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	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Nursing and Rehab	10200 LA Plata Road LA Plata, MD 20646

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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 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. 42783 Based on observation and interviews it was determined the facility failed to respect the resident's dignity as evidenced by the resident meal tray taken away before the meal was finished. This was evident for 1 out of 1 resident (resident #50) reviewed for dignity. The findings include: During an observation conducted on 08/06/2024 at 07:51 AM, this surveyor observed Resident #50 in bed with an empty cold cereal cup on the tray table and a breakfast casserole that sat directly on top of the tray table. This surveyor asked the resident if he/she had a plate that the food was on, the resident stated yes, they took his/her plate and left the resident with casserole. On 08/06/2024 at 07:53 AM an interview was conducted with Licensed Practical Nurse (LPN) #5. During the interview the LPN asked Resident #50 if he/she was done with the breakfast casserole. The Resident stated yes, and the LPN removed the breakfast casserole off the tray table with a napkin. The LPN further stated that she would find out who the Geriatric Nurse Assistant (GNA) was that removed the resident's meal tray and speak to them. During an interview conducted 08/14/24 11:05 AM, this surveyor advised the Nursing Home Administrator (NHA) of the observation. The NHA stated she would find out who the GNA was and investigate. On 08/16/2024 at 11:12 AM the NHA provided this surveyor a copy of a Grievance/Complaint form. The summary of pertinent findings section stated: GNA caring for [Resident's name] on above date states when she removed breakfast tray from the room resident had the breakfast casserole in [resident's gender] hand feeding [gender self]. The section Resolution of Grievance/Complaint had a box checked off for Yes, describe resolution for was grievance/complaint resolved. The section had a statement that read Resident stated [resident's gender] was okay [resident's gender] likes to hold [resident's gender] plates/bowls close to [resident's gender] mouth sometimes when [resident's gender] eats. However, the resident plate and meal tray was removed from the resident although the resident had not finished the breakfast casserole.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 14894 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. The findings include: 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. A review of the electronic health record revealed the last documented shower was on 9/19/23. 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. 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. 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. 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.

