STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215106	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Nursing and Rehab	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an investigation into a complaint, record review, and staff interviews, it was determined that the facility failed to ensure a resident remained free from abuse. This deficient practice was evident for 1 (Resident #5) of 5 residents reviewed for abuse during the complaint survey.The findings include:According to CMS, the Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.The Brief Interview for Mental Status (BIMS) is a screening tool used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur. A series of standardized questions in the BIMS are scored and when added result in a total score between 0-15. The numeric value falls into one of three cognitive categories: Intact which is 13 to 15 points, Moderate which is 8 to 12 points or Severe cognitive impairment which is 0 to 7 points.A review of complaint intake #2977399 on 5/13/2026 revealed concerns related to an alleged incident of resident-to-resident sexual abuse that reportedly occurred on 3/15/2026 involving Residents #5 and #8.A review of the facility's timeline of events and investigative documentation on 5/13/2026 at approximately 1:00 PM revealed the following: On 3/15/2026 at approximately 5:20 PM, while delivering meal trays, CMA #16 observed Resident #8 in Resident #5's room with their pants pulled down to thigh level exposing their genitals while Resident #5 was in bed. Facility investigative documentation further revealed CMA #7 reported observing Resident #8 rubbing Resident #5's stomach underneath the blanket.A review of Resident #5's clinical record revealed diagnoses including Dementia, Anxiety Disorder, Difficulty Walking, Generalized Muscle Weakness, and Need for Assistance with Personal Care. Review of Resident #5's admission MDS assessment dated [DATE] revealed a BIMS score of 0. Facility documentation revealed Resident #5 was unable to provide responses regarding the incident.A review of Resident #8's clinical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Dementia, Psychotic Disturbance, Anxiety, Cerebral Infarction, and Amnesia. Further review confirmed Resident #8 was an emergency discharge from the facility on 3/17/2026 following the 3/15/2026 incident.On 5/13/2026 at 12:51 PM, during an interview, the local Ombudsman stated the facility had prior awareness of concerns related to Resident #8's sexual behaviors before the 3/15/2026 incident. The Ombudsman stated that on 3/17/2026 she received email notification of Resident # 8's emergency discharge from the facility following the incident on 3/15/26. The email titled Emergency Discharge Documentation included three attachments: the emergency discharge letter, incident summary and the facility's timeline of events. Review of the the timeline included an investigation background that indicated the facility was contacted by a public defender on 8/5/2025 regarding concerns about whether the facility was equipped to manage Resident #8. The public defender did not provide further details about the legal matter and instructed the facility to contact Resident #8's Resident Representative (RP) for more information. On 08/05/2025, the facility contacted Resident #8's RP to request more information. On 08/07/2025, Resident #8's RP returned (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	the call and stated that in August 2023, s/he was contacted by Resident #8's previous facility with an allegation that Resident #8 had been involved in an inappropriate sexual act. The Ombudsman provided copies of the documentation to the surveyor for review.Further review of the facility's investigative documentation revealed the facility became aware in August 2025 of prior allegations involving inappropriate sexual behavior related to Resident #8 at a previous facility. The facility's investigative documentation further confirmed the information obtained during the Ombudsman's interview.A review of Resident #8's care plan on 5/13/2026 at 2:09 PM revealed a care plan related to sexually inappropriate behavior was initiated on 3/16/2026 following the incident. Prior to the incident, there was no documented care plan related to sexually inappropriate behavior, increased supervision, monitoring related to sexual behaviors, or interventions related to Resident #8 entering other residents' rooms without permission.Continued review of Resident #8's clinical record revealed a nursing progress note dated 3/9/2026 documented Resident #8 entered other residents' rooms without permission and required staff redirection.On 5/13/2026 at 3:15 PM, during an interview, the Administrator stated that facility was aware of prior concerns related to Resident #8's sexual behaviors before the 3/15/2026 incident. The Administrator further confirmed there were no additional monitoring or supervision interventions in place related to sexual behaviors prior to the incident because Resident #8 had not displayed sexual behaviors in the facility before 3/15/2026.On 5/13/2026 at 3:32 PM, during an interview, the Director of Nursing (DON) confirmed Resident #8's genitalia was exposed during the incident and confirmed interventions related to sexually inappropriate behavior were initiated following the incident.On 5/15/2026 at 11:18 AM, during an interview, CMA #7 confirmed observing Resident #8 in Resident #5's room with their pants pulled down, exposing genitalia, while Resident #5 was in bed. CMA #16 further stated Resident #8's hand was underneath Resident #5's blanket on their stomach.A subsequent review of Resident #5's clinical record did not reveal evidence that Resident #5 displayed any emotional or behavior changes related to the 3/15/2026 incident.On 05/15/2026 1:42 PM, during an interview, Resident #5's RP stated I can't say. I know s/he is mouthy when asked how Resident #5 would have responded to the incident prior to his/her dementia diagnosis. The RP further stated Resident #5 was not modest at all prior to his/her dementia. When the surveyor asked how Resident #5 would have responded to unwanted physical contact, the RP stated Resident #5 would not have wanted to be touched. The RP further stated she had not observed any emotional or behavioral changes in Resident #5 following the incident.The Administrator and Director of Nursing were made aware of the findings at the time of exit conference.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on investigation into a complaint, record review, and staff interviews, it was determined that the facility failed to ensure allegations of abuse were reported to the Office of Health Care Quality (OHCQ) as required. This deficient practice was evident for 1 (Resident #5) of 5 residents reviewed for abuse during the complaint survey. The findings include:A review of complaint intake #2977399 on 5/13/2026 revealed concerns related to an alleged incident of resident-to-resident sexual abuse that reportedly occurred on 3/15/2026 involving two dementia residents, Residents #5 and #8.Further review of the facility's internal investigation documentation revealed the facility contacted local law enforcement regarding the incident and a police report was generated.On 5/13/2026 at 3:15 PM, during an interview, the Administrator confirmed the incident was not reported to OHCQ because the facility did not consider the incident reportable based on the information available at the time. The Administrator stated the facility notified law enforcement because Resident #8's genitalia was exposed during the incident and just to be on the safe side.On 5/13/2026 at 3:32 PM, during an interview, the Director of Nursing (DON) confirmed the facility did not report the 3/15/2026 incident to OHCQ at the time of occurrence.On 5/14/2026, during a follow-up interview with the Administrator, it was revealed that the facility submitted a Facility Reported Incident (FRI) related to the 3/15/2026 incident to OHCQ on 5/13/2026 at 11:23 PM following surveyor inquiry during the complaint investigation.The findings were discussed with the Administrator and DON during the exit conference.