

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>14894</p> <p>Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to honor resident choices with showering. This was evident for 2 (#21 and #73) out of 52 residents in the survey sample.</p> <p>The findings include:</p> <p>1. Resident #21 was interviewed on 8/6/24 at 11:26 AM. The resident stated that they do not always get 2 showers each week. The resident stated that their scheduled days are Tuesday and Friday, but they will not get a shower unless there are 4 or more geriatric nursing aides (GNA's) on duty.</p> <p>A review of the electronic health record revealed the last documented shower was on 9/19/23.</p> <p>The Administrator and Director of Nursing (DON) were interviewed on 8/16/24 at 1:25 PM. The resident allegation of no showers was presented to them. They said they understood the findings and would review both electronic medical records as well as review the shower sheets.</p> <p>2. Resident #73 was interviewed on 8/08/24 at 09:00 AM. The resident stated that they do not receive showers and only get bed baths. The resident had a very distinct odor suggesting the lack of bathing.</p> <p>A review of the clinical records revealed that the resident only received a shower on 8/11/24 and 8/15/24 based on a 30 day look back period with no refusals noted.</p> <p>The Administrator and Director of Nursing (DON) were interviewed on 8/16/24 at 1:33 PM. The resident allegation of no showers was presented to them. They said they understood the findings and would review both electronic medical records as well as review the shower sheets.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215106
		If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783</p> <p>Based on interviews and record review it was determined that the facility failed to ensure the Power of Attorney (POA) was notified of a pressure ulcer. This was found to be evident for 1 (Resident #29) out of 1 resident reviewed for notification.</p> <p>The finding include:</p> <p>Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as bedsores or pressure sores. Pressure ulcers are categorized into four stages based on the extent of skin damage:</p> <p>Stage 1: The skin is intact but may appear red, even when no pressure is applied. It may also feel warmer or colder, softer or harder, or more sensitive to pain than the surrounding tissue.</p> <p>Stage 2: The upper layers of the skin are damaged, and there may be a blister, scrape, or bruise. The skin may appear as a shallow open ulcer with a red or pink wound bed.</p> <p>Stage 3: The skin is completely damaged, and the ulcer may extend to the subcutaneous fat. The lesion may be foul-smelling, and slough or eschar may be visible.</p> <p>Stage 4: The skin and much of the surrounding tissue is damaged and has died . The ulcer may extend through the fascia and involve muscle, bone, tendon, or joint.</p> <p>During an interview conducted on [DATE] at 11:33 AM, the POA stated she had not been notified that Resident #29 had a stage 2 sacrum pressure ulcer.</p> <p>A record review conducted on [DATE] at 11:45 AM revealed a wound evaluation dated [DATE]. The evaluation showed a stage 2 sacrum pressure ulcer that was acquired prior to re-admission to the facility on [DATE]. No record of POA notification.</p> <p>During an interview conducted on [DATE] at 3:06 PM, Licensed Practical Nurse (LPN) #16 stated that she notified Resident #29's POA in person of the stage 2 sacrum pressure ulcer. When asked if it was documented in the resident's medical record that she had notified the POA the LPN stated no. The LPN further stated that the facility's policy was to notify the Resident Representative of a change and to document the notification in the resident's medical record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>14894</p> <p>Based on facility investigations, record reviews, interviews and observations, the facility failed to protect residents from abuse and neglect. This was found to be evident for 5 (# 7, # 27, # 50, # 62, # 82) out of 38 residents investigated during the annual survey for abuse and neglect.</p> <p>The findings include:</p> <p>1. A review of a facility investigation on 08/14/24 at 3:37 PM for an allegation made by the Responsible Party (RP) for Resident #7 revealed the following. On 9/29/23, the RP arrived at the facility at 11:00 AM. The RP dressed the resident and then placed the resident in bed but on top of the sheets. The RP arrived the next day at 12 noon. The resident was still on top of the bedsheets and still dressed in the clothes from the day before. Bed sheets were folded under the resident and the resident's catheter bag was full. The RP asked the nurse about being dressed in the same clothes, but she did not know for sure since she had not worked the day before. RP asked the Geriatric Nursing Assistant (GNA) who had worked the day before. She said the resident was dressed like this when she started the day, and the resident was on top of the bed laying on the bedsheets. RP said the resident was wearing the same clothes as the day before and had not been changed for 23 hours. RP also said the resident's brief was cold and urine soaked.