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47758 Based on observation and interviews it was determined the facility staff failed to have the most recent survey results in a place readily accessible to residents, family members, and legal representatives of residents. This has the potential to affect all the residents and visitors within the facility. The findings include: The survey team searched in the lobby on 08/06/24 at 08:07 AM for the survey binder. No signage was visible, and no binder was found in the lobby. On 08/06/24 at 09:03 AM, the surveyor asked Receptionist #12 for the location of the survey binder. No signage was visible. She stated she had not seen it we should ask the Director of Nursing (DON). The DON, the Human Resources Director, and Receptionist #12, commenced a search for the binder in the lobby. The surveyor requested to see the binder if it was located. The survey binder was provided to the surveyors on 08/06/24 at 09:13 AM by the DON. The DON stated it had been on the table in the lobby, but someone had moved it. When told that the surveyors had looked there when they arrived, and it was not there she said someone had been looking at it and just brought it back. She further stated that it was kept at the reception desk. On 08/06/24 at 10:20 AM, Receptionist #12 had the binder available behind the reception desk. When asked about signage she pointed to a new sign posted by the front desk stating that the survey binder was available from the Receptionist. The Receptionist confirmed that the sign was newly posted. Upon entrance to the facility on [DATE] at 07:17 AM, the surveyor noted signage stating the binder was available from the Receptionist but there was no receptionist on duty. Receptionist hours are 8A to 8P. On 08/09/24 at 08:46 AM, the surveyor observed new signage in the lobby on the desk stating that the survey binder located beneath the TV on the table in the lobby. The survey binder was observed resting on the table under the TV in the lobby. At 8:10 AM on 8/9/24 the surveyor reviewed the survey binder in the front lobby and did not find any Life Safety Inspections or local fire department inspections in the binder. At 8:30 AM, the surveyor interviewed the Nursing Home Administrator (NHA). The surveyor requested from the NHA any local fire department inspections and any Life Safety Inspections. The NHA stated that since she has been here there has not been any of those inspections and that she would check with her Maintenance Director for inspections as he keeps these types of inspections. The surveyor observed that there was a new survey binder sitting on the table under the TV on 08/21/2024 at 11:13 AM.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 14894 Based on clinical record review and staff interview it was determined that the facility staff failed to ensure a resident had an Advance Directive or was offered the opportunity to create one. This was evident for 5 residents (#21, #98, # 286, # 287, and # 296) out of 52 in the survey sample. The findings include: 1. A review of Resident #21's clinical record on 8/6/24 revealed the resident did not have a copy of an Advance Directive in either the current electronic health record or the previous record used by the former nursing home company. A progress note dated 7/21/23 listed, Patient states POA [Power of Attorney] is in progress of being completed. No evidence of follow up to this request. The DON and Administrator were interviewed on 8/16/24 at 1:20 PM. They were informed that an Advanced Directive could not be located, and that the resident started the process but there was no follow up. They said they understood the findings and would review the electronic records and speak with the Social Worker. 2. A review of Resident #98's electronic clinical record on 8/8/24 at 10:00 AM revealed there was not an Advance Directive located there. A progress note on 1/3/23 stated that the resident requested one at admission but the facility did not follow up. The Social Worker was interviewed on 8/9/24. She confirmed that there was not an Advance Directive in the chart, but the resident was offered one at admission. The DON and Administrator were interviewed on 8/16/24 at 1:42 PM. They were informed that an Advanced Directive could not be located, and that the resident started the process but there was no follow up. They said they understood the findings and would review the electronic records and speak with the Social Worker. 47758 During a record review on 08/08/24 at 08:10 AM, the surveyor was unable to locate Advanced Directives on the charts of Residents # 286, # 287, and # 296. The facility was asked to provide documentation that Advanced Directives were offered to the residents. An interview was conducted with Social Worker (SW) #6 on 08/09/24 at 09:40 AM. SW #6 stated she did not see where advanced directives were offered to Residents # 286, # 287, and # 296. She stated the process is that we offer to the Resident or Responsible Party (RP) if a resident is not able to make decisions. If a family member stated they had Advanced Directives, I ask them to bring them in and, follow up in about a week if I don't receive them. I document this in the Interdisplinary Team (IDT) note or social services note. I did not find documentation for Residents # 286, #287, and # 296. The Director of Nursing further stated that the facility was working on the Advance Directives process.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 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. The finding include: 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: 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. 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. 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. 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. 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. 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. 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.

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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. 14894 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. The findings include: 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. 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. 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. 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. 49815 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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). 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. 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. 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. 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).

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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. 49815 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. The findings include: 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. 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. 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48393 Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure the local Ombudsman was notified of a facility initiated resident discharge or transfer. This was evident for 2 (#19 and #108) of 7 residents reviewed for hospitalization s during the annual survey. The findings include: 1. On 08/13/24 at 12:55 PM, a review of Resident # 19's clinical record revealed that Resident #19 was transferred to the hospital for treatment and further evaluation of his/her medical needs on 1/15/2024. Further review of Resident #19's clinical record revealed no documentation that the local ombudsman was notified of the hospital transfer. On 08/15/24 at 01:25 PM, an interview conducted with Social Work Director #6 revealed that the Ombudsman is sent a monthly transfer log by email. The Social Work Director #6 stated that prior to February 2024, she was not responsible for sending the transfer notices to the Ombudsman and that it was being done by the previous DON. The Social Work Director #6 further stated that some transfer notices to the Ombudsman may have been missed since she started sending them out in February 2024. On 8/15/24 at 2:25 PM, an interview conducted with the Nursing Home Administrator (NHA) revealed that she was not able to locate any evidence that the transfer notice was provided to the Ombudsman for the hospital transfer on 01/15/2024. At the time of the exit conference, the facility did not provide any evidence that the transfer notice was provided to the Ombudsman for the hospital transfer on 01/15/2024. 2. On 8/15/24 at 1:34 PM, a review of Resident #108's clinical record revealed that Resident #108 was transferred to the hospital for treatment and further evaluation of his/her medical needs on 6/7/2024. Further review of Resident #108's clinical record revealed no documentation that the local ombudsman was notified of the hospital transfer. On 08/15/24 at 01:25 PM, an interview conducted with Social Work Director #6 revealed that the Ombudsman is sent a monthly transfer log by email. The Social Work Director #6 stated that prior to February 2024, she was not responsible for sending transfer notices to the Ombudsman and that it was being done by the previous DON. The Social Work Director #6 further stated that some transfer notices to the Ombudsman may have been missed since she started sending them out in February 2024. On 08/15/24 at 2:25 PM, an interview conducted with the Nursing Home Administrator (NHA) revealed that she was not able to locate any evidence that the transfer notice was provided to the Ombudsman for hospital transfer on 06/07/24. At the time of the survey exit conference, the facility did not provide any evidence that the transfer notice was provided to the Ombudsman for the hospital transfer on 06/07/24.

