any type of water treatment and does not conduct water testing for Legionella or other waterborne pathogens. When asked whether the water management system includes mixing valves, he reported that the system does not have mixing valves. When asked if the facility had experienced any outbreaks of Legionella or other waterborne pathogens, he reported that there had been none to his knowledge.On 01/13/2026 at 10:46 AM, a follow-up interview was conducted with the Maintenance Director. During the interview, he confirmed that the facility's water system does not have mixing valves. When asked how hot water is supplied for resident use, he explained that the facility uses a boiler to heat the domestic water. He reported that the boiler heats the water to approximately 120 degrees Fahrenheit before it is distributed throughout the building for resident use. He further confirmed that water temperatures likely decrease by the time the water reaches resident use areas and that the boiler does not heat the water above 120 degrees Fahrenheit.On 01/13/2026 at 11:03 AM, this surveyor conducted an interview with the Administrator. When asked whether the facility had measures in place to prevent the growth of Legionella or other opportunistic waterborne pathogens in the building's water systems, he reported that he was not sure and stated that he would need to obtain additional information.On 01/13/2026 at 2:37 PM, a follow-up interview was conducted with the Administrator. He confirmed that the facility has not had outside testing performed by a company for Legionella or other opportunistic waterborne pathogens. At that time, it was communicated that this is a concern, as the facility does not have preventive measures in place to reduce the risk of waterborne pathogens. It was also communicated that the Maintenance Director had confirmed to this surveyor that the facility does not have preventive measures in place to address Legionella or other opportunistic waterborne pathogens. The Administrator acknowledged and understood the concern.(2)On 01/12/2026 at 11:29 AM, this surveyor observed in the clean linen room that there was a large hole in the ceiling directly above the area where clean clothes are being folded. The hole exposed pipes, dust, and drywall. Photographs of the observation were taken at this time.On 01/14/2026 at 09:57 AM, this surveyor observed in the Laundry Room, within the clean linen area, two bins of clean linens left uncovered directly beneath a large hole in the ceiling. The hole exposed pipes, drywall, and dust. Photographs of the observation were taken at this time.On 01/14/2026 at 10:00 AM, this surveyor conducted an interview with the Housekeeping Services Manager regarding the observation of clean linens left uncovered beneath a hole in the ceiling. Photographs of the observation were shown to the Housekeeping Services Manager. He confirmed understanding of the concern, stated that he would address the issue promptly, and reported that he would review and reinforce expectations with laundry aide staff to ensure clean linens are kept covered.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews and record reviews, it was determined that the facility failed to ensure 1) medication carts were locked and resident health information was protected. This was found to be evident for 2 out of 3 medication carts observed and 7 out of 29 opportunities to protect resident health information, 2) a physician order was implemented. This was found to be evident for 1 (Resident #2) out of 1 Resident reviewed for physician orders, 3) behavior monitoring was conducted. This was found to be evident for 3 (Resident #56, #12 & #66) out of 3 Residents reviewed for behavior monitoring, and 4) medication was properly administered. This was found to be evident for 1 (Resident #22) out of 1 Resident reviewed for medication administration. It was determined that the facility failed to provide care that meets professional standards of practice during the recertification survey. The findings include: 1) On 01/08/2026 at 5:57 AM, during first-floor unit rounds on B-Wing, the surveyor observed a medication cart left unlocked and unattended. At the same time, an unlocked laptop with resident-specific information visible on the screen was observed unattended at the doorway of Room B140. On 01/08/2026 at 6:01 AM, during a medication administration observation with Registered Nurse (RN) #17, the surveyor observed the medication cart left open and the computer screen unlocked. This occurred in Room A104 at 6:01 AM, Room A108 at 6:04 AM, Room A117-B at 6:11 AM, Room A112 at 6:17 AM, Room D108-B at 6:24 AM, and Room D110-B at 6:26 AM01/08/2026 at 6:20 AM: The surveyor observed at the 1st floor lobby RN#17 left the medication cart open, and the computer screen unlocked and unattended, with residents' information visible. On 01/08/2026 at 6:32 AM, during an interview, RN #17 stated that the medication cart and computer screen are expected to remain locked at all times during medication administration. RN #17 confirmed leaving the medication cart open and the computer screen unlocked and unattended in the lobby while retrieving applesauce. On 01/12/2026 at 8:25 AM, during further observation on the second floor, the surveyor observed the B-Wing medication cart C open and unattended. On 01/12/2026 at 8:30 AM, during an interview, Licensed Practical Nurse (LPN) #20 stated, I was going to get medication from the medication room. The nurse further confirmed that the facility's expectation is for medication carts to always remain locked when not in use. The above concern was reviewed with LPN #20, who acknowledged the expectations. 