</p> <p>The Unit Manager (#15) was interviewed on 8/15/24 at 1:43 PM. She said the GNA assumed the 11-7 shift changed the resident and left him/her in bed. The GNA was unaware that 2 shifts had gone by after RP changed him/her into the clothes and place him/her in bed. RP told her of the incident after he went straight to the Administrator and the Director of Nursing (DON). She said she was left out of the loop but there have been no incidents since this one.</p> <p>The DON and administrator were interviewed on 8/16/24 at 1:20 PM. This surveyor went over the incident and expressed concern regarding the failure of staff to place the resident in bed and then change him/her into clean clothes. The administrator and the DON said they understood the findings and would review.</p> <p>As of 08/20/24 at 1:27 PM there was no additional information presented to the survey team.</p> <p>42783</p> <p>2. BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. A BIMS score can range from 0 to 15, with lower scores indicating a decline in cognitive performance. A BIMS score 0 to 7 points suggests severe cognitive impairment, 8 to 12 points suggests moderate cognitive impairment, and 13 to 15 points suggests that cognition is intact.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/16/2024 at 11:00 AM a review of the Facility Reported Incident (FRI) investigation was conducted for an allegation of neglect. The review of the investigation revealed a witness statement from the facility's Maintenance Worker #22. The Maintenance Worker stated that he witnessed Geriatric Nursing Assistant (GNA) # 23 push Resident #50 in a wheelchair and kick the resident in the foot after repeatedly telling the resident to put his/her feet up. The facility stated in their investigation that there was limited video that showed the resident being pushed to the dinning room without foot pedals, and GNA did use her feet to lift the residents leg and pushed her to the table. The investigation also included a statement from GNA #23 who denied kicking the resident. The GNA stated that the resident decided to put [resident's gender] feet down so she slid her leg under [resident's gender] to lift it and then pushed [resident gender] under the table.</p> <p>The investigation further stated that the Resident was assessed to have a BIMS of 09 and was unable to recall the incident. The facility found evidence to support neglect because the employee failed to provide services such as foot rest or repositioning appropriately while pushing [resident gender].</p> <p>During an interview conducted on 08/16/2024 at 11:17 AM, Resident #50 stated he/she remembered that his/her foot was kicked and that it hurt but could not recall when, why or who kicked his/her foot.</p> <p>During an interview conducted on 08/19/24 at 09:59 AM, the Assistant Director of Nursing (ADON) stated she no longer had access to the video. The ADON stated that she reviewed the video at the time of the incident and observed GNA #23 pushing the resident down the hallway towards the day room of the 200-nursing unit, the GNA stopped at the double doors prior to the day room walked to the side of the resident and lifted the resident legs up with her leg and then continued to push the resident to the dayroom table. The ADON stated she did not see the GNA #23 kick the resident on the video.</p> <p>3. On 08/21/2024 at 10:30 AM a review of the Facility Reported Incident (FRI) investigation file for an allegation of neglect was conducted. The investigation revealed a statement from GNA #14 that advised the facility that she observed Resident #27 soiled in urine, dry feces, laying on urine-stained sheets and was wearing the night gown from the previous day. Another statement from Unit Manager # 15 also advised that she observed the Resident #27 soiled in urine, dry feces, laying on urine-stained sheets.</p> <p>During an interview conducted on 08/21/2024 at 11:00 AM, Resident #27 did not respond when asked if he/she had experienced abuse, neglect or had a concern with his/her care.</p> <p>A record review of Resident #27's medical record conducted on 08/21/2024 at 11:19 AM revealed a BIMS assessment score of 07.</p> <p>On 08/21/2024 at 12:14 PM an interview was conducted with Unit Manager #15. The Unit Manager stated that GNA #14 had made her rounds and noticed that Resident #27 was soiled in urine, dried fecal matter and stained sheets. The GNA reported the incident to the Unit Manager who went to the Resident's room and confirmed the resident was soiled in urine, dry feces and urine soiled sheets. The Unit Manager also stated that she immediately had care provided to the resident and investigated the incident. The Unit Manager stated that she discovered that 2 GNAs went against their assignment and switched residents and as a result Resident #27 was missed and did not receive care on the day shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47758</p> <p>4. During a review of intake # MD00191221 on 8/16/24 at 07:34 AM, Resident # 82 was found on the floor next to his/her wheelchair. There were no witnesses, and this was determined to be an unwitnessed fall until the next morning when Resident # 82 told staff s/he had been pulled out of her wheelchair by another resident. The facility reviewed video footage that showed Resident # 49 rolling his/her wheelchair up to Resident # 82 and pulling him/her out of his/her wheelchair and kicking him/her. No injuries were found on assessment of Resident # 82.