STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Monroe Manor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 236 West Claiborne Street Monroeville, AL 36460	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview, record review, review of the facility's Director of Nursing's (DON) Job Description, and review of the facility's Administrator's Job Description, the facility failed to be administered in a manner that ensured residents attained and maintained their highest practicable physical, mental, and psychosocial well-being. The facility's Administrator and DON failed to identify and/or act on identified failures related to abuse and implementation of their abuse policy. These deficient practices affected four of 29 sampled residents (Resident (R) 44, R86, R21, and R90) reviewed for abuse. R86 was a cognitively intact resident who set relationship boundaries with R41; however, R41 crossed the boundaries and R86 sustained verbal sexual abuse. The facility was aware of and enabled R41 to touch the cognitively impaired residents inappropriately. R44 had been adjudicated and declared to be incapacitated by a judge. Per the Code of Alabama (state law), R44 was a protected person and could not consent to sexual contact; however, the facility assessed and care planned to be able to do so. Additionally, R21 and R90 engaged in physical abuse.Cross Reference F600 and F607.Findings include:Review of the facility's Director of Nursing Services Job Description, modified 05/2003 revealed General Purpose: To plan, organize, develop and direct the overall operation of the Nursing Services Department in accordance with federal.standards and regulations governing the facility, and as may be directed by the Administrator, to ensure that the highest degree of quality of care is maintained at all times.Essential Job Functions: 1A. Administrative Functions. Duties: Plan, develop, organize, implement, evaluate and direct the Nursing Services Department, its programs and activities; develop, maintain and periodically update nursing policies, procedures.B. Nursing Care Functions. Duties: .monitor residents' treatment and medications to ensure residents are receiving proper care, review nurses' notes to ensure proper documentation is maintained related to residents' treatment, medications and conditions.E. Residents' Rights Function. Duties: .know and comply with and ensure that all nursing services personnel know and comply with Residents' Rights.monitor nursing services to ensure that residents' rights and needs are met.During an interview on 04/12/2026 at 10:23 PM, the Director of Nursing (DON) stated it was his/her expectation the abuse policy would have met all federal requirements. Review of the Facility Administrator Job Description, modified 05/2003 revealed General Purpose: The position of the Facility Administrator is responsible for the overall management and daily operations of the facility. To plan and direct the operations of the facility to ensure quality and appropriateness of resident/patient care meets or exceeds the company and regulatory standards. Responsible to ensure the well-being and good health of each resident and to ensure compliance with applicable federal.standards and regulations governing the facility.Specific Job Duties: Direct and facilitate activities and departmental meetings.Monitor and directs execution of policies and procedures and needed procedural changes.Essential Job Functions: A. Administrative Functions. Duties: Planning developing, organizing, implementing, evaluating, maintaining, monitoring, supervising, and directing all administrative procedures.C. Residents' Rights Functions. Duties: .treat Residents with kindness, dignity and respect.During an interview on 04/12/2026 at 12:37 PM, the Former Director of Nursing (FDON) stated R41 would try to initiate a relationship with any new resident who was admitted to the facility. FDON stated a lot of facility staff had concerns with R41's relationship with R44 and R87. (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FDON stated she brought these concerns up more than once during the facility's morning meetings and she had even brought it to the attention of the corporate leadership staff and it was brought to the attention of the owner of the facility in the presence of the Administrator. The FDON further stated she wanted to report sexual abuse; however, she was directed not to by the administrator and corporate superiors. The FDON stated it was concerning when the nursing staff would repeatedly report to her that they witnessed R44 being touched by R41 in sexual ways and areas such as hugging, kissing on the mouth, R41 touching R44's breast, inner thighs, in a very affectionate way. The FDON stated corporate leadership advised the facility to care plan the residents to be able to engage in sexual touching. The FDON stated R44 was repeatedly being redirected not to have the doors closed nor to be in the room alone with the female residents. During an interview on 04/12/2026 at 11:49 PM, when asking what his expectations were related to the survey teams identified areas of concerns, the Administrator stated the questions were redundant and his expectation was that all code requirements were met.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, record review, and review of the facility's abuse policies, the facility failed to ensure residents were free from abuse perpetrated by other residents. Specifically:(1) The facility failed to ensure Resident (R)86 was free from verbal abuse perpetrated when R41 put both his/her hands on both of his/her face cheeks and stated to him/her, I want to f*** you so bad.(2) The facility failed to assess R87, a cognitively impaired resident, for his/her capacity to consent before developing a care plan for resident's desire to engage in sexual expression.(3) The facility failed to ensure R44 was free from sexual abuse following an assessment of his/her capacity to consent to sexual contact using a facility assessment questionnaire that indicated R44 did not have the capacity to consent. Multiple staff reported observing kissing and touching between R41 and R44 including touching of his/her chest/breast area and inner thighs. Facility staff had inconsistent understanding of sexual abuse and inconsistent knowledge of the level of supervision required to ensure R44's safety. In addition staff reported that R41 was in R44's room unsupervised.The facility further failed to ensure R21, R90, and R15 were free from physical abuse perpetrated by other residents.The failure affected six of eight residents sampled and investigated for abuse.Findings Include: Cross-Reference F607 On [DATE] the State Agency received an anonymous third-party complaint alleging that R41 engaged in sexual expression with dementia residents of opposite sex as R41. The residents were listed by name as R86, R87, and R44. The complainant further alleged that R41 had been observed by staff touching the residents in their private areas, and that he/she went in the dementia resident's rooms to touch them and closed their doors to further express sexual activities with them when they could not consent to sexual expression. Review of the initial facility's policy titled, Abuse, Neglect and Exploitation, revised [DATE], revealed Each resident of any facility managed by [Name of Facility Corporation] has the right to be free from verbal, sexual, physical or mental abuse, neglect. Review of the facility's policy titled, Determination of Ability to Consent, revised 11/2017, revealed The following procedure will be used in determining of ability to consent: 1). Upon admission and at least quarterly thereafter, the facility will assess the resident's mental status and general decision-making ability. 2. Upon the identification of any flirtatious or affectionate behavior, physical advances, or other sexual contact between a resident and another person, the facility will determine the resident's ability to consent to sexual contact in the following manner: a. The resident will be interviewed by the Social Service Director, Administrator and/or designee to determine the resident's intent. b. The Interdisciplinary Care Plan Team will meet to discuss the resident's sexual behavior, and with the consultation of the resident's attending physician and other health professionals, if deemed appropriate for consultation by the attending physician, will determine whether the resident has the ability to consent to sexual contact. The resident's responsible representative will be encouraged to attend and participate in the care plan meeting. c. The Social Services Director will meet with the resident's responsible representative to discuss the resident's behavior and involve the responsible representative in discussions concerning the resident's care. d. The facility will implement a separate care plan addressing the resident's social/sexual behavior. The care plan will, at a minimum, include whether the resident is capable of consenting and the interventions designed to address social/sexual behavior. e. The interdisciplinary Care Plan team will review the resident's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan for social/sexual behavior quarterly or more frequently if indicated by the resident's behavior or change in status. f. A Social Service note will be entered into the clinical record regarding findings of the assessment of the resident's ability to consent. Review of R41's Resident Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease with late onset, dementia, and adjustment disorder. Review of R41's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the resident's EMR under the RAI [Resident Assessment Instrument] tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The MDS also revealed the facility assessed the resident to be independent with transfers to and from his/her wheelchair to the bed and could self-propel in his/her wheelchair. The facility also assessed the R41 was able to walk 150 feet with supervision or touching assistance. R41's MDS also revealed diagnoses which included Alzheimer's disease and non-Alzheimer's dementia. Review of R41's Care Plan located in the resident's EMR under the RAI tab, revealed Problem.Resident.educated on shaving other resident legs.edited [DATE]. Approach. Redirect resident as needed. Problem Start Date: [DATE]. Resident Desires to engage in sexual expression with another resident. Goal. Resident will have no negative outcome r/t engaging in sexual expression thru next review. Approach. Access [sic] resident for capacity to consent in sexual expression annually and/or if resident has a significant change. Problem Start Date: [DATE].Socially inappropriate/disruptive behavior. Resident makes sexually inappropriate gestures and comments towards staff. Goal. Resident will maintain appropriate behavior x 90 days.Approach.Place resident in area where more direct observation can be provided if possible.Provide privacy for sexual activity. (1) Review of R86's Resident Face Sheet, located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] and discharged from the facility on [DATE] with diagnoses which included Alzheimer's disease and major depressive disorder. Review of R86's Assessment for Capacity to Consent to Sexual Relations, dated [DATE] and located in the resident's hard chart medical record indicated R86 had the capacity to consent to sexual contact and the level of intimacy R86 was comfortable with was holding hands and kissing. The facility developed a Care Plan for R86 on [DATE] and last revised on [DATE] that included .Problem.Problem start date: [DATE].Resident desires to engage in sexual expression with another resident. Goal. Resident will have no negative outcome r/t engaging in sexual expressions thru next review. Edited: [DATE]. Approach. Approach Start Date: [DATE]: Always knock before entering resident's room, even when door is partially open, in order to provide privacy and dignity for resident and sig other. Approach Start Date: [DATE]: Assess resident for capacity to consent in sexual expression annually and/or if resident has a significant change. Approach Start Date: [DATE]. Educate resident if/as needed on safe sexual practices. Approach Start Date: [DATE]. Educate staff on ways to allow for and support resident's decision to engage in sexual expression prn.Approach Start Date: [DATE]. provide privacy sign if needed or requested, encourage resident to use privacy if desired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R86's quarterly MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. During a telephone interview on [DATE] at 11:24 AM, R86 stated he/she was friends with R41 while he/she was a resident of the facility. R86 stated he/she and R41 became friends first and then companions. R86 stated he/she really cared about R41 and that R41 cared about him/her. R86 stated he/she let R41 know upfront that he/she did not want any type of sexual relationship and told