2). On 01/14/26 at 9:16AM during a record review related to complaint , it was revealed that on 09/10/2025, Resident #2's physician ordered a Complete Blood Count (CBC) laboratory test for the diagnosis of pneumonia. The order was documented in the resident's medical record to monitor the resident's condition and to guide treatment. On 01/14/2026 at 9:20 AM, during a medical record review, it was revealed that the physician's order was not followed as written. On 01/14/26 at 12:20 PM, during an interview, the Assistant Director of Nursing (ADON) stated that physicians enter laboratory orders, and the receiving nurse transcribes the orders. The ADON further stated that the 11:00 PM–7:00 AM shift is responsible for ensuring the laboratory tests are (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed, unless the order is designated as STAT. On 01/14/26 at 1:50 PM, during an interview, the ADON reported that Resident #2's laboratory test was not completed as ordered by the physician and stated that the reason was unknown. The surveyor informed the ADON and the Clinical Services Director of the above concerns, and both acknowledged receipt. 3) On 01/07/2026 at 8:28 AM, a review of Resident #56's medical record revealed diagnosis for depression, anxiety, and insomnia. Resident #56 had an order on their Treatment Administration Record (TAR) for: Behavior Monitoring Every Shift. On 01/08/2026 at 9:15 AM, a review of Resident #56 's TAR revealed Resident #56 was documented to have the highest number of behaviors at 20 observed on 12/20/25, there were no progress notes in the medical record for the type of observed behaviors on 12/20/25. A SBAR is a comprehensive nursing assessment done when there is a change in a Resident's condition. SBAR stands for Situation, Background, Assessment, and Request. The assessment prompts nurses to collect comprehensive information about a resident's change in condition in advance of calling a doctor to report the change. Behavior monitoring tools for psychotropic medications are structured systems used by healthcare teams and caregivers to track the efficacy and safety of medications prescribed for mental health and behavioral symptoms. These tools ensure that medications are used appropriately, at the lowest effective dose, and with minimal side effects. It is a holistic communication tool used by interdisciplinary teams in long-term care to report a resident's status, including behavioral distress and non-pharmacological attempts to the prescribing physician. On 01/09/2026 at 9:17 AM, an interview with Licensed Practical Nurse (LPN) #4 confirmed that when behaviors are documented on the TAR it is the facility's process to then document in a progress note the type of behaviors observed and applied interventions. If the behavior persists after interventions are implemented or is a newly observed behavior, then a SBAR is completed and notification sent to the medical provider. On 01/12/2026 at 8:57 AM, a review of Resident# 56's TAR revealed Behavior frequencies were documented on 12/06/25 for 3pm - 11pm, 12/10/25 3pm -11pm shift, 12/20/25 for the 7am-3pm shift, 12/20/25 for the 3pm -11pm shift, 12/21/25 3pm -11pm shift, 12/31/25 3pm -11pm shift, 01/09/26 3pm-11pm shift. The TAR does not indicate what behaviors were observed, only the number of times a behavior was observed. There were no progress notes in Resident #56's medical record for behaviors observed and documented on the TAR for the previous dates and shifts. On 01/13/2026 at 9:06 AM, Interview with the Director of Nursing (DON) confirmed that if there is an escalation of behavior there should be a progress note written. The progress note is what the psych consultants will review when they come to see the Resident. The DON stated that staff will call her at all hours to consult with her if a resident is expressing behaviors and she will tell them if they need a progress note. The DON is aware that the TAR only documents the number of episodes and not the actual behaviors. DON could not answer as to why on Resident #56 there were no progress notes on date / shifts where there were documented behaviors recorded on the TAR. On 01/07/26 at 9:58 AM, Resident #12 had active physician orders for Duloxetine 40 mg, one capsule (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orally once daily for depression; Escitalopram Oxalate 20 mg, one tablet orally once daily for depression; and Olanzapine 5 mg, one tablet orally once daily for anxiety. On 01/08/26 at 7:15 AM, during review unnecessary medication review of Resident #12's medical records and Medication Administration Record (MAR) for the period of December 2025 through January 8, 2026, it was revealed that the resident received the prescribed antipsychotic and antidepressant medications. Review of the MAR confirmed the medications were administered as ordered; however, there was no documented evidence of behavior monitoring, nor was there documentation of monitoring for effectiveness related to the antipsychotic therapy. Further review of Resident #12's medical records on 01/08/26 at 7:30 AM revealed no evidence of documentation regarding behavioral monitoring or assessment for side effects associated with the prescribed medications, indicating a lack of ongoing evaluation of the necessity and safety of the medication regimen. On 01/08/26 8:22 AM interview with Assistant Director of Nursing (ADON) regarding effective monitoring for antipsychotic medications, ADON stated that staff monitor effectiveness using behavior monitoring flow sheets and document any observed behaviors in the progress notes. On 01/08/26 8:28 AM the surveyor and ADON reviewed Resident #12's MAR and nursing progress notes. ADON confirmed that the resident has been receiving psychotropic medications; however, no behavior monitoring flow sheets or related documentation were found in the nursing progress notes. During an interview with the Director of Nursing (DON) on 01/08/26 at 9:55 AM, she stated that the expectation is for nurses to administer medications, document the effectiveness of the medications, monitor resident behaviors, complete assessments on the behavior assessment sheet, and notify the physician of any unusual changes. On 01/08/26 at 10:15 AM the surveyor informed the DON and Clinical Services Director of the above concerns, and both acknowledged receipt. On 01/12/26 at 3:00 PM, review