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	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 14894 Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a bed hold policy was provided to the resident upon hospitalization . This was evident for 1 (#88) out of 52 residents that were part of the survey sample. The findings include: A review of Resident #88's clinical record on 8/12/24 revealed that the resident was sent to the hospital on 7/30/24. A transfer form was found but no evidence that a bed hold policy was provided to the resident and/or their Responsible Party, if appropriate, was found. The Director of Nursing (DON) and the Administrator were interviewed on 8/16/24 at 1:30 PM. This surveyor presented the finding to them, and they said they understood the need for the bed hold policy to be sent. They said they would review the electronic health records for any evidence it had been provided.

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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. 14894 Based on resident interview, clinical record review and staff interview it was determined that the facility staff failed to ensure that the resident had care plan meetings. This was evident for 2 (#4 and #21) out of 52 residents that were part of the survey sample. The findings include: 1. Resident #4 was interviewed on 8/6/24 at 9:16 AM. The Resident stated not having a care plan meeting since admission. A review of the resident's clinical record suggested a care plan meeting may have been held on 2/14/24. A sign-in sheet and/or other evidence of a meeting where the resident was invited could not be found. A second care plan meeting should have been held 90 days later in May but evidence of that was also not present. The Administrator and Director of Nursing were interviewed on 8/16/24 at 1:28 PM. The finding was presented. They acknowledged the importance of care plan meetings as well as the need to invite a resident. They said they would review the clinical records. Evidence of care plan meetings was not presented to the team prior to the survey exit. 2. Resident #21 was interviewed on 8/6/24 at 11:31 AM. The resident said the facility normally had care plan meetings every 3 months but has not had one for them in 2024. A review of Resident #21's clinical record revealed that the facility had a care plan meeting for the resident on 1/31/24 but the only staff in attendance were from Activities and from the Social Service Department. The care plan section of the clinical record included a date of 5/1/24 for a meeting but noted it as, in progress and it was not clear that a meeting was held. The Administrator and the Director of Nursing were interviewed on 8/16/24 at 1:25 PM. The finding was discussed, and they said they would search through the electronic health records for evidence of care plan meetings.

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	215106	A. Building B. Wing	08/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42783 Based on record review and interview it was determined that the facility failed to ensure that a Resident received care in a timely manner. This was found to be evident for 1 (Resident #57) out of 1 Resident reviewed for Quality of Care during the recertification survey. The findings include: On 08/16/2024 at 8:43 AM a review of the Facility's Reported Incident (FRI) investigation was conducted. The investigation revealed that Resident #57 had notified Licensed Practical Nurse (LPN) #31 that he/she had pain in his/her right arm. According to the investigation the physician was notified, a new order for an X-ray of the right arm was obtained, and Tylenol was administered. However, the facility staff failed to place the order for Resident #57 to receive an X-ray for 3 days. The resident received the Xray of the right arm on 08/23/2023 although the order for an Xray was obtained on 08/20/2023. The Xray showed the resident had a fracture of the right proximal humerus. The resident was sent to the emergency per physician orders after the result of the Xray. During an interview conducted on 08/16/2024 at 9:10 AM, the Unit Manager #15 stated that the facility's expectation is for the nurse who obtained the order to follow through and place the order. The Unit Manager stated that she recalled the incident and stated that staff were educated on following physician orders.