R41 he/she did not want him/her to use any nasty words with him/her. R86 also stated they would visit each other in each other's rooms. R86 further stated one night he/she was in R41's room and R41 put both his/her hands on both of his/her face cheeks and stated to him/her, I want to f*** you so bad. R86 stated he/she went cold as ice, and this made him/her feel dirty. R86 stated he/she backed out of R41's room. R86 stated he/she and R41 talked a few times after that, but not in a relationship manner anymore. R86 stated after that, R41 would go down the hall by his/her room repeatedly with the new resident. R86 stated he/she would see them in common areas of the facility, and they would be hugging and kissing, and staff would joke about it. R86 stated R41 never touched him/her inappropriately but he/she knew that he/she did not want any sexual activity and had told him/her not to use the word he/she did. R86 stated he/she was upset and crying for some days after the event. When asked if the SSD or any staff asked what was wrong, he/she stated no, but they probably knew. When asked if the facility had asked her about the relationship ending, would he/she have told them what he/she said to make him/her turn cold as ice, R86 stated yes. (2) Review of R87's Resident Face Sheet located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. The resident expired on [DATE]. Review of R87's quarterly MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R87's significant change in status MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R87's Care Plan located in the resident's EMR under the RAI tab revealed Problem. Problem start date: [DATE]. Resident desires to engage in sexual expression with another resident. Goal.Resident will have no negative outcome r/t engaging in sexual expressions thru next review. Edited: [DATE]. Approach. Approach Start Date: [DATE]. Assess resident for capacity to consent in sexual expression annually and/or if resident has a significant change.Approach Start Date: [DATE]. Educate resident if/as needed on safe sexual practices. Approach Start Date: [DATE]. Educate staff on ways to allow for and support resident's decision to engage in sexual expression prn.Approach Start Date: [DATE]. provide privacy sign if needed or requested, encourage resident to use privacy if desired. During an interview on [DATE] at 11:46 AM, F87 stated he/she was R87's decision maker as he/she could not make decisions for himself/herself. F87 stated when R87 was admitted to the facility, he/she was befriended by R41 on his/her first day at the facility. F87 stated when R87 was admitted on the first day, the facility took him/her to an activity. F87 stated R87 told him/her that he/she had (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a [NAME] and that when he/she arrived to the activity R41 made a B-line to him/her. F87 stated the facility notified him/her that R87 and R41 were getting close and were starting to do some things like hugging, holding hands, and kissing. F87 stated the social worker (SSD) was the person who notified him/her of this but did not go in detail about touching. F87 stated they had a personal sitter in place for R87 in the beginning, and the sitter would also report some of these things such as R41 and R87 touching and kissing. F87 stated he made facility aware of this. F87 stated that R87 reported to F87 that R41 asked him/her to have sex with him/her. F87 stated R87 told R41 that if he/she was going to have sex with anyone it would have been with his/her husband, and that he/she asked R41 to leave his/her room. F87 stated R87 stated to him/her that he/she was scared to go back to the facility because of R41. F87 stated at that time he called the social worker (SSD) at the facility and the social worker told him/her that R41 would be banned from R87's hall. F87 stated R87 still reported that R41 would still bring him/her gifts trying to make up with him/her, but R87 would not. When asked about R87's care plan, F87 stated he/she was disturbed by the care plan, and never was he/she involved, approved, or would he/she have approved of such a care plan. F87 stated at no time did he/she approve for R87 to engage in any type of intimacy. F87 also stated R87 would have nightmares of hearing R41 having sex with a resident across the hall. F87 stated R87 could not make his/her own decisions during his/her stay at the facility and he/she was R87's decision maker. During an interview on [DATE] at 9:37 PM, the Social Services Director (SSD) stated that R87's son did say he wanted door open and that education was provided and re-provided for R41 not to close the door. The SSD was asked if something else should have been implemented to ensure R41 did not close the door, the SSD stated probably so. (3) a) Review of R41's Care Conference Report located in the resident's EMR under Care Plan tab, revealed a note dated [DATE], of . SSD [Social Services Director] discussed concerns regarding report by a female resident r/t [related to] [his/her] [R44] visitation early in am [morning] to [his/her] room. Resident stated that [he/she] will no longer visit early in the am. Review of R41's Resident Progress Note, dated [DATE] and located in the resident's EMR under the Progress Notes tab, revealed Behavior: . Resident continues with behaviors. [He/she] is making negative comments about other residents to [his/her] new friend/resident that [he/she] has befriended and is calling [his/her] new girlfriend. [He/she] is refusing to leave resident room while staff is trying to perform ADL [activities of daily living] care to [him/her] or roommate, staff states resident is cursing at them when they try to redirect them. Review of R41's Resident Progress Note, dated [DATE] and located in the resident's EMR under the Progress Notes tab, revealed Licensed Practical Nurse (LPN) 1 documented R41 had been to a friend's room to visit. Review of R41's Care Conference Report located in the resident's EMR under Care Plan tab, revealed a note dated [DATE], of . IDT [interdisciplinary] team met with Resident with sponsor present via phone . Staff made resident aware that it's okay to be friends, but [he/she] cannot be touching or kissing resident inappropriately. Resident agreed, sponsor reiterated to resident not to be doing anything inappropriate. b) Review of R44's Resident Face Sheet located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Alzheimer's disease, dementia, and mild neurocognitive disorder. Review of R44's admission MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of six out of 15 which indicated the resident was severely cognitively impaired. Review of R44's quarterly MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of seven out of 15 which indicated the resident was severely cognitively impaired. Review of R44's quarterly MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of six out of 15 which indicated the resident was severely cognitively impaired. Review of R44's quarterly MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R44's comprehensive MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R44's Resident Progress Notes located in the resident's EMR under the Progress Notes tab revealed a note, dated [DATE], of SSD reported that staff reported that resident's close male [R41] friend who also is a resident used a razor & dry shaved one of [his/her] legs.This resident stated that it was [his/her] left leg that was shaved. Observation on [DATE] at 4:02 PM revealed R41 and R44 were both in wheelchairs, in the seating room directly off from the facility's entrance. There were no staff in the vicinity of the room where R41 and R44 were sitting. Observation on [DATE] at 4:05 PM revealed R41 and R44 were still in the private area, which could not be visually seen by facility staff. A statement of LPN4, signed and dated [DATE], included that she had seen R41 kiss R44 kiss on the lips and touch R44 on his/her thigh and arms. The statement also included that LPN4 saw R41 kiss R86 and R87. During an interview on [DATE] at 5:05 PM, LPN4 stated R41 was R44's significant other. When asked what the extent was of R44's and R41's relationship, LPN4 stated the residents kissed each other and some touching and to his/her knowledge, that was all R41 and R44 were allowed to physically do. When asked what he/she meant when he/she stated the residents were allowed to touch, LPN4 stated they could touch as long as their clothes were on. During an interview on [DATE] at 5:13 PM, when asked about R44's and R41's relationship and what that looked like, the Restorative Nurse (RNN) stated he/she knew that if R41 was observed stopping at R44s door, staff were to redirect the resident. The RNN stated an incident occurred between R41 and R44 and the facility had to have a special care plan meeting because during activities they were observed hugging and kissing. The RNN could not remember the date or how long it had been since the event happened. During an interview on [DATE] at 5:41 PM, Registered Nurse Unit Manager (RNUM) 2 stated R41 and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44 were supposed to sit in the view of staff when they were together. RNUM2 stated the two residents were not allowed to kiss or touch each other inappropriately. A statement of CNA1, signed and dated [DATE], included that she had seen touching between R41 and R44 on the inner thighs close to their private parts. During an interview on [DATE] at 5:44 PM, Certified Nursing Assistant (CNA) 1 stated she was aware that R44 and R41 had a special relationship. CNA1 stated R41 and R44 were dating. When asked if the residents were ever physical in any way, CNA1 stated R41 and R44 kissed and touched each other. When asked to elaborate on the residents touching each other, CNA1 stated They touch each other in no-no spots. CNA1 further stated no-no spots were private areas like the chest/breast area and inner thighs. CNA1 stated the facility contacted R41's family member and the family member consented to them having this relationship. Continued interview revealed CNA1 had been educated by nursing staff that R41 was supposed to only be outside of R44's door and not inside the room; however, he/she had found R41 in R44's room before. CNA1 also stated he/she has attempted to redirect R41 from R44's room; however, he/she has cussed him/her out and she reported this to LPN4. When asked when this happened, CNA1 stated this happened approximately four months ago and since then when he/she observed R41 in R44's room, he/she did not say anything to R41. CNA1 further stated he/she had not been told anything different as far as what R41 and R44 could or could not do and as far as he/she knew, the residents kissing and touching each other was allowed. During an interview on [DATE] at 5:48 PM, when asked about R41 and R44's relationship, CNA6 stated R41 was not permitted to go into R44's room. CNA6 also stated he/she had caught R41 and R44 kissing and that he/she redirected them when she had caught them. CNA6 stated to his/her knowledge, R41 and R44 did not have to remain in line of sight of staff. During an interview on [DATE] at 5:57 PM, the SSD stated they tried to get R41 to sit where staff were present when he/she was visiting with R44; however, R41 did not always comply with this. The SSD stated she had told R41 multiple times that he/she could not kiss R44 and that he/should remain in staffed areas where staff could see them, and each time R41 agreed that he/she would comply with this. During a subsequent interview on [DATE] at 6:04 PM, LPN4 stated R44 had dementia and the resident's short-term memory came and went. LPN4 stated if someone had a conversation with R44 today, and then asked him/her about it tomorrow, he/she would not remember the conversation. LPN4 stated he/she had seen R41 and R44 kissing, caressing each other's hands, arms, and legs. When asked when he/she had last seen R41 and R44 kissing, LPN4 stated it had been about a week since he/she last seen them kissing. LPN4 stated he/she reported the observation to the SSD, and the SSD told him/her that it was both of the residents' right to kiss. LPN4 confirmed that CNA1 had reported to him/her that when the CNA attempted to redirect R41 from R44's room, R41 cussed at him/her. LPN4 stated after the CNA reported this to him/her, he/she went down to R44's room and had a conversation with R41. LPN4 stated she did not report this event to anyone nor document the event in his/her nursing notes. During an interview on [DATE] at 6:29 PM, when asked what system was in place to ensure R44 was not touched inappropriately when R44 was spending time with R41, the Administrator stated R41 was to stay in staffed areas when he/she was with R44. The Administrator also stated that R44 sought out R41 and that R41 did not have a level of supervision of 1:1 when he/she was with R44. When asked how the facility ensured that a female resident who was not cognitively intact and who had (continued on next page)

