STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adelphi Nursing and Rehabilitation Center	1801 Metzerott Road Adelphi, MD 20783

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 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 record review and interview, it was determined that the facility failed to ensure that residents were free from abuse. This was identified during review of facility-reported incident #2731067 and was evident for 2 (Resident #104 and #161) out of 2 residents reviewed for abuse. The findings include:On 04/03/2026 at 1:03 PM, this surveyor began the record review the facility's investigation related to a facility reported incident #2731067. It was found that the facility verified the allegation, based on the interviews collected and both residents admitted to engaging in an altercation. On 04/03/2026 at approximately 1:30 PM, a record review of the facility-reported investigative file revealed the following:On 01/24/2026 at approximately 9:00 AM, Resident #104 and Resident #161, who were roommates, were involved in a physical altercation. Injuries were documented as [Resident #161] sustained facial swelling and laceration to the right side of forehead, and [Resident #104] laceration on the right side of the cheek. An interview with the alleged victim, Resident #161, stated that his/her clothes were initially placed on a chair by the window. He/she reported that his/her roommate later placed his/her own clothes in the same location. He/she stated that he/she then moved his/her clothes to the foot of his/her bed. According to Resident #161, his/her roommate approached the clothing believing it belonged to him/her. Resident #161 stated that he/she informed the roommate that the clothes were not his/hers. Per Resident #161, the roommate then began using profanity language toward him/her, and after being told not to use such language, his/her roommate subsequently punched him/her in the face, at which point he/she punched him/her back in defense. The resident reported that he/she yelled for help, a GNA responded and removed the roommate from the room, and a nurse later provided first aid. Resident #161 requested to go to the hospital. An interview with the alleged perpetrator, Resident #104, stated that his/her clothes were placed on a chair by the window. He/she reported that the clothing belonging to his/her roommate was also in the same area. Resident #104 reported that he/she approached the clothing believing it belonged to him/her, and when informed otherwise by the roommate, a verbal exchange occurred. Resident #104 stated that a physical altercation then occurred between them, during which both punched each other. A statement from RN Supervisor #15 reported that on 01/24/2026, while serving as the nursing supervisor, a GNA assigned to the residents reported hearing Resident #161 yelling for help while passing breakfast trays. The RN Supervisor reported that upon entering the room, Resident #161 was assessed and found to have facial swelling and a laceration to the right side of the forehead. The RN Supervisor reported that Resident #161 stated that when Resident #104 was taking his/her clothes and he/she refused, Resident #104 struck him/her in the face. A statement from a GNA reported that while passing breakfast trays on 01/24/2026, he/she heard a resident calling for help, entered the room, and observed Resident #104 sitting on the bed and Resident #161 sitting at the edge of the bed with a small amount of blood on the right forehead area. The GNA reported that Resident #161 stated the two residents had argued and that Resident #104 hit him/her in the face. The GNA reported that he/she immediately removed Resident #104 from the room, remained with Resident #104, and contacted the charge nurse.A skin status evaluation completed on 01/24/2026 at 12:58 PM by LPN #16 documented that Resident #161 had a new skin condition, including a laceration (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the right side of the forehead and facial swelling.An after-visit summary from Holy Cross Health Hospital for Resident #161 stated, You were seen after an assault. Your CT scan showed a small amount of blood in your brain from being struck in the head. The repeat CT scan did not show any worsening. The summary further stated, you were found to have a small scratch of your eye that will take several days to heal.A psychiatry note dated 01/27/2026 for Resident #161 documented follow-up for patient to patient altercation, noting that the resident required EMS transport to Holy Cross Hospital Emergency Department and that the resident reports feeling safe now that [Resident #161] and [Resident #104] have been placed in separate rooms.A psychiatry note dated 01/27/2026 for Resident #104 documented evaluation following his/her second patient to patient altercation, involving a confrontation with his/her former roommate related to alleged theft of personal belongings. The note further stated that Resident #104 has a documented history of aggressive behavior, including a prior fight and recent start on mood stabilizer medication.On 04/03/2026 at approximately 1:40 PM, record review of Resident #104's care plan revealed documentation stating [Resident #104] has behaviors related to cognitive impairment. He had a physical altercation with another resident. He hit another resident on the face, with a last revision date of 01/11/2026. An additional care plan, revised on 01/24/2026, documented that Resident #104 had a physical altercation with his/her roommate and sustained a laceration on his/her right cheek area.On 04/07/2026 at approximately 11:00 AM, this surveyor conducted an interview with the Director of Nursing (DON), who confirmed that she completed the investigation and submitted the final report. The DON confirmed that the facility verified the allegation based on staff witness statements and both residents' admissions of the physical altercation.On 04/08/2026 at 9:58 AM, this surveyor conducted a follow-up interview with the DON and communicated that, as the facility verified a resident-to-resident physical altercation resulting in injury, there is a concern that the facility failed to ensure residents were free from abuse. The DON acknowledged and confirmed understanding of the concern.