STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Rockville	9701 Veirs Drive Rockville, MD 20850

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 - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review and interview, it was determined that the facility failed to respond timely when residents called for assistance. This was evident for 1 complaint (#MD00206835) of 6 complaints reviewed during the recertification survey. The findings include: On 10/08/24 at 3:00 PM, a review of complaint #MD00206835 was conducted. It alleged that staff were slow to answer Resident #152's call bell on 11/20/23, 11/21/23, 11/25/23, 11/26/23, and 12/04/23. On 10/11/24 at 10:15 AM - the Nursing Home Administrator (NHA) was asked to provide the call bell response log for Resident #125 for the days of concern. A review of those records revealed that on 11/20/23, 11/21/23, 11/25/23, 11/26/23, and 12/04/23, Resident #152's call bell went unanswered for 42 minutes or longer at least once. On 11/20/23, 11/25/23, and 12/04/23, this occurred twice. On 10/11/24 at 10:20 AM in an interview with Geriatric Nursing Assistant (GNA #13), she described how the call bell system worked. She said that when the resident pressed their call device, the GNAs received a phone notification on an app. The app showed the room number and if it was from the bed or the bathroom. She further explained that the expectation was to answer the call bell within 8 minutes, that she was told this in staff meetings and in orientation. On 10/11/24 at 10:26 AM, an interview with Licensed Practical Nurse (LPN #1) was conducted. She explained that call bell alerts went to the GNAs first, and if the GNA does not turn it off in 5 minutes, the nurses were alerted. The expectation was that the call bell was answered within 5 minutes. She also said the supervisor was notified when the call bell was answered. When asked if a call bell response time of 40 minutes or more was acceptable, she said No. On 10/11/24 at 10:41 AM, an interview with the Director of Nursing (DON) was conducted. When she was asked to provide the facility's call bell policy she replied that the facility does not have one. On 10/11/24 at 11:10 AM, an interview was conducted with the NHA and DON and they confirmed the delay in call bell response time and said they knew this was a deficiency.

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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NAME OF PROVIDER OR SUPPLIER The Village at Rockville		STREET ADDRESS, CITY, STATE, ZIP CODE 9701 Veirs Drive Rockville, MD 20850	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of medical records and facility reported incident investigation documentation and interviews, it was determined that the facility failed to keep a resident free from abuse. This was found to be evident for one (Resident #33) of twenty-one residents reviewed for potential abuse. The findings include: Review of Resident #33's medical record revealed the resident required staff assistance with transfers from bed to wheelchair and back to bed. Review of a facility reported incident (MD00189254) revealed that, on 2/19/23 the geriatric nursing assistant (GNA Staff #15) refused to assist the resident back to bed when the resident requested assistance. Review of an interview with Resident #33, dated 2/21/23, revealed that, on 2/19/23, the resident was in the dining room for lunch. After lunch the resident asked GNA #15 to take them back to their room. The GNA said no, and indicated that, when she (the GNA) was ready she would take the resident back. The resident then told the GNA that his/her legs hurt and that he/she wanted to go back to his/her room. The GNA again refused to assist the resident and, according to the resident's statement, said: Shut up. I don't want to hear you complaining. You're going to have dinner there. At 3:00 PM, the resident said I'm going back, the GNA responded: No, I'll take you after dinner. Further review of the investigation documentation revealed the resident then attempted to wheel self back to his/her room, other staff noticed the resident and asked if assistance was needed and the resident was assisted back to bed. The resident reported the incident to the then Assistant Director of Nursing (Staff #27) on the morning of 2/20/23. Review of an interview with GNA #15, dated 2/21/23, revealed that, on 2/19/23 after lunch, the resident said that [s/he] wanted to go back to [his/her] room and I told [him/her], 'no'. [S/he] also asked a few visitors if they could help [him/her] to bed and I told the visitors, 'no' and that we would assist [him/her] to bed later. On 10/10/24 at 10:39 PM, the Director of Nursing confirmed that they did substantiate the abuse and that they terminated the GNA and reported her to the Board of Nursing. The facility also provided documentation of training provided to staff on 2/23/23 and 2/25/23 regarding the Resident's [NAME] of Rights and Reporting Abuse.