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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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

been deemed incapacitated by a court was not touched or kissed by a resident who was fully cognitively intact and care planned to have a sexual interest in the female resident, the Administrator stated staff were to supervise R41 and R44 by visual supervision and rounding.

During an interview on [DATE] at 12:53, Family Member (F) 1 stated he/she was aware that R44 had a boyfriend/girlfriend, they were together all the time. F1 said the facility had let him/her know that R41 tried to shave R44's legs one time. F1 stated he/she did not approve or support any type of sexual contact, and he/she did not want R44 and R41 to be allowed in the same room together. F1 stated R44 was deemed by the courts to be incapacitated, and he/she was appointed R44's guardian and decision maker. As far as he/she knew that was still in effect because he/she had not been told differently.

During an interview on [DATE] at 8:18 PM, when asked if he/she provided primary care services to residents of the facility, the Family Nurse Practitioner (FNP) stated he/she did. When asked about R44 who the facility assessed to have a BIMS of three and had a diagnosis of dementia, if R44 would be able to consent to sexual contact, the FNP stated he/she would find it surprising for R44 or any resident like R44 to have the capacity to consent for sexual contact. The FNP stated he/she was familiar with R44, and he/she would not think the resident would have the capacity to consent.

During an interview on [DATE] at 12:37 PM, the Former Director of Nursing (FDON) stated R41 would try to initiate a relationship with any new resident who was admitted to the facility. FDON stated a lot of facility staff had concerns with R41's relationship with R44 and R87. The FDON stated he/she brought these concerns up more than once during the facility's morning meetings and he/she had even brought it to the attention of the corporate leadership staff and it was brought to the attention of the owner of the facility in the presence of the Administrator. The FDON further stated he/she wanted to report sexual abuse; however, he/she was directed not to by the administrator and corporate superiors. The FDON stated it was concerning when the nursing staff would repeatedly report to him/her that they witnessed R44 being touched by R41 in sexual ways and areas such as hugging, kissing on the mouth, R41 touching R44's breast, inner thighs, in a very affectionate way. The FDON stated corporate leadership advised the facility to care plan the residents to be able to engage in sexual touching. The FDON stated R44 was repeatedly being redirected not to have the doors closed nor to be in the room alone with the female residents.

During an interview on [DATE] at 9:37 PM, when asked if he/she would support R44 if the resident wanted to form a sexual relationship with another resident today, even though the facility had a court order that documented R44 as being incapacitated, the SSD stated she would support R44 as he/she had the capacity to consent to a sexual relationship because when he/she asked R44 the questions on the capacity assessment, the resident wanted to know why he/she was being asked the questions.

(4)

a. Review of R21's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he/she was admitted to the facility on [DATE] with diagnoses that included Alzheimer's and dementia.