of Resident #12's medical record revealed that physician orders were initiated for behavioral monitoring and effectiveness monitoring every shift. On 01/13/2026 at 6:30 AM, during an investigation regarding a verbal altercation involving Resident #66, a review of the resident's medical record revealed diagnoses of vascular dementia with psychotic disturbance, mood disturbance, and anxiety. Further review of the medical record on 01/13/2026 at 6:50 AM revealed there was no documentation assessing Resident #66's behaviors related to the diagnosis of Dementia with behavioral disturbance, and no behavior monitoring tool was in place to assess the resident's behaviors. On 01/13/2026 at 7:50 AM, during an interview, the Director of Nursing (DON) confirmed that Resident #66 has a diagnosis of dementia with behavioral disturbances, which include yelling and screaming at other residents, and that the resident prefers to protect his/her personal space. However, review of the medical record revealed there was no documented behavioral assessment, no behavior monitoring tool in place, and no care plan interventions addressing the resident's identified behaviors. On 01/13/2026 at 1:02 PM, the surveyor informed both DON and Clinical Service Director of the above (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns and both acknowledged receipt. On 01/14/2026 at 8:30 AM, the Regulatory Specialist and Clinical Service Director reported to the surveyor that a behavior monitoring tool and care plan had been initiated for the resident. A copy of the care plan and behavior monitoring sheet was submitted to the surveyor. 4) During an observation with Wound Nurse #23 on 1/08/26 at 10:34 AM it was discovered that Resident #22 had a patch on his/her midback that was dated 1/07/26. During an interview with Wound Nurse #23 on 1/08/26 at 10:38 AM she reported that the patch was a Lidocaine patch on the back of Resident #22. During a review of the medication orders for Resident #22 on 1/08/26 at 10:40 AM it was discovered that the resident did not have a doctor's order for him/her have a Lidocaine patch and had no documentation of a Lidocaine patch being applied in his/her medical record. During an interview with Unit Manager #28 on 1/08/26 at 11:34 AM he confirmed that Resident #22 had a Lidocaine patch on and there was no doctor's order for the resident to have the patch so it was removed by the Resident's nurse.During an interview with the Director of Nursing on 1/08/26 at 11:46 AM she confirmed that Resident #22 did not have a doctor's order so he/she should not have had a Lidocaine patch on his/her back. She added the Lidocaine patch required a doctor's order prior to placing it onto the resident and the order would need to be signed off after administration. During a review of the facilities Nursing Policies and Procedures: Medical Management Program on 1/14/26 at 10:42 AM it stated that Documentation of medications administered is completed according to State and Federal Requirements. The initials and verifying signature are generally required. The Policy continued with The authorized staff member validates the following information is documented in the Medication Administration Record (MAR): Correct physician's order and diagnosis for each medication. Medication and label are correct. The policy added, If applying a transdermal patch or giving an injection, the location of administration site must be documented, and sites must be rotated.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. cite:Based on record review and interview, it was determined that the facility failed to educate and offer the COVID-19 immunization to residents. This was found to be evident for 4 (Resident #3, #6, #4 and #56) out of 5 Residents reviewed for vaccination status. The findings include:On 01/12/2026 at 9:32 AM, a record review revealed that Residents #3, #4, #6, and #56 did not have documentation of COVID-19 vaccine administration or refusal for 2025. Resident #3's last COVID-19 vaccine was 04/04/2022, Resident #4's was 11/20/2024, Resident #6's was 10/08/2022, and Resident #56's was 11/13/2021.On 01/12/2026 at 2:11 PM, this surveyor conducted an interview with the facility's Infection Preventionist (IP) regarding the process for offering COVID-19 vaccination to residents. The IP reported that each year she offers the vaccine to all residents, and that for the 2025-2026 season, she began offering COVID-19 vaccines in October. She stated that education is provided to residents at the time the vaccine is offered. When asked if refusals are documented, the IP reported that refusals are not documented when a resident declines after receiving education. She was unable to provide an explanation for this practice. It was communicated to the IP that this is a concern, as there is no documentation verifying that residents were offered COVID-19 education or had the opportunity to refuse the vaccine. The IP confirmed understanding of the concern.

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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. Based on observation, interviews, and record review it was determined that the facility failed to ensure an environment that promotes resident dignity. This was evident for 2 (Resident #56 and #61) of 2 residents observed for dignity during the recertification survey.The findings include: 1) On 01/05/2026 at 8:31 AM, the Surveyors observed Geriatric Nursing Assistant (GNA) #2 enter Resident #56's room without knocking or introducing herself. GNA #2 tried to quickly exit the room once she saw the Surveyors inside the room. During an interview conducted on 01/05/2026 at 8:31 AM, GNA#2 could not provide an explanation as to why she entered Resident #56's room without knocking or introducing herself. GNA #2 stated I saw the door closed and I came to see why. On 01/12/2026 at 12:50 PM, an interview with the Director of Nursing (DON) confirmed it is the facility's expectation for a GNA or any staff to knock on the door and wait for a response from