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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 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. 2) A review of Resident #33's medical record revealed the resident required staff assistance with transfers from bed to wheelchair and back to bed. A review of the facility reported incident (MD00189254) revealed that on 2/19/23 the geriatric nursing assistant (GNA Staff #15) refused to assist Resident #33 back to bed when the resident requested assistance. The incident was reported to the state survey agency on 2/20/23. A review of the facility's interview with Resident #33, dated 2/21/23 revealed that on 2/19/23 the resident was in the dining room for lunch. After lunch the resident asked GNA #15 to take the resident back to his/her room. The GNA said No, and indicated when she (GNA) was ready she would take the resident back. The resident then told the GNA that his/her legs hurt and that he/she wanted to go back to his/her room. The GNA again refused to assist the resident and, according to the resident's statement, said: Shut up. I don't want to hear you complaining. You're going to have dinner there. At 3:00 PM the resident said I'm going back, the GNA responded: No, I'll take you after dinner. The resident then got upset and called the GNA a son of a #####. The resident then proceeded to wheel him/herself back toward his/her room until another staff person (GNA #24) came to assist the resident. A review of the facility's interview with GNA #15, dated 2/21/23, revealed the statement of events on 2/19/23: After lunch [the resident] said that [s/he] wanted to go back to [his/her] room and I told [the resident], 'no'. [The resident] also asked a few visitors if they could help [him/her] to bed and I told the visitors, 'no' and that we would assister [him/her] to bed later. Did [the resident] tell you that [s/he] called me a '#####'? A review of the facility's interview with Nurse #16, dated 2/20/23, revealed that on 2/19/23 Resident #33 requested to be put to bed. The Nurse #16 asked the assigned GNA (#15) to assist the resident back to bed but GNA #15 said: No, she is not going to put [the resident] to bed because [the resident] called her a #####. Nurse then asked GNA #24 to assist the resident. The Nurse #16 then informed the Care Coach (Staff #1) what happened on the unit. A review of the interview statement from Care Coach (Staff #1), dated 2/21/23, revealed she spoke with the GNA #15 after Nurse #16 had reported that the GNA did not assist a resident to bed when requested. The statement included: [GNA #15] stated to me that she just got the resident up and that she wanted to wait until after dinner to assist the resident back to bed. She told me that the resident called her a son of a ##### Further review of the Care Coach's interview statement failed to reveal documentation to indicate the Care Coach spoke with the resident on the evening of 2/19/23. On 10/10/24 at 9:35 AM an interview was conducted with Care Coach (Staff #1). She reviewed her statement from 2/21/23 and confirmed that it was correct. The Care Coach was unable to recall if she spoke with the resident that evening. When asked if she told anyone else about the incident that evening, the Care Coach reported that she did not think it was a customer complaint, she was not aware at the time that the resident had requested, and GNA had refused, to assist; and that she just thought it was the GNA telling the nurse no. Further review of the investigation documentation revealed the resident reported the incident to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the then Assistant Director of Nursing (ADON) on the morning of 2/20/23. On 10/10/24 at 10:39 AM the Director of Nursing (DON) was interviewed. The DON confirmed that she was not aware of the incident until the day the report was sent in, and stated: I wasn't made aware until the 20th, from what I understand he/she (Resident #33) requested to speak with the ADON. When the surveyor expressed the concern that there was no follow up with the resident that evening, the DON reported they did identify the concern that the incident was not identified as abuse when it occurred. The DON went on to report that she did inform the Care Coach that she should have spoken with the resident and taken the GNA off the schedule. The facility also provided documentation that training was conducted with staff on 2/23/23 and 2/25/23 regarding the Resident's [NAME] of Rights and Reporting Abuse. 