Review of R21's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R21 was severely cognitively impaired.
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Monroe Manor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 236 West Claiborne Street Monroeville, AL 36460	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R21's Care Plan dated [DATE] and located in the residents' EMR under the Care Plan tab, revealed R21 was care planned for psycho-social wellbeing. Resident had experienced trauma related to war experiences. During an interview on [DATE] at 10:16 AM, R21 was sitting in his/her wheelchair in his/her room and stated that he/she remembered the incident that happened last year on [DATE]th, 2025. R21 said that his/her roommate at the time, R90, had made some remarks about black people and white people. And so, R21 said he/she was going to straighten him/her out. R21 told R90 that they'd been through that before, and then he/she said the next thing you know, R90 was swinging at him/her and he/she was swinging his/her arms to keep R90 from hitting him/her, but R90 hit him/her in the face with an open hand like a fist. R21 stated that it was the first time that this happened and that they moved his/her roommate after that. Review of R21's Nurse's Note, dated [DATE] at 1:59 PM and located in the EMR under the Notes'' tab, written by Licensed Practical Nurse (LPN) 5, revealed 1220 [12:20 PM] this writer was called to resident's room by cna [Certified Nursing Assistant]. staff reported that resident had physical contact with [his/her] roommate. resident was standing over resident by the time this writer came to room being held back by staff. resident's roommate was sitting on [his/her] bed. Both residents were separated. Resident had a scratch to [his/her] nose and the right side of [his/her] face. resident stated to this writer, 'shouldn't have done that. I couldn't believe that I done that' . b. Review of R90's admission Record located under the Profile tab of the EMR revealed R90 was admitted to the facility on [DATE] with diagnoses that included adjustment disorder with mixed disturbance and emotions and conduct. Review of R90's quarterly MDS with an ARD of [DATE] and located under the MDS tab of the EMR, revealed a BIMS score of 13 out of 15 which indicated R90 was cognitively intact. Review of R90's Care Plan, dated [DATE] and located in the resident's EMR under the Care Plan tab, revealed R90 was care planned for mood state. Resident had experienced trauma related to his/her son being killed. Review of R90's Nurse's Note, dated [DATE] at 1:58 PM and located in the EMR under the Notes'' tab, written by LPN5, revealed this writer was called to resident's room by cna. staff reported that resident had physical contact with [his/her] roommate. resident's roommate was standing over resident by the time this writer came to room being held back by staff. R90 was sitting on [his/her] bed. Both residents were separated. Resident with no injuries noted. R90 stated that [he/she] turned off the light, and [his/her] roommate came over on [his/her] side and [he/she] grabbed [his/her] ass. Review of the facility's Investigation Summary and Conclusion, provided by the facility and dated [DATE], revealed the facility determined the event did occur. During an interview on [DATE] at 3:00 PM, Certified Nurse Aide (CNA) 5 said on [DATE], she and CNA3 were passing trays in the hallway when they heard yelling. CNA5 stated CNA3 went into the residents' room and found R21 leaning over R90 in his/her bed and they were both hitting at each other. CNA5 stated she left and went to get a nurse. CNA5 stated she did not have any other involvement, but she provided a statement about the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:39 PM, Licensed Practical Nurse (LPN) 5 stated when the incident on [DATE] occurred, she was called to the resident's room by CNA5 and CNA3. LPN5 stated by the time she got there, she had missed the altercation. LPN5 stated the CNAs were already in the process of separating them. LPN5 stated it was unsure who grabbed whose butt as she indicated in her progress note but she remembered taking one of the residents out of the room, and the other one was sent out for behaviors but unsure which one. LPN5 stated was unsure of the findings of the investigation. During an interview on [DATE] at 1:23 PM, CNA3 stated on [DATE], she remembered running into the room and seeing R90 on top of R21. CNA3 stated they were both on top of R21's bed and R90 was hitting R21 in the face/head area, with a closed fist. CNA3 stated she was unable to remember what R21 was doing while this was happening. CNA3 stated she wasn't sure what initially made her run into the room, but she remembered R21 telling R90 don't touch that light again. During an interview on [DATE] at 10:22 PM, the Director of Nursing (DON) stated she did not complete the investigation. (5) a. Review of R15's Resident Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizophrenia, dementia, and intellectual disabilities. Review of R15's quarterly, MDS, with an ARD of [DATE] and located in the resident's EMR under the RAI tab, revealed the facility assessed the resident to have a BIMS score of 10 out of 15, which indicated the resident was moderately cognitively impaired. Review of R15's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab, revealed a note dated [DATE] of 1000 [10:00 AM] Staff reported that resident was assisted from dining room to his/her room via w/c [wheel chair] for safety. Staff stayed with resident until calm. Resident c/o [complaint of] headache & neck pain. Resident stated that his/her head & neck always hurt (history of) & then stated that the pain was no worse in comparison to past headache/neck pain. Resident st[TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy, and review of the Code of Alabama the facility failed to implement the facility's abuse policies to ensure residents were free from all forms of abuse and failed to ensure their policy was developed to meet the minimum federal regulatory requirements related to sexual abuse, including residents' capacity to consent to sexual activity for two of 29 sampled residents, Resident (R) 44 and R87.Specifically, the facility failed to ensure R87, a cognitively impaired resident, was assessed for their capacity to consent before developing a care plan related to his/her desire to engage in sexual expression.In addition, the facility failed to ensure R44's assessment for capacity to consent was conducted in accordance with the facility's abuse policy, the facility's assessment tools, and in accordance with State Law regarding protection of an incapacitated person before developing a care plan related to his/her desire to engage in sexual expression. The facility's failure to ensure their abuse policy was implemented allowed for R44 who was adjudicated as an incapacity person to receive sexual contact from a resident who was cognitively intact.Further, the facility failed to ensure its abuse policy's definition of Sexual Abuse was reflective of the current regulatory language of Definitions S483.12(a)(1); .Sexual Abuse is defined at S483.5 as non-consensual sexual contact of any type with a resident.The facility's policy further failed to include any type of process or procedure for residents who had been adjudicated by a court to be incapacitated. Additionally, the facility failed to follow their policy related to the Social Services Director (SSD) interviewing the resident to determine the resident's intent and then consulting with the resident's physician to determine if a resident had the ability to consent to sexual contact.Findings Include: Cross-Reference F600 On [DATE] at 1:03 PM, the survey team requested the facility's Abuse Policies. Review of the initial facility's policy titled, Abuse, Neglect and Exploitation, revised [DATE], revealed Each resident of any facility managed by [Name of Facility Corporation] has the right to be free from verbal, sexual, physical or mental abuse, neglect. This policy failed to include procedures to ensure residents were protected from sexual abuse. The policy also failed to include protocols for determining residents' capacity to consent for sexual contact. Review of the facility's policy titled, [Name of Facility Corporation] Administrative Procedure, revised 12/2016, revealed Subject: Definitions. Abuse. The definition of abuse encompasses a broad scope of behavior. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. In addition, abuse includes depriving the resident of goods and/or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. Any instance of abuse creates a presumption that the act caused physical harm, pain or mental anguish to the resident, even a resident in a coma.The following are definitions of specific types of abuse: . 2. Sexual-Sexual abuse includes, but is not limited to: sexual harassment, sexual coercion or sexual assault. 3. Physical-Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. Review of the facility's policy titled, Determination of Ability to Consent, revised 11/2017, revealed The following procedure will be used in determining of ability to consent: . 2. Upon the identification of any flirtatious or affectionate behavior, physical advances, or other sexual contact between a resident and another person, the facility will determine the resident's ability to consent to sexual (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact in the following manner: a. The resident will be interviewed by the Social Service Director [SSD], Administrator and/or designee to determine the resident's intent. b. The Interdisciplinary Care Plan Team will meet to discuss the resident's sexual behavior, and with the consultation of the resident's attending physician and other health professionals, if deemed appropriate for consultation by the attending physician, will determine whether the resident has the ability to consent to sexual contact.d. The facility will implement a separate care plan addressing the resident's social/sexual behavior. The care plan will, at a minimum, include whether the resident is capable of consenting and the interventions designed to address social/sexual behavior.f. A Social Service note will be entered into the clinical record regarding findings of the assessment of the resident's ability to consent. Review of the Code of Alabama, Section 13A-6-60 Definitions, revealed . (2) INCAPACITATED. The term includes any of the following: a. A person who suffers from a mental or developmental disease or disability which renders the person incapable of appraising the nature of his or her conduct. (3) SEXUAL CONTACT. Any touching of the sexual or other intimate parts of a person done for the purpose of gratifying the sexual desire of either party. The term does not require skin to skin contact. Review of the Code of Alabama, Section 13A-6-70 Lack of Consent, revealed . (a) Unless otherwise stated, an element of every offense defined in this article is that the sexual act was committed without the consent of the victim. (b) Lack of consent results from either of the following: . (2) Being incapable of consent. (c) A person is deemed incapable of consent if he or she is either: . (2) Incapacitated. (d) Consent to engage in sexual intercourse, sodomy, sexual acts, or sexual contact may be communicated by words or actions. The existence of a current or previous marital, dating, social, or sexual relationship with the defendant is not sufficient to constitute consent. Evidence that the victim suggested, requested, or otherwise communicated to the defendant that the defendant use a condom or other birth control device or sexually transmitted disease protection, without additional evidence of consent, is not sufficient to constitute consent. (1) Review of R87's Resident Face Sheet located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. The resident expired on [DATE]. Review of R87's quarterly MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R87's significant change in status MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R87's Care Plan located in the resident's EMR under the RAI tab revealed Problem. Problem start date: [DATE]. Resident desires to engage in sexual expression with another resident. Goal.Resident will have no negative outcome r/t engaging in sexual expressions thru next review. Edited: [DATE]. Approach. Approach Start Date: [DATE]. Assess resident for capacity to consent in sexual expression annually and/or if resident has a significant change.Approach Start Date: [DATE]. Educate resident if/as needed on safe sexual practices. Approach Start Date: [DATE]. Educate staff on ways to allow for and support resident's decision to engage in sexual expression prn.Approach Start Date: [DATE]. provide privacy sign if needed or requested, encourage resident to use privacy if desired. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:22 PM during an interview with the facility's Social Services Director (SSD), the SSD stated she did not have a copy capacity assessment. (2) Review of R44's Hospital Progress Note, for visit date [DATE] and completed by a Medical Doctor (MD) revealed Subjective-Patient is awake and alert .has a history of dementia and requires legal guardian . signed by a MD on [DATE]. Review of an Order Granting Temporary Guardianship, dated [DATE] revealed the court found that the alleged incapacitated person (R44) has no guardian, and emergency existed and no other person appeared to have authority to act in the circumstances, pursuant to 26-2A-107, Code of Alabama. The court appointed F1 guardian (temporary) over R44 for a period of 30 days from the date of the order. Review of a Order Appointing Guardian and Conservator, dated [DATE] revealed the court found that R44 was an incapacitated person who had no guardian, and who was unable to manage his/her personal medical needs nor her assets and financial matters, was appointed guardian and conservator by the court. The order was signed by a probate judge. Review of a Letters of Guardianship/Conservatorship, dated [DATE] revealed, Be It REMEMBERED, AND MADE KNOW TO ALL WHOM IT MAY CONCERN: That on the application of the Guardian and Conservatorship named below to my said Court I have caused these LETTERS OF GUARDIANSHIP AND CONSERVATORSHIP to issue in favor of the said [F1's Name], Guardian and Conservator in and upon the person and estate, real and personal property of [R44's Name], a protected person, and in every case which occasion may require, the said Guardian and Conservator is authorized and directed to exercise the following powers and duties: ALL POWERS AND DUTIES CONFERRED UNDER ALABAMA CODE 26-2A-78 AND 26-2A-152, as the lawful Guardian and Conservator of the said protected person. Signed by Probate Judge and Dated [DATE]. Review of R44's Resident Face Sheet located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, and mild neurocognitive disorder. Review of R44's admission MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of six out of 15 which indicated the resident was severely cognitively impaired. Review of R44's Assessment for Capacity to Consent to Sexual Relations, dated [DATE] and located in the resident's hard chart medical record, revealed Question: Has resident been declared incompetent by a judge? [Answer check marked Yes] If the answer to the above question is Yes, the resident has been assessed to not have the capacity to consent. The assessment included that level of intimacy R44 was comfortable with was holding hands and kissing. The assessment was signed by the SSD and RNUM1. During an interview on [DATE] at 12:15 PM, the Social Services Director (SSD) stated after she completed the capacity to consent assessment for R44, she developed an initial a care plan for sexual expression for R44. The SSD stated the care plan included the problem for resident desires to engage in sexual desire with another resident. The SSD said the care plan's goal was for resident not to have any negative outcomes with engaging in sexual expression through next review. The SSD said the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approaches included: always knock prior to entering resident's room even when door is partially open to provide privacy and dignity when resident desires it and educate staff on ways on allow for and support decision for resident to engage in sexual expression. Review of R44's quarterly MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R44's comprehensive MDS with an ARD of [DATE] revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. A statement of LPN4, signed and dated [DATE], included that she had seen R41 kiss R44 kiss on the lips and touch R44 on his/her thigh and arms. The statement also included that LPN4 saw R41 kiss R86 and R87. During an interview on [DATE] at 5:05 PM, Licensed Practical Nurse (LPN) 4 stated the R41 and R44 were allowed to kissed each other and some touching and to his/her knowledge, that was all R41 and R44 were allowed to physically do. When asked what he/she meant when he/she stated the residents were allowed to touch, LPN4 stated they could touch as long as their clothes were on. A statement of CNA1, signed and dated [DATE], included that she had seen touching between R41 and R44 on the inner thighs close to their private parts. During an interview on [DATE] at 5:44 PM, Certified Nursing Assistant (CNA) 1 stated R41 and R44 kissed and touched each other in private areas like the chest/breast area and inner thighs. During an interview on [DATE] at 3:30 PM, the facility's Medical Director stated R44 had the capacity to consent and engage in the relationship he/she wanted. When asked about how he/she came to this decision, the Medical Director stated when he/she spoke with R44, he/she asked the resident if he/she would know if someone was unkind to him/her or mistreated him/her and stated R44 would. When asked what if R44 wanted to engage in sexual intercourse, the Medical Director stated R44 could. The Medical Director stated when he/she asked R44 if he/she would like to be kissed, hugged, and/or to have sexual intercourse, R44 told him/her that he/she did not want those things. The Medical Director further stated he/she asked R44 if he/she had ever felt harmed or abused from R41, and R44 stated he/she had not. The Medical Director stated R44 may not remember what he/she had for lunch, or even remembered being kissed but the resident would know if he/she was being harmed or abused and just because the resident's memory and higher brain function was not there, he/she could still interact with others and say if he/she was being hurt. When asked if he/she knew if there were Alabama state laws related to if a resident who had impaired cognition and who was incapacitated by a court, if the resident could make informed consent, the Medical Director stated he/she did not know if there were any laws of such. When asked if R44 had the ability to give informed consent, the Medical Director stated, Yes emotionally, in a social relationship. During an interview on [DATE] at 8:18 PM, when asked if he/she provided primary care services to residents of the facility, the Family Nurse Practitioner (FNP) stated he/she did. When asked about R44 who the facility assessed to have a BIMS of three and had a diagnosis of dementia, if R44 would be able to consent to sexual contact, the FNP stated he/she would find it surprising for R44 or any resident like R44 to have the capacity to consent for sexual contact. The FNP stated he/she was familiar with R44, and he/she would not think the resident would have the capacity to consent.