</p> <p>5. During a review of intake # MD00192185 on 08/19/2024 at 1:24 PM, the facility reported that Resident # 318 was observed slapping Resident # 62 across the face by staff. This appeared to be an unprovoked attack when observed by the facility on video. No injuries were found on assessment of Resident # 62.</p> <p>When the Director of Nursing (DON) and the Nursing Home Administrator (NHA) were interviewed on 08/20/2024 at 7:12 AM, regarding the concern of abuse, resident to resident, they questioned how an altercation was considered abuse when Residents # 49 and #318 were deemed mentally incompetent. The surveyor told them that any willful act was considered abuse regardless of the mental status of the perpetrator and that all residents have the right to be free from abuse. The surveyor referred the DON and NHA to the F600 tag and interpretive guidelines for clarification. The NHA stated they would be exploring options to improve practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>14894</p> <p>Based on family interview, staff interview, and clinical record reviews, it was determined that the facility failed to ensure that allegations of missing money was reported to the State Survey Agency (Maryland Department of Health - Office of Healthcare Quality) and neglect were reported within the required time frame. This was evident for 2 (#7, #136) out of the 52 residents reviewed for reporting of alleged violations.</p> <p>The findings include:</p> <p>1. A review of a facility investigation on 08/14/24 at 3:37 PM for an allegation made by the Responsible Party (RP) revealed the following. On 9/29/23, the RP arrived at the facility at 11:00 AM. The RP dressed the resident and then placed the resident in bed but on top of the sheets. The RP arrived the next day at 12 noon. The resident was still on top of the bedsheets and still dressed in the clothes from the day before. Bed sheets were folded under the resident and the resident's catheter bag was full. The RP asked the nurse about being dressed in the same clothes, but she did not know for sure since she had not worked the day before. RP asked the Geriatric Nursing Assistant (GNA) who had worked the day before. She said the resident was dressed like this when she started the day, and the resident was on top of the bed laying on the bedsheets. RP said the resident was wearing the same clothes as the day before and had not been changed for 23 hours. RP also said the resident's brief was cold and urine soaked.</p> <p>The facility submitted the initial report to the Office of Healthcare Quality (OHCQ) on 10/1/23 which was the day the RP reported it, but the final report was not sent until 10/23/23. The final investigation needed to have been reported within 5 days.</p> <p>The Unit Manager (#15) was interviewed on 8/15/24 at 1:43 PM. She said the GNA assumed the 11-7 shift changed the resident and left him/her in bed. The GNA was unaware that 2 shifts had gone by after RP changed him/her into the clothes and place him/her in bed. RP told her of the incident after he went straight to the Administrator and the Director of Nursing (DON). She said she was left out of the loop but there have been no incidents since this one.</p> <p>The DON and Administrator were interviewed on 8/16/24 at 1:20 PM. This surveyor went over the incident and expressed concern regarding the failure of staff to place the resident in bed and then change him/her into clean clothes. The Administrator and the DON said they understood the findings and would review.</p> <p>49815</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 8/14/2024 at 7:30 AM the surveyor reviewed the facility investigation file for the Facility Reported Incident (FRI) dated and timed for 8/14/2023 2:38 PM (initial self-report) and 8/21/2023 11:33 AM (final self-report) for Resident #136. Review of this investigation file revealed that Resident #136 reported initially missing \$100, and then changed to missing \$160. In this facility investigation file, there were 6 employee interviews documented on employee statement forms that were conducted on these dates: 11/19/2023, 11/20/2023 and 11/22/2023; a copy of a check dated 8/30/2023 for \$160, pay to the order of Resident #136; a copy of two check requests, one dated 8/22/2023 for \$160 and one dated 11/22/2023 for \$110; and a copy of emails dated and timed for 8/14/2023 at 3:16 PM and 8/22/2023 at 11:37 AM that the Nursing Home Administrator (NHA) sent to the Office of Health Care Quality (OHCQ) with the initial self-report and the final self-report as attachments.</p> <p>Further review of the facility investigation file on 8/14/2024 revealed that the facility had reported the allegation of Resident #136 missing money in August of 2023 to the Office of Health Care Quality (OHCQ), but the facility failed to report the allegation of Resident #136 missing money in November of 2023 to the Office of Health Care Quality (OHCQ).</p> <p>At 10:07 AM on 8/14/2024 the surveyor interviewed the Nursing Home Administrator (NHA) and the NHA confirmed that the facility investigation file that was provided to the surveyor was a complete investigation file for Resident #136 for the allegation of missing money in August of 2023. The surveyor reviewed with the Nursing Home Administrator (NHA) that there were two allegations of missing money for Resident #136 included in this facility investigation file, one from August 2023 and one from November 2023 for Resident #136. The Nursing Home Administrator (NHA) stated that she would have to look into this.