the resident before entering the Resident's room. If the Resident is nonverbal, staff are to still knock and wait to see if there are any visitors inside the room to invite them in. Once the staff open the Resident's door, it is the expectation that they greet the Resident and introduce themselves and state why they are there. This was confirmed as the facility practice every time a staff member enters a Resident's room. 2) On 01/05/2026 at 3:15 PM, this surveyor conducted an interview with Resident #61. When asked whether he/she had ever felt mistreated by a staff member, Resident #61 reported mistreatment by Geriatric Nursing Assistant (GNA) #5. The resident explained that this staff member, instead of speaking directly, would use her fingers to communicate rather than verbally interacting. Resident #61 stated that he/she had shared this concern with a family member, who subsequently reported it to the facility, although the Resident was unsure to whom the report was made. On 01/07/2026 at 11:01 AM, a record review of the facility's investigation file for a facility-reported incident of alleged neglect involving Resident #61 by GNA #5 was conducted. The investigation file showed that Resident #61's Power of Attorney (POA) reported concerns to the facility, stating that GNA #5 had no communication with the resident, just pointing, and that the Resident became anxious at the mention of the GNA's name. In a statement dated 10/30/2025, GNA #5 reported that she used both verbal and non-verbal communication, including hand gestures, while providing care to Resident #61. The facility concluded the investigation with a determination that the allegation of neglect could not be verified. On 01/08/2026 at 9:13 AM, a record review of a psychiatric note dated 11/12/2025 for Resident #61 showed that the chief reason for the visit was patient seen due to patient-to-staff conflict. The note documented that the Resident reported feeling anxious when a particular staff member provided care. The Resident stated that the staff member did not communicate verbally, but instead used hand gestures, which caused the Resident to feel anxious. On 01/08/2025 at 9:43 AM, a follow-up interview was conducted with Resident #61. When asked about his/her experience with GNA #5, the Resident reported that this staff member communicated using hand gestures rather than verbal communication. When asked how this made him/her feel, the Resident stated that it made him/her feel offended. When asked if he/she felt disrespected by GNA (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#5, the Resident confirmed that he/she did, due to the use of hand gestures for communication. On 01/09/2026 at 1:38 PM, this surveyor conducted an interview with the Administrator to discuss the investigation into the allegation of neglect by GNA #5. The Administrator confirmed that the facility was able to substantiate that GNA #5 used non-verbal communication with Resident #61, as documented in her statement in the investigation file. He further confirmed that following the investigation, GNA #5 was educated not to use hand gestures or pointing when communicating with residents. It was discussed with the Administrator that multiple sources of documentation indicated Resident #61 experienced anxiety and offense when receiving care from GNA #5, including reports from the Resident's Power of Attorney, surveyor interviews with the Resident, and a psychiatric note stating the Resident felt anxious when a staff member used hand gestures while providing care. This was communicated as a concern for resident dignity, as it was confirmed that GNA #5's non-verbal communication caused Resident #61 to feel anxious, offended, and disrespected. The Administrator acknowledged and agreed that this was an issue impacting resident dignity.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. cite:Based on record review and interviews, it was determined that the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to resident who was discharged from Medicare Part A services but had benefit days remaining and intended to remain at the nursing facility receiving non-skilled care. This was evident for 1 resident (#11) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification. The findings include: The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The NOMNC (Notice of Medicare Non-coverage) informs the beneficiary of his or her right to file appeal of the decision and right to an expedited review of Medicare non-coverage of services. On 01/14/2026 at 2:15 PM, a review of the facility's SNF Beneficiary Protection Notification Review Worksheet indicated that Resident #11's last covered day under Medicare Part A was 07/11/25. The worksheet further indicated that the SNF Advance Beneficiary Notice (ABN) and the Notice of Medicare Non-Coverage (NOMNC) were not provided to the resident and/or resident representative as required. On 01/14/2026 at 2:36 PM, during an interview, the Business Office Manager confirmed that there was no record indicating Resident #11 was issued the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) or the Notice of Medicare Non-Coverage (NOMNC). On 01/14/2026 at 2:45 PM, the surveyor informed the Clinical Services Director and the Regulatory Specialist of the above concern. Both individuals acknowledged receipt of the information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. cite:Based on observation and interview, it was determined that the facility failed to ensure adequate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and safe environment. This was evident during the Infection Control review conducted as part of the annual survey. This deficiency has the potential to affect all residents.The findings include:On 01/12/2026 at 10:55 AM, this surveyor observed a large hole in the ceiling in the Laundry room, in the clean clothes drying area. The hole exposed pipes, dust, and drywall. Photographs of the observation were taken at this time.On 01/12/2026 at 11:29 AM, this surveyor