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	01/20/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews it was determined the facility failed to store food in accordance with professional standards for food safety and failed to ensure that the facility dishwasher provided safe heat sanitization. The findings include the following: 1. An initial tour of the facility kitchen was completed on 01/14/2026 at 08:05 AM with staff #4 the following items were found to be missing an expiration date on the product: a) One 36 OZ Lemon Meringue Pieb) One large bag of chicken tendersc) Several spice containers of spices d) Several 4 OZ Orange Juice containerse) One platter containing slices of tomatoes and cucumbers f) Two 1-gallon containers of Heavy-Duty Mayonnaise During the tour interview on 01/14/2026 at 08:05 AM with staff #4 he/she confirmed and stated that the above items did not have an expiration date on them, and staff are supposed to label all food items with an expiration date. During interview on 01/14/2026 at 8:30 AM staff #5 stated that all food items are to be labeled by staff with delivery and/or expiration date upon being received. 2. During observation rounds on 01/14/2026 at 12:20 PM with staff #6 the facility High Temperature Dishwasher (heat sanitization) monitor device was flashing a warning screen indicating that the wash temperature was low and reading 128.4F. Staff #6 verified this reading and stated that he/she would call and have this fixed. During an interview on 01/14/2026 at 12:45 PM with staff #5 stated that the facility was going to use paper products for all meals until the dishwasher was fixed. After surveyor intervention, during interview and review of facility documentation on 01/15/2026 at 12:00 PM staff #1 provided a invoice indicating that the facility dishwasher was serviced and fixed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview during facility environmental observations, it was determined that the facility failed to ensure a safe, clean, comfortable, homelike environment. This was evident for 13 (rooms 102, 103, 104, 107, 111, 112, 115, 116, 118, 117, 119, 120, and 122) out of 24 resident rooms observed for Homelike Environment during the annual survey.The findings include: 1. On 01/14/2026 at 8:22 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom there was caulking missing and brown discoloration was present at the base of the toilet. 2. On 01/14/2026 at 8:25 AM the Surveyor observed resident room [ROOM NUMBER], upon entering the bathroom the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area.3. On 01/14/2026 at 8:26 AM the Surveyor observed resident room [ROOM NUMBER], upon entering the bathroom the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area. 4. On 01/14/2026 at 8:36 AM the Surveyor observed resident room [ROOM NUMBER], there were incomplete wall repairs noted to 2 of 3 of the walls within the bathroom with areas of dry spackle present; there were no signs indicating 'work in progress'. Additionally, between Bed A & B the wall area had heavily scuffed and chipped areas to the paint. 5. On 01/14/2026 at 8:45 AM the Surveyor observed in resident room [ROOM NUMBER], within the bathroom there was caulking missing and brown discoloration was present at the base of the toilet; and the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area.6. On 01/14/2026 at 8:57 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom there was missing caulking and brown discoloration was present at the base of the toilet; and the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area.7. On 01/14/2026 9:01 AM the Surveyor observed resident room [ROOM NUMBER], between Bed A & B there were incomplete wall repairs with dry spackle areas and multiple paint colors on the wall. Additionally, within the bathroom, the caulking was missing and brown discoloration was present at the base of the toilet, and the far wall with the toilet paper dispenser had dry spackle repair areas that appeared to be incomplete; there were no signs indicating 'work in progress'.8. On 01/14/2026 at 9:09 AM the Surveyor observed resident room [ROOM NUMBER], upon entering the bathroom the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area.9. On 01/14/2026 at 9:10 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom there were 5 open holes and the outline of a dispenser that was possibly affixed to the wall just adjacent to the mirror, there was no evidence of repairs in progress; the area was left unrepaired. Additionally, there was missing caulking, and brown discoloration was present at the base of the toilet.10. On 01/14/2026 at 9:14 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom the caulking was missing, and brown discoloration was present at the base of the toilet. Additionally, the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area and the far wall with the toilet paper dispenser had an area of dry spackle present near the bottom of the wall where it meets the Cove Base area; there were no signs