</p> <p>In a follow-up interview with the Nursing Home Administrator (NHA) at 1:10 PM on 8/14/2024, the NHA stated that the allegation of the missing money in November of 2023 for Resident #136 was not reported to the Office of Health Care Quality (OHCQ). The Nursing Home Administrator (NHA) further stated during the interview that there was not a complaint form for Resident #136 for the November 2023 allegation of missing money. The Nursing Home Administrator (NHA) provided the surveyor with a copy of a check dated 12/5/2023 in the amount of \$110 pay to the order of Resident #136.</p> <p>Facilities are required to submit an initial first self-report to the Maryland Department of Health - Office of Health Care Quality (OHCQ) for abuse, neglect, injury of unknown origin and misappropriation of resident property within 2 hours if serious bodily harm resulted, all others within 24 hours, and to forward investigation results, final follow-up self-report within 5 business days.</p> <p>The record review on 8/14/2024 of the facility investigation file for Resident #136 further revealed that the allegation of missing money in August of 2023 was not reported to the Office of Health Care Quality (OHCQ) by the Nursing Home Administrator (NHA) in the required time frame. The Nursing Home Administrator (NHA) submitted the initial self-report attached to an email on 8/14/2023 at 3:16 PM to the Office of Health Care Quality (OHCQ), but the final self-report attached to an email was not submitted to the Office of Health Care Quality (OHCQ) until 8/22/2023 at 11:37 AM by the Nursing Home Administrator (NHA).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>49815</p> <p>Based on facility record review and interviews it was determined that the facility failed to ensure that thorough investigations were conducted for alleged violations. This was found to be evident for 2 (Resident #72 and #136) out of 2 Residents reviewed for investigation of alleged violations.</p> <p>The findings include:</p> <p>The surveyor reviewed the facility investigation file for the facility reported incident (FRI) for Resident #72 on 8/13/2024 at 7:45 AM for an allegation of sexual assault. The initial report was submitted by the facility Nursing Home Administrator (NHA) at 11:45 AM on 6/28/2024 to the Maryland Department of Health - Office of Health Care Quality (OHCQ). The final report was submitted by the Nursing Home Administrator (NHA) on 7/2/2024 at 5:25 PM to the Office of Health Care Quality (OHCQ). The Ombudsman, local police department, Responsible Party and Medical Director were notified of the allegation of sexual assault. Resident #72 was transferred to the hospital for further assessment and evaluation.</p> <p>Further review of the facility investigation file for Resident #72 on 8/13/2024 revealed three employee interviews were conducted, and three Resident interviews were conducted which included Resident #72.</p> <p>The surveyors interviewed the Nursing Home Administrator (NHA) and the Director of Nursing (DON) at 1:10 PM on 8/13/2024. The surveyor asked the Nursing Home Administrator (NHA) if the facility investigation file that was provided for Resident #72 was a complete file, and the NHA stated that the investigation file for Resident #72 was a complete file. The surveyor reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) that there was only documentation of three Resident interviews and three employee interviews in the facility investigation file for Resident #72, and that there was no documentation of skin assessments of other residents in the facility. Additionally, the surveyor reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) the expectation for a thorough investigation, with interviews of residents and employees, and completion of skin assessments of other residents in the facility. The Nursing Home Administrator (NHA) stated that she would have to look into this.</p> <p>Follow-up interview with the Nursing Home Administrator (NHA) on 8/13/2024 at 1:30 PM, the NHA stated that there were only three staff that were interviewed because there were only three staff members that worked on the unit where Resident #72 resided. There was no response from the Nursing Home Administrator (NHA) regarding additional interviews of other residents or regarding additional skin assessments of other residents. The Nursing Home Administrator (NHA) did provide the surveyor with a fourth employee interview statement, and an investigation summary report which was a synopsis of the initial and final reports that were sent to the Office of Health Care Quality (OHCQ) by the Nursing Home Administrator (NHA) for Resident #72. This investigation summary report and the fourth employee interview statement was not part of the complete facility investigation file for Resident #72 that was provided by the Nursing Home Administrator, initially.