1d) On 10/10/24 9:40 AM, a review of facility reported incident, MD00187540 revealed documentation that, on 1/9/23 at 1:16 PM, a family member of Resident #138 reported to facility staff that Resident #138 alleged s/he was being abused and retaliated against by the staff. Review of email confirmation of when the facility's initial self-report was sent to the state agency revealed documentation that the incident was reported to the state agency on 1/9/23 at 6:34 PM. The facility failed to forward a first report of an allegation of abuse to the state agency immediately, but not later than 2 hours once the facility staff became aware of the abuse allegation. On 10/10/24 at 4:05 PM, during an interview, the concerns with failing to report an allegation of abuse immediately, but not later than 2 hours were discussed with the Director of Nurses (DON). At that time, the DON acknowledged the concerns and stated that the time to report an allegation of abuse was within 2 hours. Based on record review and interview, it was determined that the facility failed to 1) report allegations of abuse within two hours, and 2) identify and report potential abuse to the administrator. This was evident for 1) four facility reported incidents (FRIs) (#MD00202347, #MD00198954, #MD00181634, MD00187540) of seventeen FRIs, and 2) one (Resident #33) of twenty-one residents reviewed for potential abuse. The findings include: 1a) On 10/08/24 at 11:55 AM, a review of the facility reported incident #MD00202347 revealed that Resident #36's responsible representative made the facility aware of an allegation that female residents on the second floor were being compromised at night. Staff were made aware of the allegation on 2/06/24 at 3:15 PM, but failed to report the allegation to the Office of Healthcare Quality until 2/07/24 at 6:07 PM. On 10/09/24 at 8:24 AM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to report an allegation of abuse within 2 hours. 1b) On 10/09/24 at 9:03 AM, a review of the facility self reported incident #MD00198954 revealed that Resident #67's responsible representative made the facility aware of an allegation that Resident #67 told him a staff member put his/her head in the toilet but could not indicate if it happened at the facility. Staff were made aware of the allegation on 10/25/23 at 2:40 PM but failed to report the allegation to the Office of Healthcare Quality until 10/26/23 at 7:17 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 08:25 AM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to report an allegation of abuse within 2 hours. 1c) On 10/10/24 at 8:50 AM, facility report MD # 00181634 was reviewed. This review revealed that Resident # 139 reported an allegation of abuse on 8/2/22 at 4:30 PM. The date of the initial email regarding the self-report was sent to the state survey agency on 8/3/22 at 11:23 AM. On 10/10/24 at 4:04 PM, the Director of Nursing was asked what the time frame was to report an allegation of abuse. The DON's response was 2 hours. She confirmed that the facility reported incident #MD00181634 was reported after the required timeframe.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility reported incident investigations and interview, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 1 (#138) of 21 residents reviewed for abuse. The findings include: On 10/10/24 9:40 AM, a review of facility reported incident, MD00187540 was conducted. The facility's initial self-report documented that, on 1/9/23, a family member of Resident #138's reported to a supervisor that Resident #138 alleged s/he was abused and retaliated against by staff assigned to the resident. Review of the documents included with the facility's investigation revealed documentation of interviews that were conducted with staff members assigned to the resident during the time frame the alleged abuse was reported to have occurred, and interviews conducted with some residents. However, continued review of the facility's investigation failed to reveal documentation of the interview conducted with the family member who reported Resident #138 had an allegation of abuse. In addition, there was no documentation in the self-report to indicate who the supervisor was that initially received the report of alleged abuse from the family member, and there was no documented interview of the supervisor was found with the facility's investigation. On 10/10/24 at 4:05 PM, during an interview, the concerns with failing to thoroughly investigate an allegation of abuse were discussed with the Director of Nurses (DON). At that time, the DON was made aware that an interview with the complainant, an interview with Resident #138, and an interview with the supervisor who received the complaint were not included with the facility's investigation and the concerns with failing to thoroughly investigate an allegation of abuse were discussed with the DON. At that time, the DON acknowledged the concerns and indicated she was surprised that the interviews were not with included in the investigation.