indicating 'work in progress'.11. On 01/14/2026 at 11:00 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom there was caulking missing and brown discoloration was present at the base of the toilet. Additionally, the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area.12. On 01/14/2026 at 11:02 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom there was caulking missing and brown discoloration was present at the base of the toilet. Additionally, the left wall had scrapes and chipped paint areas to the lower half of the wall just above the Cove base area. Additionally, between Bed A & B the wall area had chipped and lifting areas to the paint.13. On 01/14/2026 at 11:04 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was missing caulking and brown discoloration was present at the base of the toilet. The bathroom floor tiles appeared heavily stained. Additionally, the left wall had an area of dry spackle present scrapes and chipped paint areas near the bottom of the wall where it meets the Cove Base area; there were no signs indicating 'work in progress'.On 01/14/2026 at 11:30 AM during interviews with the LPN Manager staff #22, the Surveyor shared the resident room findings. When asked how do needed repairs or room concerns get reported; staff #22 stated everyone is responsible for speaking about room repair concerns, and the orders are placed in the Maintenance system called TELS.On 01/14/2026 at 12:00 PM during interviews with NHA staff #1, this Surveyor shared the resident room findings. After Surveyor discussion, NHA staff #1 stated the rooms will be reviewed for repairs.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, record review and interview, it was determined that the facility failed to develop and implement a baseline care plan for a resident, requiring patient-centered Dementia Care, that meets the professional standards of quality care. This was evident for 1 (resident #4) out of 7 residents investigated for Care Planning during the annual survey.The findings include:On 01/14/2026 at 9:07 AM during the initial observation, resident #4 was observed in bed and eating breakfast, being fed by GNA #24 while seated. Resident #4 was relaxed, smiling at and able to respond to this Surveyor interaction. Resident #4 denied any discomfort and concerns, yet was unable to answer detailed questions and appeared pleasantly confused.On 01/15/2026 at 11:18 AM during record review it revealed resident #4 had diagnoses of 'UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (F03.90)'. Review of the Minimum Data Set (MDS) Resident Assessment and Care Screening Annual review, dated 12/11/25, revealed a Brief Interview for Mental Stats (BIMS) score of ?0', indicating sever cognitive impairment and no behaviors. Additionally, review of the Quarterly assessment, dated 9/11/25, revealed an impaired cognitive status and no behaviors. However, review of resident #4 Care Plan Report, Baseline initiated, 12/4/24 did not have a patient-centered comprehensive care plan written for Dementia Care.On 01/15/2026 at 2:00 PM during an interview with DON staff #2 and NHA staff #1, the Surveyor shared these findings and reviewed the care plans with the facility; both agreed no Care Plan was present for Dementia care and concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, it was determined that the facility failed to develop and initiate a comprehensive person-centered care plan for residents residing in the facility. This was evident for 1 (resident #4) out of 7 residents investigated for Care Planning during the annual survey.The findings include:On 01/14/2026 at 9:07 AM during the initial observation, resident #4 was observed in bed and eating breakfast, being fed by GNA #24 while seated. Resident #4 was relaxed, smiling at and able to respond to this Surveyor interaction. Resident #4 denied any discomfort and concerns, yet was unable to answer detailed questions and appeared pleasantly confused.On 01/15/2026 at 11:18 AM during record review it revealed resident #4 had diagnoses of 'UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (F03.90)'. Review of the Minimum Data Set (MDS) Resident Assessment and Care Screening Annual review, dated 12/11/25, revealed a Brief Interview for Mental Status (BIMS) score of ?0', indicating severe cognitive impairement and no behaviors. Additionally, review of the Quarterly assessment, dated 9/11/25, revealed an impaired cognitive status and no behaviors. However, review of resident #4 Care Plan Reports, Baseline initiated 12/4/24, revisions initiated 3/1/25 and 5/26/25, and the current plan, initiated 8/22/25, did not have a patient-centered comprehensive care plan written for Dementia Care: demonstrating four missed opportunities to provide Dementia patient-centered care for the resident.On 01/15/2026 at 2:00 PM during an interview with DON staff #2 and NHA staff #1, the Surveyor shared these findings and reviewed the care plans with the facility; both agreed no Care Plan was present for Dementia care and concern.