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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** Based on interview, record review, and facility policy review, the facility failed to ensure the attending physician was immediately notified of a significant change in condition (low blood glucose levels) for one of one resident (Resident (R) 12) reviewed for notification of changes. R12 experienced repeated blood glucose levels ranging from 32 mg/dL (milligrams/ deciliter) to 44 mg/dL across multiple shifts without physician notification. This deficient practice resulted in a delay in medical evaluation and treatment.Findings include:Review of R12's Face Sheet located in the Resident tab of the electronic medical record (EMR) indicated admission on [DATE] with diagnoses including type two diabetes mellitus and multiple sclerosis.Review of R12's quarterly Minimum Data Set (MDS) located in the EMR under the RAI [Resident Assessment Instrument] tab, with an Assessment Reference Date (ARD) of 01/13/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R12 was cognitively intact.Review of the Comprehensive Care Plan located in the EMR under the RAI tab, indicated R12 was at risk for blood sugar fluctuation related to diagnosis of diabetes and at risk for hypoglycemia. The care plan was created on 04/02/2025 and included approaches included notify MD (Medical Doctor) as needed of any complications.Review of the Orders tab of the EMR revealed no physician orders to reflect blood glucose parameters or when to notify the physician. Review of R12's Medication Administration Record (MAR) located in the EMR under the Resident tab of Reports, revealed:-03/29/2025 at 6:00 AM: blood glucose of 44 mg/dL [documented by Registered Nurse (RN) 1]-03/29/2025 at 6:00 PM: blood glucose of 42 mg/dL [documented by Licensed Practical Nurse (LPN) 3]Review of R12's Progress Notes located in the EMR under the Resident tab of Reports, revealed RN1 wrote:-03/29/2025 at 5:29 AM: blood glucose 43 mg/dL.-03/29/2025 at 7:13 AM: blood glucose 38 mg/dL. There was no documentation indicating the physician was notified of these low blood glucose levels.During an interview on 04/10/2026 at 3:29 PM, LPN1 stated R12 had low blood glucose during the night shift and continued to have poor intake during the day shift. LPN1 stated a blood glucose of 32 mg/dL was obtained and interventions were provided. LPN1 confirmed she did not notify the physician.During an interview on 04/11/2026 at 3:54 PM, the Registered Nurse Unit Manager (RNUM) 1 stated that a blood glucose level in the 30s or 40s should be reported to the physician. RNUM1 denied being informed of R12's low blood glucose levels.During an interview on 04/12/2026 at 12:23 PM, the former Director of Nursing (FDON) stated blood glucose levels ranging from 38 mg/dL to 43 mg/dL were significant findings and expected nursing staff to notify the physician or on-call provider. The FDON stated nursing staff failed to notify the physician.During an interview on 04/12/2026 at 7:49 PM, RN1 stated she did not notify the physician because she was not concerned.During an interview on 04/12/2026 at 10:53 AM, LPN3 stated the physician was ultimately contacted when R12's condition declined, and the resident was transferred to the emergency room.Review of the facility's policy titled, Physician Notification of Change of Condition, dated 05/1999, indicated immediate notification was defined as informing the physician at the time the event occurs.The facility took immediate corrective action to correct the identified deficient practice; thus, past non-compliance was cited.********The facility's action include:A formal investigation was initiated. An action plan was created.On 04/08/2025 all nurses directly involved with RI# 12 were required to complete remediation on the Alabama Board of Nursing website completion reviewed by the previous Director of Nursing, that included the following online courses Documentation: A Case Study, Scope of Practice for RN's and LPN's, Standardized Procedures: Practice Beyond Basic Nursing Education and Medication Administration & Safety for Charge Nurses. All nurses involved received appropriate disciplinary action on 4/2/2025. The disciplinary actions were administered by the previous Director of Nursing.On 04/23/2025 through 05/04/2025 all nurses involved were monitored for medication pass validations by the previous Director of Nursing. On 04/21/2025 all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor Health & Rehabilitation Center	236 West Claiborne Street Monroeville, AL 36460

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed nurses in the facility were educated on Diabetic Medications with hypoglycemia effects, recognition of signs/symptoms of hypoglycemia, required interventions and notifying the NP/PA/MD for all changes in residents' conditions relative to diabetic changes. This education was provided by the Pharmacy Consultant.No other residents were affected during the time frame of 3/28/2025 through 3/30/2025. 7 residents were identified for fingerstick/blood glucose monitoring. A total of 12 residents had orders for fingerstick/blood sugars. 5 of those residents were not in the facility or did not have fingerstick/blood sugars ordered for that timeframe. 0 of 7 residents had low fingerstick/blood sugars and did not receive hypoglycemic medications in the presence of low blood sugars. The audit results could not be located as a result, the Fingerstick Blood Sugar order report has been printed and denotes residents who were diabetics during that time frame with fingerstick/blood sugar orders. The audit was completed by the MDS Coordinator on or about 4/8/2025.*********

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNC) notification was provided and that the responsible party was notified for two of three residents (Residents (R) 21 and R36) reviewed for beneficiary notification out of a total sample of 29 residents. This had the potential to affect all residents being discharged from services. Findings include:1.Review of R21's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he/she was admitted to the facility on [DATE] with diagnoses that included Alzheimer's and dementia.Review of R21's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/2025 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R21 was severely cognitively impaired.Review of R21's SNF [Skilled Nursing Facility] Beneficiary Notification Review [SNF Advanced Beneficiary Notice of Non-Coverage (ABN)] form revealed the Medicare Part A skilled services start date was 11/12/2025 and the last day covered was 12/02/2025. Further review revealed that R21 signed his/her SNF ABN form on date illegible. The resident was designated as severely cognitively impaired. 2. Review of R36's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he/she was admitted to the facility on [DATE] with diagnosis that included cerebral infarction. Review of R36's quarterly MDS with an ARD of 03/27/2026 and located under the MDS tab of the EMR, revealed a BIMS was unable to be completed. Further review revealed resident was assessed to have short- and long-term memory problems. R36's cognitive skills for daily decision making were assessed as moderately impaired-decisions poor; cues/supervision required. Review of R36's SNF Beneficiary Notification Review [SNF ABN] form revealed the Medicare Part A skilled services start date was 03/14/2026 and the last day covered was 04/02/2026. Further review revealed that R36 signed his/her SNF ABN form on 03/31/2026. The resident was designated as moderately cognitively impaired. There was no evidence that the family was notified of the information. During an interview on 04/12/2026 at 1:59 PM Family Member (F) 2 said he/she was the person responsible for anything that pertained to R21 because R21 did not have the ability to make informed decisions because he/she had Alzheimer's. F2 stated it was the stroke he/she had that affected his/her ability to make decisions. F2 said he/she was not made aware of R21's therapy services and he/she would have liked staff to have contacted her and informed him/her of the decision to appeal. F2 said he/she would rather R21 not sign anything unless the nurse explained the information to him/her first. F2 stated he/she wished R21 could have continued the therapy part. During an interview on 04/12/2026 at 4:12 PM, the Bookkeeper stated there was a care plan meeting to discuss the resident being discharged from services. The Bookkeeper stated she would talk with the resident and their representative. The Bookkeeper said if the resident was competent she would allow them to sign, but if the resident was not competent, she would look at their diagnosis. The Bookkeeper stated she spoke with both residents' representatives, but she did not document those conversations, and she did not mail a hard copy to them. During an interview on 04/12/2026 at 10:22 PM, the Director of Nursing (DON) said she would have to look at the paper when asked if she was familiar with the process of SNF NOMNC notifications. She stated the insurance required that the resident signed.