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to provide Cardiopulmonary Resuscitation (CPR) to an unresponsive resident whose active Maryland Orders for Life Sustaining Treatment (MOLST) instructed to Attempt CPR if cardiac and/or pulmonary arrest occurs. This was evident for 1 (#137) of 21 residents reviewed for abuse during the survey. This deficient practice led to an immediate jeopardy for Resident #137 on [DATE]. Following the incident, the facility implemented effective and thorough corrective measures. The facility's plan and action were verified during this survey; therefore, this deficiency was cited as past noncompliance. The date of correction was [DATE]. The findings include: Cardiopulmonary resuscitation (CPR) refers to any medical intervention used to restore circulatory and respiratory function that has ceased. Maryland MOLST is a portable and enduring form for orders about cardiopulmonary resuscitation and other life-sustaining treatments. It makes one's treatment wishes known to healthcare professionals. Do Not Resuscitate (DNR)Order refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Code Status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops. A review of Resident #137's medical record revealed a MOLST, completed on [DATE], with Resident #137 as the decision maker and instructed to Attempt CPR. A review of a facility self-report MD00203965 for Resident #137, dated [DATE] indicated that, at approximately 4:30 AM on [DATE], staff #7, a geriatric nurse aid (GNA), noticed that Resident #137 was unresponsive upon entering his/her room. Staff #7 alerted the assigned nurse for Resident #137, staff #8, a registered nurse (RN). Further review revealed a clinical note for Resident #137 written by staff #8 and dated [DATE]. The note recorded that during routine check, resident was observed to have a cold clammy skin, no rise and fall of chest wall, pupils dilated to bright light. Vitals signs [respiration, pulse, blood pressure, temperature] weren't recordable. However, the review failed to show that staff #8 initiated CPR on Resident #137, as indicated on his/her MOLST form. A continued record review showed that staff #8 notified staff #9, the RN nurse supervisor, that Resident #137 was unresponsive and had a DNR order. Staff #9 then checked the resident's physical chart, which contained a MOLST that instructed staff to attempt CPR. The review failed to show that CPR was initiated at this point. In an interview on [DATE] at 1:04 PM with staff #1, an RN supervisor, she revealed that the form the nurses previously used for their change of shift report used to contain residents' code status. Staff #1 added that, due to inconsistencies, staff were educated to review the residents' physical (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	charts for code status. In an interview on [DATE] at 9:06 AM, the director of nursing (DON) indicated that her investigation revealed that staff #8 used a form for her change of shift report with a code status for Resident #137. However, the DON was unaware of the form and expected staff # 8 to review Resident #137's MOLST for his/her code status. During an interview on [DATE] at 3:10 PM, staff #8 reported that this was her first time working with Resident #137 on [DATE]. Staff #8 continued to say that she did not initiate CPR on Resident #137 on that day because she was handed a report form at the start of her shift by the off-going nurse, which indicated that Resident #137's code status was DNR. Staff #8 added that she notified staff #9, who called Resident #137's attending provider. The provider ordered not to initiate CPR at that point because the resident was already cold to the touch and had no vital signs. A review of the certificate of death showed that Resident #137's date and time of death was [DATE] at 5:00 AM. In an interview on [DATE] at 8:33 AM, staff #16, a licensed practical nurse (LPN), indicated that the nursing staff used a form for their change of shift report, which contained residents' code status. However, after Resident #137's incident on [DATE], the nursing staff had been educated to check residents' physical charts for code status. A corrective action plan was developed and started on [DATE] after the incident occurred: 1) The staffing agency was notified of the occurrence, and staff #8 was placed on the Do Not Return list for the facility. 2) A document review was conducted on all units to ensure code status information was only available on the MOLST form in the residents' physical charts. 3) Nursing staff were re-educated on MOLST and the CPR process on [DATE]-[DATE] by the RN unit managers. 4) Policy on MOLST and CPR and education were activated in the facility's training software program for nursing staff review and acknowledgment. 5) The 3 Unit Managers (Care Coaches) also provided in-person training to all nursing staff. 6) The Medical Director provided education to all attending physicians (including Resident #137's attending provider) on [DATE]. 7) The facility audited and reviewed all residents' MOLST forms and orders. On [DATE] at 12:28 PM, after a review of the credible evidence of education, audits, and interviews with multiple staff, it was determined that the facility had identified this deficient practice and implemented interventions to prevent a recurrence. The date of compliance, as identified by the date on which the training was completed, was determined to be [DATE].