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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. Based on record reviews and interviews, it was determined that the facility failed to: 1) ensure that each member of the interdisciplinary team was involved in updating the residents' care plans. This was evident for 2 residents (Resident #16 and Resident #65) out of 14 residents reviewed; and 2) develop and implement person-centered care plans with specific, individualized interventions to address residents' diagnosed conditions. This deficient practice was evident for 2 (Residents #10, #109) of 7 residents reviewed.The findings include: 1a) On 01/20/2026 at 10:12 AM, the surveyor reviewed Resident #16's records. The resident record review revealed that the resident had a Care Plan Meeting Attendance Sheet, dated 11/26/25, for a care plan meeting that occurred on 11/26/25. It was documented on the care plan meeting attendance sheet that the following interdisciplinary team members attended the resident's care plan meeting on 11/26/25: Nursling, Dietician, Activities, Social Services, resident's wife via telephone, and Resident #16. According to the Care Plan Meeting Attendance Sheet for the meeting that occurred on 11/26/25, the physician and the nursing aide, who had responsibility for the resident, did not participate in updating Resident #16's care plan on 11/26/25. On 01/20/2026 at 11:27 AM, the surveyor asked the Nursing Home Administrator staff #1 and the Director of Nursing staff #2 for any progress notes from the physician and nurse aide, with responsibility to the resident, about their input on the resident's care plan, since according to the Care Plan Meeting Attendance Sheet dated 11/26/25, they were not in attendance. Staff #1 and staff #2 mentioned that they would check Resident #16's progress notes for documentation communicating the attending physician's and nurse aide's updates to Resident #16's care plan. On 01/20/2026 at approximately 4:35 PM, at the end of the exit conference, the surveyor had not received the copies of the progress notes indicating the physician's and nurse aide's updates to Resident #16's care plan meeting. 1b) During Resident #65's record review on 01/15/2026 at 1:18 PM revealed a Care Plan Meeting Attendance Sheet, dated 12/09/2025, for a care plan meeting that did not include the attendance of the resident's physician and the nursing aide, who has responsibility for Resident #65. During an interview on 01/16/2026 at 1:30 PM staff #1 Nursing Home Administrator and staff #9 verified that the care plan meeting did not occur with physician and the nursing aide, who has responsibility for Resident #65. 2) On 1/15/26 at 1:56 PM, record review revealed that Resident #109's most recent care plan was dated 8/22/25 and had not been reviewed and updated on a quarterly basis. The care plan was due for review three months from that date and had not been updated for approximately five months, failing to reflect the resident's current condition. On 1/15/26 at 2:49 PM, the Director of Nursing (DON) was informed of the overdue quarterly care plan review for Resident #109. 3) On 1/20/26 at 11:38 AM, record review revealed that Resident #10 and Resident #109 both had a diagnosis of dementia; however, their care plans lacked specific, individualized interventions to address cognitive impairment, safety needs, or dementia-related behaviors. At 11:45 AM, the surveyor requested that the DON review the care plans for Residents #10 and #109 to identify and provide individualized, measurable interventions addressing dementia-related needs, including but not limited (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to supervision, redirection, communication approaches, or safety precautions. At 4:27 PM, the concerns regarding the lack of dementia-specific care plan interventions were again discussed during the exit conference. The DON did not provide additional information, documentation, or clarification regarding care plan updates or interventions for either resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review and interview, it was determined that the facility failed to ensure nursing services were provided in accordance with professional standards of practice related to medication preparation and administration. This deficient practice was evident for 1 of 5 residents reviewed (Resident #122) and had the potential to affect