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	215106	A. Building B. Wing	08/22/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 14894 Based on resident interview, staff interview, observation, and clinical record review it was determined that the facility staff failed to ensure a resident wore an ordered brace. This was evident for 1 (#73) out of 3 residents reviewed for range of motion in the survey sample. The findings include: Resident #73 was interviewed on 8/8/24 at 9:31 AM. Resident #73 was asked about the brace on the bedside table. The resident replied that not all staff put the brace on the arm. There was a sign on the wall above the bed observed to say that the brace should be put on after morning care. Interviewed the resident on 8/16/24 at 11:40 AM. Resident was in the dining room sitting at a table with a glass of water. The resident did not have the brace on. I asked him/her if he/she had it on earlier and he/she replied no. I asked if it was his/her choice not to have it on. The resident replied no, some put it on and some don't. I'm tired of complaining so I accept it. The Administrator and Director of Nursing were interviewed on 8/16/24 at 1:40 PM. This surveyor informed them of the interviews and observations. They said they would speak with the nurses and possibly the resident. Observed the resident on 8/21/24 at 12:35 PM attempting to eat lunch without the brace on. Told the Geriatric Nursing Assistant (GNA) (Staff #32) who proceeded to retrieve the brace from the resident's room and put it on the resident.

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	215106	A. Building B. Wing	08/22/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 14894 Based on clinical record review, observation and staff interview, it was determined that the facility staff failed to ensure that additional water ordered for flushes via gastrostomy tube (G-tube) was administered according to the prescriber's orders and notify the physician of a change in the color of the tubing. This was evident for 2 (Resident #6, #73) of 4 residents reviewed for tube feeding during the annual survey. The findings include: 1. A feeding tube is a device to administer nutrition to a person who cannot safely take food by mouth. A review of Resident #73's clinical record revealed that on 6/29/24 a nursing note read Patient's gtube [gastrostomy tube] is black in color. I am a bit concern[ed] of infection. I recommend tube change. The Unit Manager (Staff #15) was interviewed on 8/16/24 at 8:47 AM. She confirmed the resident had a g-tube and that it was not being used so it was not changed. Once shown the specific note she replied: Okay, I see it. I don't have an answer, but I'll look into it and get you one. Staff #15 was interviewed on 8/16/24 at 11:16 AM. She stated that the resident had it upon admission and that he/she only needed it for 1 or 2 medications. One of which was Ferrous Sulfate which is why the tube was black. The nurse who wrote the note was an agency nurse, and she did not tell anyone or call the doctor. The doctor ordered a gastro-intestinal (GI) consult which was scheduled for September. The Administrator and Director of Nursing were interviewed on 8/16/24 at 1:30 PM. They were informed of the findings, and they said they would review the electronic health record and speak with the Unit Manager. 48393 2. On 08/16/24 at 8:02 AM, a clinical record review revealed that Resident #78 had a feeding tube for nutritional support due to having difficulty swallowing. On 08/16/24 at 8:55 AM, further review of Resident #78's treatment administration record (TAR) for August 2024 revealed enteral feeding orders that included administering Jevity 1.5 tube feeding, which is calorically dense liquid food, via a pump every 6 hours and to flush the G-tube with 250 ml of water every 4 hours. On 08/16/24 at 11:08 AM, an observation of Resident #78 revealed that he/she was being prepared by Agency Licensed Practical Nurse (LPN) #5 to start his/her bolus tube feeding via pump. It was noted that Agency LPN #5 flushed Resident #78's G-tube with 120 ml of water without verifying Resident #78's water flush orders. (continued on next page)