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NAME OF PROVIDER OR SUPPLIER Monroe Manor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 236 West Claiborne Street Monroeville, AL 36460	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to: 1.) identify and intervene for a change in the resident's condition and ensure the resident received prompt assessment and emergency care for one of one resident (Resident (R) 88) reviewed for changes in condition out of 29 sampled residents. Licensed Practical Nurse (LPN) 9 failed to listen to R88's airway when the resident presented with signs and symptoms of aspiration. This failure caused a potential delay in R88's treatment. R88 was admitted to the hospital for aspiration pneumonia; and 2.) ensure residents were appropriately screened and had documentation to support the use of wander guards for one of two residents (Resident (R) 41) reviewed for wander guards out of a total sample of 29. This had the potential to cause skin breakdown, injuries from falls, increased agitation, and a deviation from person-centered care. Findings include: 1.Review of R88's Resident Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hemiplegia and hemiparesis follow cerebral infarction, chronic obstructive pulmonary disorder (COPD), and gastro-esophageal reflux disease. Review of R88's Medication Administration Record (MAR), dated [DATE] and located in the resident's EMR under the Reports tab revealed LPN9 administered the resident an enema on [DATE] at 10:17 AM which was one hour and three minutes earlier than the first documented assessment that indicated a change in the resident's condition where it was noted R88 received an enema. Review of R88's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab revealed a note completed by LPN9 dated [DATE] at 11:20 AM of Resident lying in bed. Hard to arouse. This nurse noticed vomit on resident's shirt. Vital signs: B/P [Blood Pressure] - 106/61, P [Pulse] - 109, R [Respirations] - 22, T - 99.1, O2 Sat [Blood Oxygen Saturation] - 85% on RA [room air]. New order for Oxygen via nasal cannula at 2L/min [liters per minute] and Zofran [an antiemetic medication] 4 mg [milligram] PO [by mouth] Q4Hr [every four hours] PRN [as needed]. Oxygen applied. Oxygen came up to 90% on 2L/min. Zofran administered. Bowel sounds hypoactive. PRN enema administered. Liquid stool noted. Resident cleaned up, and following commands from CNA [Certified Nursing Assistant], pulled [himself/herself] up in bed. Oxygen came up to 95% on RA. Will continue to monitor. Sponsor, [Family Member (F) 12], at bedside. Review of R88's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab revealed a note completed by LPN9 dated [DATE] at 12:21 PM of Sponsor [F12], requested for resident to go out to hospital for evaluation. New order.to send resident to [name of hospital] for evaluation.Resident transported via stretcher at 12:19 pm. Review of R88's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab revealed a note completed by Registered Nurse Unit Manager (RNUM) 1 dated [DATE] at 12:48 PM of .Resident in bed with HOB [head of bed] elevated with eyes closed & mouth opened. Resp [respirations] 24 and snoring-like. Resident did not squeeze this nurse hand to command. No moaning or groaning observed.Resident did not respond to verbal or tactile stimuli. No secretion from mouth. Breath sounds with no congestion but diminished bilateral.O2 sat 86% with O2 at 2 L/min/nc [nasal canula] .Coolness to both feet. Staff reported BP 104/47.PULSE 109. Staff reported random fsbs [finger stick blood sugar] 201. Staff reported @ [at] this time that resident was talkative earlier this am on 7-3 shift. Notified MD [medical doctor] office and spoke with [staff name] regarding this nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment and change of condition. Then MD order received to send to [name of hospital] for further eval [evaluation] .Ambulance notified by transport staff. Staff reported sponsor no longer at facility but notified via phone regarding order to send to ER [emergency room] .Resident transported to [name of hospital] ER [Emergency Room] @ 1220 PM. During an interview and record review on [DATE] at 3:54 PM, RNUM1 was asked what vital sign parameters would indicate a change in a resident's condition. She stated if respirations were below 16 or above 24, and if oxygen saturation was below 90, then that would be changes in condition, and the physician should be notified. When asked about a pulse of 109, RNUM1 stated, Yes that would be a change in condition. When asked about blood pressure of 104/47, RNUM1 stated 47 would be concerning. RNUM1 reviewed R88's note dated [DATE] at 11:20 AM and completed by LPN9. When asked his/her opinion about LPN9's note as a RN, RNUM1 stated there should have been some kind of additional documentation by LPN9 showing a change in the resident's condition. RNUM1 then reviewed the note she wrote on [DATE] at 12:48 PM. RNUM1 stated LPN9 should have listened to R88's breath sounds to rule out or confirm possible aspiration. RNUM1 stated if LPN9 had listened to the resident's breath sounds and had heard the same as she did during her assessment of the resident's breath sounds, the resident would have been sent out to the hospital sooner as it would have indicated possible aspiration given the vitals and the resident vomiting. RNUM1 stated LPN9 reported to her the resident's vitals and that was why she came to assess R88. During an interview on [DATE] at 10:23 PM, when asked about LPN9's assessment of R88 on [DATE], the Director of Nursing (DON) stated essentially RNs do the assessments. When asked if the LPN should have notified RNUM1 sooner or assessed R88's breath sounds, the DON stated they did not know that the LPN did not notify RNUM1 sooner to complete the assessment. When asked what her expectations were as the DON, the DON stated she would have expected the LPN to notify a RN. During a return phone call from F12 on [DATE] at 9:57 AM, F12 stated he/she was a RN. F12 stated the day R88 was transferred to the hospital, he/she had gotten a telephone call from a family friend that visited R88 frequently and was told that something was not right with R88 and also that R88 had vomited a good bit. F12 stated he/she received the call around 9:45 AM while he/she was at work. F12 stated the RN reported his/her assessment to him/her and that is when he/she requested that R88 be sent to the hospital. F12 stated R88 was admitted to the hospital for aspiration pneumonia where he/she became septic and expired. 2. Review of R41's admission Record located in the Profile tab of the electronic medical record (EMR) revealed R41 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. Review of R41's Care Plan located under the Care Plan tab of the EMR, dated [DATE], revealed the resident was care planned for risk of elopement and wore a wander guard. Interventions included to place wander guard on resident. Further review revealed no updates to the care plan since [DATE]. Review of R41's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R41 was severely cognitively impaired. Further review revealed no wandering behavior was exhibited. Review of R41's Physician Orders located under the Orders tab in the EMR, dated [DATE], revealed .code alert intact and functioning every shift . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R41's Elopement Risk Assessment located under the Observations tab in the EMR, dated [DATE], revealed R41 was not at risk for elopement. Review of R41's General Notes located under the Notes tab of the EMR, dated [DATE] through [DATE], revealed no documentation of any wandering or exit seeking behaviors. Review of R41's Care Plan Conference meeting notes, located under the Care Plan tab, dated [DATE], revealed the resident was no longer at risk of elopement, and his/her elopement bracelet would be removed. During observations on [DATE] at 5:53 PM, [DATE] at 11:45 AM, and [DATE] at 6:46 PM, R41 had a wander guard on his/her right ankle. During an interview on [DATE] at 5:29 PM, Registered Nurse/Unit Manger (RNUM) 2 stated he/she was present during the care plan conference on [DATE] when they discussed discontinuing the resident's wander guard. RNUM2 stated she was unsure which nurse would have been responsible for discontinuing the order for the code alert (wander guard) and that it had never been clearly stated who was responsible. RNUM2 said it would most likely be the restorative nurse since she put the code alert bracelet on. During an interview on [DATE] at 10:23 AM, Restorative Nurse (RNN) said she had not seen anything in the last couple of months that demonstrated elopement or exit seeking behaviors for R44. RNN stated they did not remove the wander guard because they decided they were going to reassess the resident for a while but there was nothing documented about that. During an interview on [DATE] at 9:36 PM, the Social Services Director (SSD) stated all residents were assessed for elopement risk on admission, quarterly and as needed, and the interdisciplinary team (IDT) team would discuss. The SSD stated she was the staff responsible for completing the assessments. The SSD stated R44 was assessed as a wander risk because when R41 was first admitted , he/she wanted to go home. The SSD stated they discussed discontinuing the wander guard during R41's care plan meeting and they decided to keep the wander guard on a little while longer. The SSD stated she was not sure why it was not documented during that meeting on [DATE] and agreed it should have been documented. The SSD stated they should have notified the responsible party if they continued the wander guard use or it should have been removed. During an interview on [DATE] at 10:22 PM, the Director of Nursing (DON) stated there was criteria that staff reviewed to indicate if a person was an elopement risk such as, them making statements that they were trying to leave or if there was an elopement history. The DON stated if an assessment indicated a resident was not at risk, they may want to continue to monitor. Review of the facility's policy titled Elopements and Wandering Residents revised 04/2008 revealed, .Residents making an adjustment to the facility, or who do not understandwhere they are, may be subject to leaving the facility without supervision. Unsupervised activity outside the facility could lead to serious injury of a resident due to the many hazards such as traffic, water, storms and hot/cold temperatures. 'Elopement' means the unplanned, unauthorized leaving of the facility by a resident. (See state protocols for the definition of and reportingrequirements for an elopement). Residents should be assessed for elopement risk on admission using NM.I-18a and b, then quarterly using NM.I-I8b if the resident is identified as anelopement risk. The facility is equipped with door locks/alarms to help avoid elopements.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure there was a current physician's order for a resident to receive dialysis treatment for one of one resident (Resident (R) 3) reviewed for dialysis out of a total sample of 29. This had the potential to affect the continuity of care for residents who received dialysis treatment. Findings include:Review of R3's Face Sheet in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included end stage renal disease.Review of R3's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/2026 located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated R3 was severely cognitively impaired. R3 was documented as receiving hemodialysis. Review of R3's Care Plan, dated 02/24/2026 and located in the EMR under the Care Plan tab, revealed R3 was care planned for a diagnosis of end stage renal disease and received dialysis. Review of R3's Physician Orders located under the Orders tab in the EMR, dated 04/10/2026, revealed no current order for dialysis treatment. During an interview on 04/11/2026 at 2:39 PM, Licensed Practical Nurse (LPN) 5 stated there should always be a physician's order for dialysis. LPN5 said the order told nursing staff to check the site or check the thrill and bruit. LPN5 stated it should be checked throughout the day and before and after they left for dialysis. LPN5 stated nursing staff should have checked off on the Medication Administration Record (MAR) after treatment was done. LPN5 stated if there was no order she would tell the Registered Nurse (RN) supervisor as soon as possible. LPN5 stated nursing staff should have noticed if there was no order for dialysis. During an interview on 04/11/2026 at 3:18 PM, LPN1 said a resident receiving dialysis would normally have a physician order that would tell nursing staff how to provide treatment such as if the residents had a shunt or port for the access site. LPN1 stated nursing staff needed to make sure they monitored residents on dialysis for sign and symptoms of bleeding, ensure the site remained dry with no drainage or irritation, and ensure there was no sign or symptom of infection. LPN1 also stated nursing staff needed to check for the thrill and bruit and make sure it was present every shift and to document that on the MAR. LPN1 said most nurses knew if a resident was a dialysis patient they required monitoring, and they could document that in a progress note. LPN1 stated having an order was very important, to ensure nursing staff monitored the access site since that area was their line to receive treatment, if it was not properly functioning, or if there was active bleeding that was uncontrolled; it could cause the residents to bleed out. LPN1 said not putting in a physician order was an oversight, and there should have been an order. During an interview on 04/12/2026 at 4:02 PM, RN3 said she completed R3's admission and that staff were responsible for matching the physician orders with orders from the hospital. RN3 confirmed the dialysis order should have been put in at that time. During an interview on 04/12/2026 at 10:22 PM, the Director of Nursing (DON) stated it was the physician's discretion to put in an order. The DON also stated as a nurse, she would not provide treatment without a physician's order. Review of the facility's policy titled, Hemodialysis Care, dated 02/01/04, revealed to provide care for residents receiving hemodialysis. Physician's orders for care of the hemodialysis resident should include information regarding visit to a dialysis center along with care of the access site.