resident safety and clinical outcomes.The findings include:On 01/16/26 at 9:35 AM, during observation of a medication pass, Staff #21, a licensed nurse, was observed crushing and preparing divalproex sodium 125 mg delayed-release (DR) for administration to Resident #122. Delayed-release medications are formulated to release medication over time and should not be crushed, as doing so alters the medication's delivery mechanism and may increase the risk of adverse effects. On 01/16/26 at 9:47 AM, during the same medication pass, Staff #21 administered Humalog insulin to Resident #122 via injection into the deltoid region. Insulin is intended for subcutaneous administration at appropriate sites to ensure proper absorption and glycemic control. Administration into the deltoid muscle is inconsistent with accepted nursing practice and may result in altered absorption and unpredictable blood glucose response.On 01/16/26 at 10:40 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the findings. The DON acknowledged the concerns and stated that in-service education would be provided to nursing staff

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, it was determined that the facility failed to document that informed consent was obtained and retained from residents and/or their resident representatives prior to the use of bedrails. This was evident for 6 out of 6 residents observed (Resident #83, #103, # 118, #10, #13 and #14) during the survey conducted at the facility. 1) On 01/14/2026 at 08:25 AM the surveyor observed that the beds in room [ROOM NUMBER] A and B both had 1/4 length bedrails in place on both sides of the bed. The residents, # 83 and # 118 agreed to be interviewed by the surveyor. On 01/15/2026 at 1:30 PM a review of the electronic medical record of both residents #83 and #118 failed to reveal a consent form for bedrail installation. On 01/14/2026 at 08:35 AM the surveyor observed that the bed assigned to resident # 103 had 1/4 length bedrails in place and up on both sides of the bed. A review of the electronic medical record on 01/15/2025 at 2:00 PM failed to reveal a consent form for bedrail installation. On 01/15/2026 at 10:30 AM the surveyor observed during a tour of unit three, that all three residents' beds had 1/4 siderails in place. On 01/15/2025 at 2:50 PM the director of maintenance, staff # 11 stated that the bedrails are attached to bed when the beds arrive at the facility. The last bed rail inspection was completed in October 2025. The director of maintenance, staff #11 stated that he does not fill out a formal form used for each bed railing assessment. On 01/16/2026 at approximately 07:30 AM the surveyor was informed by the Director of Nursing staff #2 that the resident representatives had been contacted by telephone and that approval of the 1/4 siderails were obtained verbally or by email the evening of 01/16/2026. On 01/16/2025 at 1:30 PM staff #2 stated that there are no signed consents for the bed railings currently in any of the resident's charts. The DON was notified that this was considered a potential deficiency. 2) On 01/14/2026 at 9:25 AM, the surveyor observed bedrails in use for Residents #10, #13, and #14 during the initial tour of the nursing unit. On 01/15/2026 at 1:12 PM, the surveyor requested documentation for the bedrails in place for the three residents observed. During an interview with the Nursing Home Administrator staff #1, she stated that maintenance staff installs bed rails when requested and that the documentation would be provided. At 2:56 PM, staff #2 informed the surveyor she was still working on providing the informed consent documentation authorizing the use of bed rails for the residents. On 01/20/2026 at 11:45 AM, the facility was requested to provide informed consent documentation for the use of bed rails for Residents #10, #13, and #14. On 01/20/2026 at 12:11 PM, the facility provided informed consent forms for all three residents, which were dated 01/15/2026, indicating the consents were completed after the bed rails were already in use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, it was determined that the facility failed to ensure medications were properly removed and disposed of when no longer appropriate for use, including after resident discharge and upon expiration. This deficient practice was evident for 2 of 3 medication rooms reviewed.The findings include:On 01/16/2026 at 12:38 