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	215106	A. Building B. Wing	08/22/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/24 at 11:26 AM, a follow up interview with Agency LPN #5 confirmed that she did not flush Resident #78's G-tube with 250 ml of water as ordered stating, I flushed Resident #78's G-tube with 120 ml of water. I filled the 60 ml syringe up two times and let the water go down before I started the tube feeding. Agency LPN #5 further stated that she did not review Resident #78's physician orders to verify the correct water flush amount of 250 ml before flushing Resident #78's G-tube. On 08/16/24 at 11:45 AM, the Unit Manager (UM) #8 was interviewed regarding expectations for staff caring for residents with G-tubes. The UM #8 stated, it is my expectation that staff review and follow MD orders prior to starting any feedings, flushes and giving any medications via G-tube. UM #8 further stated, we will do more education on tube feedings. On 08/21/24 at 2:37 PM, the DON provided documentation that on 08/19/2024 Agency LPN #5 received one on one coaching and counseling on tube feedings which included the topics/issues not following guidelines for tube feeding administration and not administering correct hydration amount.

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	215106	A. Building B. Wing	08/22/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47758 Based on observations, review of facility documentation, clinical record review, and staff interview it was determined that the facility failed to maintain oxygen therapy equipment according to facility policy and physician orders. This was found to be evident for 2 (# 62, #286) out of 4 residents reviewed for respiratory care during the annual survey. The findings include: 1. During an observation on 08/06/24 at 08:48 AM, the surveyor observed oxygen in use by Resident #286. There was no label or date on the oxygen tubing or humidifier bottle. On 08/07/2023 at 08:05 AM, the surveyor observed the oxygen lying on the floor by Resident #286. There was no label or date on the oxygen tubing or humidifier bottle. During an interview conducted on 08/07/24 12:35 PM, the 300 Unit Manager was asked if she could find a label and date on the oxygen tubing. The Unit Manager confirmed that there was no label or date on the oxygen tubing or humidifier bottle. When asked about the facility policy, she stated that oxygen tubing is changed, labeled, and dated every Sunday. I will get new tubing and educate staff. On 08/07/24 at 12:38 PM, the surveyor interviewed the Director of Nursing (DON) about the concern of the oxygen tubing not being labeled. The DON stated that the tubing is changed on Sundays and since the resident just came in the tubing hadn't been labeled yet and staff would be educated. 48393 2. During an observation on 08/08/24 at 08:50 AM, Resident #62's oxygen tubing was not labeled and the humidification bottle was dated 08/04/2024. On 08/12/24 at 09:48 AM, review of Resident #62's clinical record revealed the following physician orders: Date 03/26/2024 Oxygen therapy: O2 (oxygen) via NC (nasal cannula) at 2L/min (liters per minute) for shortness of breath every shift. Date 07/28/2024 Oxygen therapy: Change humidification bottle and oxygen tubing weekly on Sunday 11-7 DATE/TIME TO BE ON TUBING AND BOTTLE every night shift every Sun Further review of the August 2024 treatment administration record (TAR) revealed that the humidification bottle and oxygen tubing was changed on following dates: 08/04 and 08/11. Review of the facility Oxygen Administration Policy with effective date 04/01/2024 did not reveal procedures or guidelines on changing and/or dating oxygen tubing and humidification bottles. (continued on next page)