observed a large hole in the ceiling in the clean linen folding room. There was a ceiling fan near the edge of the hole, and the hole exposed pipes, dust, and drywall. Photographs of the observation were taken at this time.On 01/14/2026 at 09:45 AM, this surveyor conducted an interview with the Maintenance Director regarding building maintenance and plumbing concerns. The Maintenance Director reported that he has observed ongoing leaks in the building since his employment began in 2014. He confirmed that there are currently no issues with mold despite the leaks. He explained that leaks are being repaired as they occur; however, a full plumbing replacement is needed, which has been delayed due to budget constraints and other priorities. He reported that these concerns have been communicated to the Administrator and discussed during morning meetings when leaks occur, although these discussions are not documented. When asked about the holes in the ceiling, he confirmed that the holes were created to access plumbing for repairs. He stated that the holes remain open due to limited maintenance staffing, which prevents timely repair of the ceiling with drywall.On 01/14/2026 at 09:57 AM, a dual observation was conducted with the Maintenance Director of holes in the ceiling in the Laundry/dryer room. The Maintenance Director confirmed that these holes were created last week to repair a leak. During the observation of the clean linen room, where clean clothes are folded, the Maintenance Director confirmed that the holes in the ceiling were created in December to address a separate leak.On 01/14/2026 at 1:00 PM, this surveyor conducted an interview with the Administrator regarding environmental concerns related to the ongoing leaks in the facility and the resulting holes in the ceilings. The Administrator acknowledged the concern and reported that he would begin utilizing a service to bring in a maintenance staff member on a rotating basis from other facilities to assist with maintenance issues, including repairing exposed ceilings.On 01/14/2026 at approximately 2:00 PM, the Administrator showed this surveyor photographs of maintenance staff repairing the holes in the ceiling of the Laundry/dryer room.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of records and interviews, it was determined that the facility failed to ensure a comprehensive care plan was developed and implemented for 1 (Resident #7) out of 1 residents reviewed for care plans during the recertification survey. The findings include:Care plans provide direction for individualized care of the resident. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 01/12/2026 at 9:58 AM, review of Resident #7 records revealed medical orders for: Encourage oral fluid intake 300 ML(milliliters) every shift. Fluids to be provided by a Licensed Nurse every shift. Activities of daily living are basic routine tasks that most healthy individuals can perform without assistance. These activities include personal care tasks such as eating, dressing, bathing, toileting, managing continence, and transferring (moving from 1 position to another). The ability to perform activities of daily living is an essential measure of an individual's functional status. The inability to perform basic activities of daily living may lead to unsafe conditions and a poor quality of life.On 01/12/2026 at 10:00 AM, a review of Resident #7's care plan showed goals related to nutrition and Activities of daily living (ADLs) with interventions that include Monitor and encourage intake of meals - offer alternate if <75%; Provide assistance with meals/snacks as necessary - refer to Occupational Therapy (OT) for self-feeding review as needed, EATING: Assist of 1.Further review of the resident's care plans revealed the facility staff failed to develop and implement a care plan with specific interventions and approaches to manage the resident's risk for dehydration. The Minimum Data Set (MDS) is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified and care is planned based on these individualized needs. The Brief Interview for Mental Status (BIMS) is used to determine the Resident's attention, orientation, and ability to register and recall new information. The total possible BIMS score ranges from 00 to 15: 13-15 cognitively intact; 08- 12 moderately cognitively impaired; 00-07 severely cognitively impaired. On 01/12/2026 at 11:29 AM, a review of Resident #7's medical record showed: Minimum data set (MDS) quarterly assessment on 10/30/25 was triggered for Brief interview for Mental Status (BIMS) 02, Mechanically altered diet (chopped, bite size), speech therapy. Resident #7 was under speech therapy services from 02/14/2025 - 11/14/2025.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review it was determined that the facility failed to ensure a resident was provided quarterly care plan meetings. This was evident for 3 (Resident#35,# 8 and #1) out of 26 Residents reviewed for care plan meetings during the recertification survey. The findings include: A Care Plan is used in nursing facilities to summarize a resident's health conditions and care needs. It is used to ensure resident's needs are met and consistent care is provided to the resident based on those needs. Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse with responsibility for the resident, nursing assistant with responsibility for the resident, dietary services, the resident, and the resident's representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly and as needed. 1) During an interview with Resident #35 on 1/05/2026 at 2:20 PM he/she denied having any recent care plan meetings. During a medical record review for Resident #35 on 1/06/2026 at 1:41 PM it was discovered that Resident #35 had care plan meetings held on 8/20/2024, 5/27/2025, 8/29/2025 and 12/02/2025. He/she did not have any documented care plan meetings from 8/20/2024 – 5/07/2025. During an interview with Social Services Assistant #8 on 1/15/2026 at 10:55 AM he confirmed that Resident #35 had no additional care plan meetings from August 2024 through May 2025 and care plan meetings were missed. He reported he was not with the facility at the time the care plan meetings were missed. 