PM, during an observation of the Unit 400 medication room, a vancomycin solution labeled for Resident #166 was observed stored in the refrigerator door. During interview at the time of observation, Staff #8 stated she did not believe the resident was still in the facility. At 12:43 PM, review of the electronic medical record revealed Resident #166 had been discharged from the facility on 12/13/2025. The medication had not been removed from the medication refrigerator following the resident's discharge.At 1:22 PM, during an observation of the Unit 100 medication storage room, a medication labeled for Resident #97 was observed stored in the refrigerator. Review of the medication label revealed the medication was expired 04/2025 and had been filled on 09/27/2023.At 1:26 PM, the Director of Nursing (DON) was notified of the above findings. The DON acknowledged the concerns about expired medications and medications for discharged residents kept in the storage rooms and stated the issue would be addressed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation and interview, it was determined that the facility failed to ensure medications were administered in accordance with professional standards of practice, resulting in an overall medication administration error rate of 11.54%. This deficient practice was evident for 3 of 26 medication administrations observed. The findings include:On 01/16/26 at 9:35 AM, during observation of medication administration, Staff #21 was observed crushing divalproex sodium 125 mg delayed-release (DR) and preparing it for administration to Resident #122. Delayed-release medications are not to be crushed due to alteration of the medication's intended release properties.At 9:47 AM, Staff #21 administered Humalog insulin to Resident #122 via injection into the deltoid region, rather than the recommended subcutaneous injection site on the back of the arm, inconsistent with accepted medication administration practices.At 9:52 AM, Staff #21 prepared and attempted to administer medication to Resident #152 immediately after administering medication to Resident #122 without performing hand hygiene between residents.At 10:40 AM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) were informed of the medication error concerns and cumulative medication error rate of 11.54% observed during the medication pass. The DON and NHA stated that in-service education would be conducted immediately with nursing staff.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and interviews, it was determined that the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are accurately documented the resident current medical diagnosis. This was evident for 1 (resident #4) out of 7 residents' Care Plans reviewed during the annual survey.The Findings include:On 01/14/2026 at 9:07 AM during the initial observation, resident #4 was observed in bed and eating breakfast, being fed by GNA #24 while seated. Resident #4 was relaxed, smiling at and able to respond to this Surveyor interaction. Resident #4 denied any discomfort and concerns, yet was unable to answer detailed questions and pleasantly confused.On 01/20/2026 at 11:18 AM during record review it revealed resident #4 has the following diagnosis of: PAROXYSMAL ATRIAL FIBRILLATION (I48.0), CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE (I50.32), ESSENTIAL (PRIMARY) HYPERTENSION (I10), VITAMIN D DEFICIENCY, UNSPECIFIED (E55.9), DEPRESSION, UNSPECIFIED (F32.A), NEURALGIA AND NEURITIS, UNSPECIFIED (M79.2), OTHER HYPERLIPIDEMIA (E78.49), ESSENTIAL TREMOR (G25.0), OTHER CONSTIPATION (K59.09), PRESSURE ULCER OF SACRAL REGION, STAGE 4 (L89.154), UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (F03.90), ANTIPHOSPHOLIPID SYNDROME (D68.61), PRESENCE OF CARDIAC PACEMAKER (Z95.0), CHRONIC EMBOLISM AND THROMBOSIS OF UNSPECIFIED VEIN (I82.91), ANEMIA, UNSPECIFIED (D64.9). However, review of resident Care Plan Report initiated 8/22/25, a Focus entry later added, read: [Resident #4] is prescribed a psychotropic medication (specify medication(s)) for alteration in mood/behavior related to Schizophrenia. Date Initiated: 10/28/2025; despite this resident not having an active diagnosis for Schizophrenia.On 01/20/2026 at 2:00 PM during an interview with DON staff #2, the Surveyor shared these findings and reviewed the care plans with staff #2, who agreed the listed diagnosis was not an active diagnosis for resident #4.