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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 observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; documented discussion related to risk versus benefits; and signed informed consent prior to bed rail use for two of three residents (Resident (R) 3 and R6) reviewed for side rails out of 29 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. Findings include: 1.Review of R3's Face Sheet in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included end stage renal disease. Review of R3's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/28/2026 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated R3 was severely cognitively impaired. Review of R3's Care Plan located under the Care Plan tab of the EMR revised 02/26/2026, revealed R3 had upper side rails for mobility. Review of R3's Physician Orders located under the Orders tab in the EMR dated 04/10/2026 revealed, no current order for side rail use. During an observation on 04/09/2026 at 2:45 PM, R3 was resting in bed, head of bed (HOB) upright, with side rails up on both sides. Review of R3's Side Rail/Enabler/Entrapment Evaluation located under Assessments tab in the EMR dated 02/25/2026, revealed no documentation that alternates were explored prior to bed rail/side rail use. Further review revealed no documentation related to risks versus benefits or informed consent. During an interview on 04/12/2026 at 10:23 AM, Restorative Nurse (RNN) said when they accessed a resident for bedrails he/she completed an assessment form. RNN said the facility tried to use top rails only to help promote transfer and mobility and enable residents to be able to pull themselves over. RNN said bedrails were preinstalled, but they could be removed. RNN stated they did not try any alternatives before the bedrail use for R3, he/she did not discuss the risks and benefits, and there was nothing for them to sign to show informed consent. During an interview on 04/12/2026 at 10:22 PM, the Director of Nursing (DON) was unable to answer if the facility completed alternative assessments and where that would be located if they did. The DON stated at the bottom of the assessment, he/she did not specify which assessment exactly, staff put what else they did. The DON was unable to state her expectations or the process of the facility to discuss risk and benefits and get informed consent. The DON said nursing staff made observations, and that only certain people looked at it. When asked which certain people, the DON stated the ones doing the assessments. The DON was also unsure if the assessment had a place to document the risk for entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R6's Resident Face Sheet located in the resident's electronic medical record (EMR) under the Face Sheet Tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included mild intellectual disabilities and dementia. Review of R6's quarterly MDS with an ARD of 02/16/2026 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R6's Care Plan located under the Care Plan tab of the EMR revealed Problem.Problem Start Date: 11/22/2024.Category: Falls.Resident is at risk for falls related to falls related to epilepsy and unsteadiness on feet and muscle weakness. Approach Start Date 11/22/2024. Side rails up while in bed to aid in bed mobility and transfers. Approach Start Date 11/22/2024. Upper siderails up for mobility. Review of R6's Physician Orders located under the Orders tab in the EMR for April 2026 revealed, no current order for side rail use. Observation on 04/10/2026 at 11:11 AM, R6 was lying in his/her bed looking at his/her phone with headphones connected to the phone. R6's head of bed (HOB) was elevated to 45 degrees and bilateral half side rails were in the raised position. Review of R6's [Facility Corporation] Side Rail Evaluation, with an observation date of 02/18/2026 and a completion date of 04/12/2026 at 11:54 AM, (indicated completed after surveyor identified concern) located in the resident's EMR under the Observations tab, revealed .Has the resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? [answered] No.Is the resident able to get out of bed safely? [answered] Yes. Does the resident have a history of falls? [answered] Yes.Does the resident use the side rails for positioning and support? [answered] Yes. Does the side rail help the resident rise from a supine position to a sitting/standing position? [answered] No.Is there evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed? [answered] Yes. Does the resident receive any medications that would require safety precautions? [answered] Yes. Is there a risk to the resident if side rails are used? [answered] No. Do the side rail alternatives/interventions create more risks than side rail use? [answered] No.Use of HALF side rails [marked included] Left, Right, Head.Care Plan updated: 02/18/2026. Family/ Responsible party notified 02/18/2026. Physician notified: 02/18/2026. The was no documented evidence of what alternatives were explored prior to the implementation of side rail use and no documented evidence that the risks versus benefits was explained to the Responsible Party and/or that informed consent was obtained. Review of the facility's policy titled, Bedrail Use, dated 02/01/2004, revealed Bedrails are used to enable a resident to become more functionally independent, and when the medicalcondition of the resident requires the use of a bedrail. Bedrails could be considered a form of physical restraint therefore, the need for bedrails should be identified in the resident assessment, and the plan of care. Continued use of bedrails requires documentation of the presence of a medical symptom, which would necessitate the use of bedrails, or that the bedrails assist the resident with mobility and transfer abilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Monroe Manor Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 236 West Claiborne Street Monroeville, AL 36460	

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's Social Service Director's (SSD's) job description, the facility failed to ensure three of 29 sampled residents (Resident (R) 44, R86, and R87) received medically related social services related to assessment for residents' capacity to consent to sexual contact with others and follow-up services for psychosocial support after a resident's companionship ended. These failures by the facility's SSD enabled the cognitively impaired residents (R44 and R87) to be exploited by a cognitively intact resident (R41), and when R86's companionship ended with R41, the SSD did not offer services to R86 to rule out any inappropriate sexual conduct R86 may have received from R41. (Cross Reference F600)Findings include:Review of the facility's Director of Social Services Job Description, modified 05/2003, revealed .General Purpose: To act as a liaison and representative of the residents' social interest and to plan, organize, develop and direct overall operation of the Social Services Department in accordance with current federal, state, and local standards governing the facility, and as may be directed by the Administrator, to ensure that the medically-related emotional and social needs of the residents are met and maintained on an individual basis.Essential Job Functions: A. Administrative Functions: Duties: Plan, develop, organize, implement, evaluate, supervise and direct the social services programs and activities.implementation of social care plans, resident assessments.C. Quality Assurance Functions. Duties: Assist in developing for each resident a preliminary and comprehensive assessment and written care plan that identifies the emotional and social problems and/or needs of the resident and the goals to be accomplished for each problem and/or need identified.D. Residents' Rights Functions. Duties: Maintain resident confidentiality; treat residents with kindness, dignity, respect; know and comply with Residents' emotional and social needs are met.1. Review of R44's Resident Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, and mild neurocognitive disorder.Review of R44's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the resident's EMR under the RAI [Resident Assessment Instrument] tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated the resident was severely cognitively impaired. Review of R44's hard chart medical record revealed a court order, dated [DATE] and signed by a Judge, appointing a guardian for R44 who was identified in the order to be an alleged incapacitated person. Review of R44's Assessment for Capacity to Consent to Sexual Relations, dated [DATE], completed by the SSD, and located in the resident's hard chart medical record, revealed Question: Has resident been declared incompetent by a judge? [Answer check marked Yes] If the answer to the above question is Yes, the resident has been assessed to not have the capacity to consent. If the answer is No, continue the assessment. Even though the assessment document indicated R44 did not have the capacity to consent and further assessment should not be continued, the SSD continued the assessment. Questions that were marked Yes included the question Does the resident have the capacity for the reasoning process inherent to sexual consent, including an understanding of sexual options and consequences of sexual choices?Review of R44's Resident Progress Notes located in the resident's EMR under the Progress Notes tab revealed a note dated [DATE] and completed by the SSD, of This writer and RN [Registered Nurse] performed assessment for Capacity to consent to Sexual Relations on resident [R44]. Resident does have some memory deficits but does state clear understanding of consent for sexual activity. The SSD then initiated a care plan for R44 with approaches which included educating the resident as needed on safe sexual practices and for staff to support the resident's decision to engage in sexual expression.During an interview on [DATE] at 6:04 PM, Licensed Practical Nurse (LPN) 4 stated approximately one week (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ago, she had observed R44 and R41 kissing. LPN4 stated she reported this to the SSD, and the SSD told her that it was the residents' rights to kiss each other. During an interview on [DATE] at 12:53, Family Member (F) 1 stated he/she was shocked when he/she was contacted by the SSD and was told that R41 and R44 had rights and could have a sexual relationship if they chose.During an interview on [DATE] at 9:37 PM, the SSD stated she supported R44 if he/she wanted to form a sexual relationship with another resident of the facility. 2. Review of R87's Resident Face Sheet, located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. The resident expired on [DATE].Review of R87's quarterly MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R86's significant change in status MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired.Review of R87's Care Plan located in the resident's EMR under the RAI tab revealed approaches developed by the SSD included to educate the resident as needed on safe sexual practices and to provide the resident with a privacy sign if needed or requested.During an interview on [DATE] at 11:46 AM, F87 stated as the resident's decision maker, he/she was never made aware of nor would he/she have supported/approved for R87 to be care planned for any kind of sexual activity. 3. Review of R86's Resident Face Sheet, located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] and discharged from the facility on [DATE] with diagnoses which included Alzheimer's disease and major depressive disorder.Review of R86's quarterly MDS with an ARD of [DATE] and located in the resident's EMR under the RAI tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact.During a telephone interview on [DATE] at 11:24 AM, R86 stated he/she was friends with R41 while he/she was a resident of the facility. R86 stated he/she and R41 became friends first and then companions. R86 stated he/she really cared about R41 and that R41 cared about him/her. R86 stated he/she let R41 know upfront that he/she did not want any type of sexual relationship and told R41 he/she did not want him/her to use any nasty words with him/her. R86 stated one night he/she was in R41's room and R41 put both his/her hands on both of his/her face cheeks and stated to him/her, I want to f*** you so bad. R86 stated he/she went cold as ice, and this made him/her feel dirty. R86 stated he/she backed out of R41's room. R86 stated he/she was upset and crying for some days after the event. When asked if the SSD or any staff asked what was wrong, he/she stated no, but they probably knew. R86 was asked if he/she would have told the SSD what R41 said to make him/her turn cold as ice if the SSD would have asked him/her about the relationship ending. R86 stated Yes.During an interview on [DATE] at 9:37 PM, the SSD stated the extent of R41's and R87's relationship was that R41 just sat in R87's room and socialized with him/her. When asked if she was aware of why R86's and R41's relationship/companionship ended, the SSD stated R41 had told him/her that he/she did not want to be with R86 anymore because R86 was lazy and in a wheelchair. The SSD stated she was aware R86 was upset about the ending of the relationship; however, she did not talk to the resident about why the resident was upset.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure nursing staff did not administer glimepiride (an oral hypoglycemic medication used to lower blood glucose levels) with documented low blood glucose levels ranging from 32 mg/dL (milligrams/ deciliter) to 44 mg/dL and poor oral intake for one of one resident (Resident (R) 12) reviewed for unnecessary drugs of 29 sample residents. This deficient practice placed R12 at risk for, and resulted in, worsening hypoglycemia requiring hospitalization.Findings include:Review of R12's Face Sheet located in the Resident tab of the electronic medical record (EMR) indicated admission on [DATE] with diagnoses including type two diabetes mellitus and multiple sclerosis.Review of R12's quarterly Minimum Data Set (MDS) located in the EMR under the RAI [Resident Assessment Instrument] tab with an Assessment Reference Date (ARD) of 01/13/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R12 was cognitively intact.Review of R12's physician order history located in the EMR under the Resident tab revealed orders, dated 03/28/2025, for blood glucose monitoring twice daily and glimepiride one mg by mouth twice daily (9:00 AM and 5:00 PM). There were no orders to reflect blood glucose parameters or physician notification. Review of R12's Medication Administration Record (MAR) located in the EMR under the Resident tab of Reports, revealed:-03/29/2025 at 6:00 AM: blood glucose of 44 mg/dL [Documented by Registered Nurse (RN) 1]-03/29/2025 at 6:00 PM: blood glucose of 42 mg/dL [Documented by Licensed Practical Nurse (LPN) 3]The MAR further revealed LPN1 administered glimepiride one mg at 9:00 AM and LPN3 administered glimepiride one mg at 5:00 PM on 03/29/2025.Review of R12's hospital records dated 03/29/2025 and located in the EMR under the Resident tab of Resident Documents, revealed R12 was admitted to the emergency department for hypoglycemia. Documentation indicated R12 received glimepiride despite a blood glucose level of 42 mg/dL. Treatment included intravenous dextrose. R12 was discharged on 04/01/2025.During an interview on 04/10/2026 at 3:29 PM, LPN1 stated R12 had low blood sugar during the night shift, continued to have poor oral intake, and a blood glucose level of 32 mg/dL was obtained during the day shift. LPN1 confirmed he/she administered glimepiride at 9:00 AM despite the low blood glucose level and limited food intake.During an interview on 04/12/2026 at 10:53 AM, LPN3 stated she was informed during shift report that R12 experienced a hypoglycemic episode with a blood glucose level of 32 mg/dL. LPN3 stated there were no specific instructions to hold the medication and administered glimepiride at 5:00 PM as ordered. LPN3 stated the blood glucose level at 6:00 PM was 42 mg/dL.During a phone interview on 04/12/2026 at 12:23 PM, the former Director of Nursing (FDON) stated blood glucose levels in the 30s and 40s were significant findings and nursing staff were expected to use clinical judgment and not administer medications that could further lower blood glucose levels.Review of the facility's policy titled, Oral Medication Administration, effective 06/01/2004, indicated staff were to obtain and assess relevant clinical information prior to medication administration.The facility took immediate corrective action to correct the identified deficient practice; thus, past non-compliance was cited.************The facility's actions included:A formal investigation was initiated. An action plan was created.No other residents were affected during the time frame of 3/28/2025 through 3/30/2025. 7 residents were identified for fingerstick/blood glucose monitoring. A total of 12 residents had orders for fingerstick/blood sugars. 5 of those residents were not in the facility or did not have fingerstick/blood sugars ordered for that timeframe. 0 of 7 residents had low fingerstick/blood sugars and did not receive hypoglycemic medications in the presence of low blood sugars. The audit results could not be located as a result, the Fingerstick Blood Sugar order report has been printed and denotes residents who were diabetics during that time frame with fingerstick/blood sugar orders. The audit was completed by the MDS Coordinator on or about 4/8/2025.On 04/08/2025 all nurses directly involved with R12 were required to complete remediation on the Alabama Board of Nursing website completion reviewed by the (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous Director of Nursing, that included the following online courses Documentation: A Case Study, Scope of Practice for RN's and LPN's, Standardized Procedures: Practice Beyond Basic Nursing Education and Medication Administration & Safety for Charge Nurses. All nurses involved received appropriate disciplinary action on 4/2/2025. The disciplinary actions were administered by the previous Director of Nursing.On 04/23/2025 through 05/04/2025 all nurses involved were monitored for medication pass validations by the previous Director of Nursing. On 04/21/2025 all licensed nurses in the facility were educated on Diabetic Medications with hypoglycemia effects, recognition of signs/symptoms of hypoglycemia, required interventions and notifying the NP/PA/MD for all changes in residents' conditions relative to diabetic changes. This education was provided by the Pharmacy Consultant.**********