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/14/2024 at 7:30 AM the surveyor conducted a record review of the facility investigation file for the Facility Reported Incident (FRI) from August 2023 for the allegation of missing money for Resident #136. Review of the facility investigation file for Resident #136 revealed that the initial self-report was dated and timed for 8/14/2023 at 2:38 PM and the final self-report was dated and timed for 8/21/2023 at 11:33 AM. Resident #136 reported an allegation of missing money in the amount of \$100 initially, and then changed to missing money in the amount of \$160 in August of 2023.</p> <p>Further review of the facility investigation file for Resident #136 on 8/14/2024 revealed that there was no documentation of resident or employee interviews conducted for this August 2023 allegation of Resident #136's missing money.</p> <p>The surveyor interviewed the Nursing Home Administrator (NHA) on 8/14/2024 at 10:07 AM and the NHA confirmed that this facility investigation file for Resident #136 was a complete file. The surveyor reviewed with the Nursing Home Administrator (NHA) that the facility investigation file did not include any resident or staff interviews for the August 2023 allegation of Resident #136 missing money. The NHA stated that she would have to look into this. The Nursing Home Administrator (NHA) did not provide any documentation of resident or employee interviews for the August 2023 allegation of Resident #136 missing money at the time of survey exit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>14894</p> <p>Based on clinical record review, a review of intake MD00166696, and staff interview it was determined that the facility staff failed to ensure a resident's assessment was accurate. This was evident for 1 (#142) out 52 records as part of the survey sample.</p> <p>The findings include:</p> <p>The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff gathers information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.</p> <p>A review of Resident #142's clinical record on 8/22/24 revealed that a nursing note on 3/24/21 at 2:24 PM said Resident's sister phoned requesting resident's glasses. This author stated that she had never seen the resident wearing eyeglasses or eyeglasses in the resident's room. Nursing was aware at this time that the resident used eyeglasses. Further review revealed that the resident had an MDS completed on 5/21/21. Section B Vision noted the resident had impaired vision but no eyeglasses. An MDS was completed on 8/10/21 and Section B noted the resident's vision was impaired and the resident uses eyeglasses.</p> <p>The Administrator and Director of Nursing were informed at the Exit Conference on 8/22/24 that an MDS was inaccurate.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>14894</p> <p>Based on clinical record review and an investigation of Intake MD00166696 it was determined that the facility staff failed to ensure that a resident wore their eyeglasses. This was evident for 1 (#142) out of 52 residents reviewed as part of the survey sample.</p> <p>The evidence includes:</p> <p>A review of complaint Intake #MD00166696 revealed family was concerned that the resident was not wearing his/her eyeglasses.</p> <p>A review of the clinical record revealed that on 3/24/21 at 2:24 PM nursing wrote: Resident's sister phoned requesting resident's glasses. This author stated that she had never seen resident wearing glasses or glasses in resident's room.</p> <p>The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure that each resident receives the care they need.</p> <p>Review of the resident's clinical record revealed that the resident had an MDS completed on 5/21/21. Section B Vision noted the resident had impaired vision but no eyeglasses. An MDS was completed on 8/10/21 and Section B noted the resident's vision was impaired and the resident uses eyeglasses.</p> <p>There was no evidence that the resident was using their eyeglasses for the first 4 months of their admission.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Green Acres Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10200 LA Plata Road LA Plata, MD 20646	
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)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47758</p> <p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>Based on interview and record review it was determined that the facility staff failed to promptly provide or obtain visit/appointments for routine dental care or treatment. This was found to be evident for 1 (Resident # 49) out of 1 resident reviewed for dental services during an annual survey.</p> <p>The findings include:</p> <p>A record review of Intake # MD00194162 on 08/19/24 at 10:45 AM, Resident # 49's daughter stated that the facility does not provide dental care.</p> <p>During a record review on 08/19/2024 at 1:24 PM, a dental consult was found on Resident # 49's chart completed on 7/20/23 with recommendations for x-rays and possible extractions. No follow up appointments or exams were found on the record.</p> <p>On 8/20/24 at 9:13 AM the 300 Unit Manager was interviewed regarding dental care for Resident # 49. She stated that Resident # 49 was part of the dental consult program, and she would investigate and let the surveyor know if he had received dental care. The surveyor was provided with a copy of the dental consult.</p> <p>During an interview with the Director of Nursing (DON) and the Administrator on 08/20/2024 at 10:48 AM, the DON was asked if they were able to provide further documentation regarding dental care and she stated she was unable to provide additional information.</p>		