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	01/20/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined that the facility failed to: 1) maintain infection prevention and control by not ensuring a sanitary and comfortable environment within the resident care areas. This was evident for 6 (rooms 101. 102, 108, 119, 121, and 123) out of 24 resident rooms observed; and 2) ensure staff performed appropriate hand hygiene during medication administration, placing residents at risk for cross-contamination. This deficient practice was evident for 1 of 5 medication administration observations.The findings include: 1) On 01/14/2026 at 8:20 AM the Surveyor observed resident room [ROOM NUMBER], the hand sanitizer dispenser on the wall near the door designated for staff use, was empty. On 01/14/2026 at 8:22 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom, a pair of discarded plastic clear gloves were observed on the floor near the rear base of the toilet. On 01/14/2026 at 8:41 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom, a soiled, yellow-stained wash cloth was observed on the floor. On 01/14/2026 at 9:06 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom a stack of open paper towels was observed placed on the safety grab bar attached to the wall, despite an intact paper towel holder mounted on the wall. On 01/14/2026 at 9:14 AM the Surveyor observed resident room [ROOM NUMBER], within the bathroom the soap dispenser was empty. On 01/14/2026 at 9:15 AM the Surveyor observed resident room [ROOM NUMBER], within the, a pair of discarded plastic clear gloves were observed on the floor near the base of the toilet. On 01/14/2026 at 11:30 AM during interviews with the LPN Manager staff #22, the Surveyor shared the resident room findings. When asked, was this the expectation of discarding items or maintaining a clean environment, staff #22 stated 'No'. 2) On 01/16/26 at 9:52 AM, during observation of medication administration, Staff #21 prepared and attempted to administer medication to Resident #152 immediately after giving an insulin injection to Resident #122 without performing hand hygiene between residents. The surveyor intervened prior to the medication being administered to Resident #152. The prepared medication was disposed of, and Staff #21 performed hand hygiene before continuing the medication pass. On 1/16/26 at 10:40 AM, the Director of Nursing staff #2 and the Nursing Home Administrator staff #1) were informed of the infection control concerns related to failure to perform hand hygiene between residents during medication administration. Staff #2 stated that there would be in-service training performed in response to the observations.

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	01/20/2026

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post required nurse staffing ratio information in a visible and accessible location on resident units. This deficient practice was evident for 3 of 4 units reviewed (Units 100, 200, and 300) during the recertification survey.The findings include:On 1/14/26 at 7:56 AM, during the initial tour of the facility for the recertification survey, observation revealed that Unit 200 did not have nurse staffing ratio information posted on the unit. Additionally, on the secured side of Unit 200, there was no visible staffing board, and residents in the secured area were unable to see any nurse staffing information. At 9:17 AM, observation of Unit 100 revealed that the nurse staffing ratio was not posted on the unit's staffing board.On 1/15/26, observations were conducted on multiple units and revealed the following:At 8:38 AM, no nurse staffing ratio was posted on the staffing board on Unit 200.At 8:42 AM, no nurse staffing ratio was posted on the staffing board on Unit 300.At 8:44 AM, no nurse staffing ratio was posted on the staffing board on Unit 100.At 9:47 AM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) accompanied the surveyor to the units. During the tour, the DON stated that the nurse staffing ratio was located on a separate paper posted on a bulletin board further down the hallway on Unit 100. Observation of the referenced document revealed that the sheet was not filled out. During the same tour, concerns were discussed regarding the lack of visibility and accessibility of the staffing ratio information for residents. It was further observed that Unit 200 did not have a staffing ratio sheet posted at all. Additionally, concerns were discussed that residents located in the secured area within Unit 200 were unable to view the staffing board. The current staffing board was only visible through a small window in the door of the secured area and the distance made it difficult to read. The NHA stated that a staffing board would be installed for the secured area.