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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, interview, record review, and facility policy review, the facility failed to ensure staff implemented appropriate personal protective equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP) during high-contact care activities (medication administration via gastrostomy tube [G-tube]), for one of one resident (Resident (R) 4) reviewed for EBP of 29 sample residents. This deficient practice had the potential to increase the risk of transmission of infectious organisms between residents and staff, and within the facility, which housed a vulnerable population of 68 residents.Findings include:Review of R4's Face Sheet located in the Resident tab of the electronic medical record (EMR) indicated admission on [DATE] with diagnoses including cerebral infarction and presence of a gastrostomy tube.Review of R4's quarterly Minimum Data Set (MDS) located in the EMR under the RAI [Resident Assessment Instrument] tab with an Assessment Reference Date (ARD) of 03/27/2026 revealed a Brief Interview for Metal Status (BIMS) was not conducted and was assessed by staff to indicate R4 was severely cognitively impaired.Review of active physician orders revealed an order, located in the EMR under the Resident tab in Reports and dated 11/20/2024 for Enhanced Barrier Precautions related to G-tube.Review of the most recent Comprehensive Care Plan located in the EMR under the RAI tab, last reviewed 01/28/2026, indicated R4 required EBP related to G-tube, with approaches including staff were to don (put on) a gown and gloves during high-contact care activities, educate staff on EBP, ensure appropriate signage was present, maintain EBP for the duration of need, and perform hand hygiene after PPE removal.During an observation and concurrent interview on 04/10/2026 at 9:21 AM, an EBP signage was observed outside R4's room identifying required PPE and applicable care activities. A vertical PPE organizer hung from the bathroom door inside R4's room with disposable gowns and gloves. Licensed Practical Nurse (LPN) 2 performed hand hygiene and donned gloves prior to administering medication via G-tube but did not don a gown. Upon completion, LPN2 removed gloves and performed hand hygiene. During an interview, LPN2 confirmed R4 was on EBP due to the G-tube and initially stated gloves were required. After reviewing the posted signage, LPN2 acknowledged that a gown was also required and stated that failure to wear a gown during such care could spread germs.During an interview on 04/12/2026 at 5:58 PM, the Infection Preventionist (IP) confirmed responsibility for implementing. monitoring EBP and ensuring staff education on PPE use. The IP stated staff were expected to perform hand hygiene and wear appropriate PPE during direct care activities, including care involving indwelling devices.Review of staff development records for in-service training, provided by the facility and dated 09/22/2025 on PPE use, did not include LPN2's attendance.Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), revised 09/2023, indicated EBP applies to residents with indwelling medical devices such as feeding tubes, signage must identify required precautions, and gloves and gowns must be worn during high-contact care activities, including device care or use such as feeding tubes.Review of the Centers for Disease Control and Prevention (CDC) guidance, titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, located at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html#print, revealed appropriate PPE for EBP, including gowns and gloves, must be readily available and utilized during applicable care activities.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure the resident's guardian gave consent prior to the resident being administered the COVID-19 vaccination for one of one resident (Resident (R) 44) reviewed for COVID-19 vaccinations out of a total sample of 29. The facility obtained consent for the vaccination from R44; however, the resident had a guardian. This had the potential to cause R44 physical harm as the resident was unable to understand the risks or benefits of the vaccination.Findings include:Review of R44's Resident Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, and mild neurocognitive disorder.Review of the Order Appointing Guardian and Conservator, dated 01/15/2025 and located on the [County of Alabama] public court records website revealed the court found R44 to be an incapacitated person with no existing guardian. The court determined that R44 was unable to manage personal medical needs, assets, or financial matters, and therefore ordered and appointed a guardian and conservator. A probate judge signed the order.Review of R44's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab revealed a note completed by the Assistant Director of Nursing/Infection Preventionist (ADON/IP) dated 07/24/2025 of Resident consented to 2024-2025 Covid Vaccine. Explain procedure to resident.Review of R44's Resident Progress Notes, located in the resident's EMR under the Progress Notes tab revealed a note dated 07/30/2025 of Resident sponsor [Family Member (F) 1] called .Ya'll already F**k-UP and gave [him/her] a shot (COVID) that [he/she] wasn't suppose [sic] to have .During an interview on 04/10/2026 at 2:02 PM, F1 stated back in July 2025, the facility called and told him/her that R44 received the COVID-19 vaccination. F1 stated he/she had already decided when the facility called to offer the vaccine for R44 that it was going to be declined because he/she did not want R44 receiving the vaccination due to the resident's dementia diagnosis. During an interview on 04/10/2026 at 2:57 PM, the ADON/IP stated he/she did obtain R44's consent for the COVID-19 vaccination. The ADON/IP stated when he/she called F1 for another reason, he/she informed F1 that R44 was administered the COVID-19 vaccination. The ADON/IP stated F1 became upset that the resident was administered the vaccine. The ADON/IP stated after the phone call, he/she looked at R44's Face Sheet in the hard chart and became aware F1 was R44's decision maker. Review of the facility's COVID-19 Vaccine Policy and Procedure revised 10/2022 revealed .V. Documenting COVID-19 Vaccine for Staff and Residents. a. The facility will maintain documentation for all residents.c. For residents, the information will be documented in their medical record. d. The information to be documented includes: a) The.resident or representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. B) Whether the.resident or their representative consented to the vaccine.