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	215106	A. Building B. Wing	08/22/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second observation on 08/12/24 at 10:38 AM, Resident #62's oxygen tubing was dated 8/12/24, however the oxygen humidification bottle was dated 8/4/2024 and the water level was noted to be very low. On 08/12/24 at 10:49 AM, an interview with Unit Manager (UM) #8 revealed that oxygen tubing and humidification bottles should be changed every Sunday on 11PM -7 AM shift and staff should label the tubing and humidification bottle with the date it was changed. The dates on Resident #62's oxygen tubing and humidification bottle were observed together. UM #8 stated that both the tubing and humidification should have been changed on Sunday on 11-7p shift according to MD orders and said, I will go ahead and change the humidification bottle now. During a follow up interview with the DON on 8/13/24 at 11:50 AM, the DON confirmed that oxygen tubing and humidification bottles are changed every Sunday on 11 PM -7 AM shift and should be dated when changed. The DON further stated that oxygen humification bottles can be changed before Sunday evening if the water level is too low.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 14894 Based on clinical record review and staff interview it was determined that the facility staff failed to administer medications according to physician's orders. This was evident for 1 (#53) of the 5 residents reviewed for unnecessary medications. A review of Resident #53's clinical record on 8/13/24 revealed the resident's primary physician ordered Novolog pen 100 unit/ml 16 units before meals and to be held if blood sugar is less than 150. A review of the resident's Medication Administration Record (MAR) revealed that the resident's blood sugar was below 150 on those days but the insulin was still administered. The blood sugars were 8/1 = 143, 8/3 = 145, 8/5 = 117 and 140, 8/6 = 143, and on 8/9 = 142. This represents 6 times out of 43 opportunities that the resident received insulin when it should have been held. The surveyor interviewed the Administrator and Director of Nursing on 8/16/24 at 1:20 PM. The concerns were presented and the facility said they understood the findings and would review the MAR's.

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	215106	A. Building B. Wing	08/22/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 42783 Based on observation, interview, and medical record review, it was determined that the facility failed to provide dental services and assessments. This was found to be evident for 1 out of 1 resident (Resident #97) reviewed for dental care. The findings include: During a phone interview conducted on 08/07/2024 at 9:39 AM, Resident # 97's family stated that the resident had missing teeth and needed a dental consult. When asked if the concern was brought to the attention of the facility, she stated she was unsure. On 08/07/2024 at 11:07 AM an observation of Resident #97 was conducted. This surveyor observed missing teeth and what appeared to be plaque buildup on the bottom front teeth. During a record review of Resident #97's medical records conducted on 08/13/24 at 07:35 AM did not reveal a dental consult. On 08/13/2024 at 09:07 AM the Director of Nursing (DON) stated during an interview that the facility had not obtained a provider for dental services since the facility changed ownership on 04/01/2024 but would work to obtain dental services. The DON returned and provided this surveyor a letter from a Maryland dental provider through the County Department of Health and stated that dental services would now be provided through that Maryland dental provider.

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	215106	A. Building B. Wing	08/22/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 14894 Based on resident interview, staff interview and observation it was determined that the facility staff failed to ensure a resident's meals matched their preferences. This was evident for 1 out of 52 residents in the survey sample. The findings include: This surveyor observed Resident #73 in the dining room on 8/21/24 at 12:40 PM. The resident waved me over and showed the plate of food. The resident had bread on the plate despite it being listed on the meal slip as a dislike. The resident was interviewed at 12:40 PM. The resident stated that he/she also requested coffee with every meal, but it was not on the tray. Staff #32 was interviewed on 8/21/24 at 12:45 PM. Staff #32 confirmed that the resident does not want bread and wants coffee with every meal. He stated that when it happens it upsets the resident. He said he would take care of it and would ensure resident received a correct plate of food and a cup of coffee.

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	215106	A. Building B. Wing	08/22/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 14894 Based on observation and staff interview it was determined that the facility staff failed to ensure food items in the kitchen were maintained in a safe and appropriate manner. The findings include: During the tour of the kitchen on 8/6/24 at 8:29 AM several slices of salami deli meat were partially wrapped in plastic wrap with the label indicating the bologna was opened on 7//26/24 with a use by date of 8/2/24. There was an opened bag of shredded mozzarella cheese (not in a sealed container), and 2 bags of bologna without dates on the labels. The Food Service Manager was interviewed on 8/6/24 at 8:36 AM. She said the lunchmeat is good for 7 days and that they wrote the wrong date. I asked for clarification -- was she suggesting that the meat was sliced and wrapped on 7/26/24 and should have had a use by date that was 7 days later. She replied that 7 days is correct. The Administrator was interviewed and informed of the findings on 8/16/24 at 12:25 PM. She acknowledged and took note.