2) During a medical record review for Resident #8 on 1/09/2026 at 7:52 AM it was discovered that Resident #8 had been admitted to the facility in April 2025 and the last two care plan meetings were completed on 5/07/2025 and 1/06/2026. He/she did not have any additional documented care plan meetings in 2025. During an interview with Social Services Assistant #8 on 1/15/2026 at 10:59 AM he confirmed that the last two care plan meetings for Resident #8 occurred on 5/07/25 and on 1/06/26 with no additional care plan meetings completed in 2025. He confirmed the care plan meetings should be completed quarterly and that Resident #8 had missed care plan meetings. 3) During an interview conducted on 01/06/2026 at 8:59 AM, Resident #1 reported that the last care plan meeting was conducted 6 months ago. A review of Resident #1's care plan meeting care conference notes conducted on 01/12/2026 at 9:23 AM revealed the Resident were provided quarterly care meetings on the following dates: 07/01/2025, 03/18/2025, 11/27/2024, 10/08/2024, 06/11/2024, 3/19/2024, ad 12/20/2023. During an interview conducted on 01/12/2026 at 9:51 AM, Social Service Assistant (SSA) #8 reported that Resident#1 had considered going home in October of 2025 and therefore they did not conduct a care plan meeting. He further stated that the Resident fell through the scheduling crack and would be scheduled this month (January 2026) for a quarterly care plan meeting.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record reviews, observations and interviews it was determined that the facility staff failed to follow procedures during wound care to a resident with a pressure ulcer. This was evident for 1 (#22) out of 5 residents reviewed for pressure ulcer care during the recertification survey.The findings include: A pressure ulcer, also known as a bed sore or decubitus ulcer, is a localized area of skin damage that develops when prolonged pressure or shear forces disrupt blood flow to the tissues resulting in damage to the underlying tissue. Pressure ulcers are staged based on their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). 1. During a medical record review 1/06/26 at 1:41 PM it was revealed that Resident #22 had a Stage IV sacral pressure ulcer (PU) since 12/2024 and was receiving wound care for the PU. During an observation with the Wound Nurse #23 on 1/08/26 at 10:34 AM it was discovered that Resident #22 had a dressing over the sacral pressure ulcer that was not dated to identify when the dressing had been placed.During an interview with Wound Nurse #23 on 1/08/26 at 10:38 AM she reported that the dressings should be dated when wound care is performed and new dressings are placed. She confirmed the dressings should have been dated with the date they were placed.During an interview with the Director of Nursing on 1/08/2026 at 11:48 AM she reported the expectations are for wound dressings to be dated upon application 2. During a medical record review for Resident #22 on 1/09/26 at 1:24 PM it was discovered that the resident had an order for wound care which ordered, Daily Wound Treatment: Clean wound to sacrum with Dakin's solution, pat dry, apply Alginate calcium with silver to wound bed, and cover with boarder gauze once every day. Further review of the Task Administration Record (TAR) revealed that the order for the Daily Wound treatment was not signed off as completed for Resident #22 on April 26, 2025, November 23 2025, December 20, 2025, and January 2nd, 2026. During an interview with the Assisted Director of Nursing (ADON) on 1/14/2026 at 11:29 AM she reported wound care treatment requires orders, and the orders should be signed off after wound care is completed. She added the wound care should be documented, while documenting color and size.During a review of the facility policy Wound Care Policies and Procedures - Dressing Wound Evaluation on 1/09/2026 at 12:32 PM it reported, With each dressing change the clinician should observe and document the following:A. General appearanceB. DrainageC. Surrounding skinD. Wound odor It also stated to Document all procedures performed and patient/resident response (including pain/discomfort to the resident) on the appropriate form.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. cite:Based on medication administration observation, medical record review, and staff interviews, it was determined that licensed facility staff failed to maintain a medication error rate of less than five percent during the medication pass observation. This was evident for 2 Residents (#85 and #16) of 10 residents observed. A total of 29 medication administration opportunities were reviewed, resulting in a medication error rate of 10.34%. The findings include:On 01/08/2026 at 6:26 AM, during a medication administration observation with Registered Nurse (RN) #17, was observed crushing Resident #16's medications; Tylenol 325 mg, two (2) tablets, and pantoprazole 40 mg, one (1) tablet and administering them mixed in applesauce. On 01/08/2026 at 6:30 AM, during reconciliation of Resident #16's Medication Administration Record (MAR), the physician's orders indicated Tylenol 325 mg, two (2) tablets by mouth at 6:00 a.m., and Pantoprazole 40 mg, one (1) tablet by mouth at 6:00 a.m. There were no orders to crush the medications or mix them in applesauce. On 01/08/2026 at 6:40 AM, review of Resident #16's physician orders and Medication Administration Record (MAR) with RN #17 revealed no instructions to crush the medications. RN #17 confirmed that the medications were crushed prior to administration. On 01/08/2026 at 6:45 AM, during an interview, RN #17 stated that the medications for Resident #16 were crushed because the resident had difficulty swallowing. RN #17 confirmed that there was no physician's order to crush the medications. On 01/08/2026 at 7:00 AM, during an interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) regarding medication administration, the ADON stated that nurses are expected to follow physician orders during medication administration. The surveyor made the DON aware of the above concern and acknowledge receipt. On 01/12/2026 at 8:00 AM, during a medication administration observation with Licensed Practical Nurse (LPN) #25. Resident #85's physician order indicated Advair HFA 45/21 mcg, two (2) puffs by mouth twice daily, with instructions to rinse the mouth after use. LPN #25 administered only one (1) puff and did not offer the resident water to rinse the mouth as ordered. On 01/12/2026 at 8:05 AM, during review of Resident #85's Medication Administration Record (MAR) with LPN #25, it was revealed that two (2) puffs were documented as administered. LPN #25 confirmed that only one (1) puff had been given. Following surveyor intervention, LPN #25 returned to Resident #85, administered the second puff as ordered, and offered water for the resident to rinse his/her mouth. Further observation on 01/12/2026 at 8:12 AM with LPN #25, the physician's order for Balsam Peru Castor oil was to apply to affected fingers and toes daily for disorder of the skin and subcutaneous tissue for Resident #85. During medication administration observation, LPN #25 administered the ointment to the left and right fingers. On 01/12/2026 at 10:15 AM interview with resident #85 stated, they only apply it to my fingers, not my toes. My toes are the same as my fingers. On 01/12/2026 at 10:55 AM, surveyor reviewed Resident #85's physician's orders with LPN #25 and confirmed that the order was to apply the ointment to both fingers and toes. LPN #25 further confirmed that the ointment was applied only to the left and right fingers and not to the toes as ordered. On 01/12/2026 at 11:05 AM, the above concerns were brought to the DON and Clinical Services Director, and both acknowledged receipt.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. citeBased on observation and staff interviews, it was determined that the facility failed to properly store medications, as evidenced by medications not being properly labeled or dated. This was evident in 1 of 2 medication rooms and 4 of 4 medication carts observed during the recertification and complaint survey. The findings include: On 01/12/2026 at 6:17 AM, during a medication cart observation on the 1st floor C and D-Wing with Registered Nurse (RN) #26, the surveyor observed opened medications without documented open dates or resident identification. Resident-specific medications included Resident #70's Albuterol and Ellipta inhalers, Resident #10's Albuterol inhaler, Resident #9's Simethicone (1 fl oz/30 mL), and Resident #1's Albuterol inhaler. Additional opened medications stored without identification or documented open dates included Calcium + D3 (1 bottle), Vitamin C 1000 mg (1 bottle), Vitamin D 125 mg (1 bottle), and Tylenol 500 mg (1 bottle). One Glucagon Emergency Kit with the label torn off was also observed without resident identification or a documented open date. On 01/12/2026 at 6:25 AM, during a 1st floor medication room observation with Registered Nurse (RN) #26, the surveyor observed 10 FA Sponge Swabs (Lot #20953) on the counter that were expired (Expiration Date: 09/2025). The above concerns were reviewed with RN #26, who acknowledged the findings and removed the swabs from the medication room. On 01/12/2026 at 6:45 AM, during a 2nd floor A and C wing medication carts observation with Licensed Practical Nurse (LPN) #4, the surveyor observed residents' medications open without documented open dates, including 1 Latanoprost Ophthalmic for Resident #86 and 1 bottle Lactulose Solution 10g/15 mL for Resident #72. Additional medications were observed open without identification or documented open dates, including 1 box Mucinex 12 hr Over the Counter (OTC), 1 bottle Polyethylene Glycol 3350, 1 bottle Milk of Magnesia, and 1 tube Mupirocin Ointment 2%. The above findings were reviewed with LPN #4, who acknowledged the observations. On 01/12/2026 at 7:01 AM, during an interview, the Director of Nursing (DON) stated that nurses are expected to ensure all bottled and over-the-counter medications are labeled once opened, that expiration dates are monitored, and that expired medications are promptly removed from the carts. The surveyor brought the above concerns to the DON's attention, and she acknowledged receipt.

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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 review of resident medical records and facility staff interviews, it was determined the facility failed to maintain an accurate medical record. This was evident for 1 (Resident #56) of 1 resident reviewed during the annual recertification survey. The findings include:Diabetes Mellitus (DM) II : Is a condition characterized by high blood glucose (blood sugar) levels caused by either a lack of insulin or the body's inability to use insulin efficientlyOn 01/07/2026 at 9:48 AM, a review of Resident #56's Medical Record confirmed a diagnosis of Diabetes Mellitus (DM) II. Finger stick: A way to check your blood glucose level (BGL) using a lancet to prick the side of a fingertip (often the middle or ring finger), collecting a drop of blood on a test strip, and inserting the strip into a glucose meter to get a reading in seconds. BGL is measured in milligrams per deciliter, or mg/dL.On 01/07/2026 at 9:50 AM, a review of Resident #56's Treatment Administration Record (TAR) showed an order for: Check finger stick blood sugar (FSBS) before breakfast and Dinner call Medical Doctor (MD) / Nurse Practitioner (NP) if BGL is less than 70 mg/dL or greater than 200 mg/dL. On 01/08/2026 at 9:20 AM review of resident TAR revealed on the following dates Resident #56's finger stick blood sugar was outside the ordered parameters and nursing staff was to notify MD/NP if less than 70 mg/dL or greater than 200 mg/dL:12/6/25 BGL 300mg/dL12/22/25 BGL 215mg/dL12/26/25 BGL 236mg/dL01/02/26 BGL 210mg/dL01/02/26 BGL 326mg/dL01/06/26 BGL 207mg/dL01/08/26 BGL 221mg/dL eMediCall is a secure medical communication system that streamlines communication between medical practitioners and nursing staff. It acts as a secure online answering service creating a documented log of all patient interactions for better care coordination and regulatory compliance. On 01/09/2026 at 9:24 AM, an interview with Licensed Practical Nurse (LPN) #4 revealed that it is the facility process to notify the Unit Nurse Manager of BGL obtained that are outside the parameters. The LPN that obtained the FSBS will contact the medical provider through eMedicall to report the findings and wait for the medical provider to respond with how to proceed. LPN#4 also confirmed that the findings and medical provider response are to be documented in the residents medical record as a progress note. LPN #4 stated that the medical providers typically respond within 30 minutes to all eMedicall notifications. No progress notes for the previously listed dates were in Resident #56's medical record for the FSBS being outside the parameters or notification of the medical provider. On 01/12/2026 at 9:31 AM, The Director of Nursing (DON) confirmed the facility was unable to provide any proof of documentation that the provider was notified that Resident #56's Blood Glucose Level (BGL) readings were outside the ordered parameters. She also could not provide documentation on how the Resident was treated on the 7 occasions (12/6/25,12/22/25,12/26/25, 01/02/26, 01/02/26, 01/06/26, and 01/08/26) when the BGL reading was outside of the ordered parameters.

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	01/14/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record reviews it was determined that the facility failed to ensure the environmental equipment was functional. This was found to be evident for 2 out of 2 Solariums observed during the recertification survey.The findings include: On 01/05/2026 at 7:30 AM the Survey team conducted an unannounced entry of the facility to conduct a recertification and complaint survey. The night Registered Nurse (RN) #17 advised the team to have a seat because he needed to contact the Administrator and Maintenance Director to assign the Survey team a room because the usual room (1st floor B-wing Solarium) did not have heat. At 8:19 AM Licensed Practical Nurse (LPN) #4 met the Survey team and moved the team from the lobby of the facility to a room on the second floor C-wing. On 01/05/2025 at 8:30 AM the Assistant Director of Nursing (ADON) met with the team and explained that the room that is usually assigned to the Surveyors did not have heat and that the Maintenance Director was working on the heat. On 01/05/2026 at the end of the day the Survey team was moved to the 1st floor B-wing Solarium. On 01/06/2026 at 6:00 AM, this Surveyor observed 2 of the 3 portable heaters on and spaced out across the room. The room was very cold and required this Surveyor to wear his/her coat throughout the day. From 01/06/2026 through 01/14/2026 the room was very cold on many of the days. The breaker would trip on most of the days cutting off the power to the portable heaters. The NHA attempted to turn on a wall heating unit however that unit was ineffective in heating the portion of the room it was located. During the time of the survey between 01/06/2026 and when the team exited 01/14/2026 the team could hear residents exercising daily to music in the room above the 1st floor B-wing Solarium around 11:30 am and 12:00 pm. During an interview conducted on 01/08/2026 at 11:47 am, the Director of Nursing (DON) heard the residents exercising to music and confirmed that it is the time of the day where residents exercise to music in the 2nd floor Solarium. During an interview conducted on 01/13/2026 at 10:09 AM, the Nursing Home Administrator (NHA) reported that he contacted the fire marshal and the Life Safety Code Coordinator to get direction on what type of portable heaters could be used to heat the 1st floor B-wing Solarium on 01/05/2026 following the entry of the Survey team. The NHA explained that the HVAC heating system malfunctioned and that Corporate required 3 estimates to have the heating system repaired. The NHA stated that he had 2 estimates and was working on obtaining a third estimate. This Surveyor requested the documentation for the repair of the heating unit. During a review of the facility documentation provided by the NHA on 01/13/2026 at 11:00 AM, it was discovered that the facility received an estimate on 11/14/2025 for the repair of the heating system for the 1st and 2nd floor B-wing Solariums. During the continued review it was discovered that there was no other evidence of the 2nd estimate that the NHA had reported previously to the Surveyor. On 01/13/2026 at 12:10 PM, this Surveyor observed several residents in the 2nd floor Solarium exercising to music. The room felt very cold and did not have any portable heaters. During an interview conducted on 01/13/2026 at approximately 1:15 PM, the NHA explained that the HVAC heating system malfunctioned in early November 2025. He stated that he had obtained 1 estimate of the 3 required for Corporate to repair the heating system. He also stated that he had not obtained the 2nd estimate because he still needed to provide the contractor with additional information. When asked what the name of the 2nd contractor was the NHA could not recall. The NHA acknowledged the delay in obtaining the 3 required estimates to repair the heating system.During the continued interview the Surveyor asked why residents were exercising in the 2nd floor Solarium without heat. The Surveyor reported her observation and expressed concern that the room felt very cold. The NHA stated that he was not aware that Residents were exercising in the 2nd floor Solarium. He stated that the Restorative Aide was on vacation when the heat went out. However, the Surveyor advised the NHA that the heat had been out in the B-wing Solariums since November of 2025.