

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Manokin Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 11974 Edgehill Terrace Princess Anne, MD 21853	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews and staff interviews, the facility failed to protect resident property and provide a safe environment by not maintaining an inventory of resident belongings and not investigating a lost item for one Resident (R28) of three sampled residents.</p> <p>The findings included:</p> <p>Record review of the resident and family grievances policy facility's dated 02/06/2024, showed the following: It is the policy of the facility to support each resident's and family members' right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. The policy documented the facility social worker has been designated as the Grievance Official and backup is the Administrator. The Grievance Official is responsible for overseeing the grievance process receiving and tracking grievance through to their conclusion; leading any necessary investigation by the facility, maintaining the confidentiality of all information associated with grievance; issuing written guidance decisions to the resident; and coordination with state and federal agencies as necessary in light of specific allegations.</p> <p>Record review of R28's face sheet showed an admission was dated 11/08/2023; diagnoses included anxiety disorder and major depressive disorder. R28's Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating cognition was intact. The R28 care plan initiated on 11/09/2023 documented the resident having impaired visual function. The care plan directed the staff to tell the residents where they were placing the items.</p> <p>Record review of Licensed Practical Nurse (LPN)27 nurse's notes dated 11/18/2023 at 10:35 AM, LPN 27 documented resident reported to his/her daughter and staff that a ring was missing. The staff searched the room, bed linens, and called the laundry. R28's daughter called the state police, and they came to take R28's statement.</p> <p>Record review of R28 nurse's notes dated 11/18/2023 at 1:30 PM, (LPN)8 documented she went and asked R28 what happened to the ring and the resident stated he/she lost it. The note documented R28 then stated I swallowed it dummy.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215179	If continuation sheet Page 1 of 7

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/05/2025 at 10:58 AM, Social Services Director (SSD) 9 stated that she was not employed at the facility in November of 2023 and did not remember talking with R28's Responsible Party (RP) about R28's ring missing. SSD9 stated that after reviewing R28's medical record, she could not find the inventory list completed during the resident's admission. SSD 9 stated that she reviewed the grievance log for the entire year of 2023, and she could not find the report indicating the staff searched for the ring and the resolution on R28's missing ring. SSD 9 stated the practice at the facility was upon the resident's admission, a staff member completes a resident s inventory list and when an item was reported missing, the staff member will complete the grievance, and they will search for the missing items and get back to the family with a resolution.</p> <p>During the interview on 06/11/2025 at 10:52 AM, LPN 8 stated she recalled a discussion with the family back in November 2023 in reference to R28's ring missing. LPN8 reported she notified the former Social Services Director (SSD) about the report of R28's ring missing but did not recall if a grievance or a follow-up was done by the SSD. She stated she did not recall observing the resident with a ring, but she recalled R28's RP reporting to her that the resident's ring was missing.</p> <p>During an interview on 06/18/2025 at 11:27 AM, the Nursing Home Administrator (NHA)1 reported that she was not employed at the facility in November of 2023 when R28's ring was reported as missing. NHA1 reported she could not find any document in R28's record indicating a follow up on the family's grievance regarding R28's missing ring. NHA1 reported that now when a resident is being admitted to the facility, the staff completes an inventory form which lists all the residents' belongings and if an item was reported missing the staff will search for it and if it cannot be found then the facility will replace the item with a comparable item.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Record review of R35's face sheet showed an admission was dated 07/20/2022; diagnoses included Generalized anxiety disorder, Alzheimer's disease, and Major depressive disorder. R35's Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 03/15 indicating cognition was severely cognitively impaired. R35 care plan initiated 07/20/2022 documented the resident had Activities of daily Living (ADL) self- care deficit due to Alzheimer's. The care plan directed the staff to assist the resident with bathing and grooming.</p> <p>Record review of R35 nurse's notes dated 10/20/2023, revealed Licensed Practical Nurse (LPN)36 documented it was reported to her that R35 smacked GNA37 in the face and then GNA37 hit R35 back. LPN36 reported this information to the former administrator. The Medical Doctor (MD) stated he was going to see R35 the next day for assessment and readjust medications. The responsible party was contacted and notified of the R35 incident and confirmed that she would like to press charges against GNA37. R35 was assessed for pain, injury, and skin assessment. R35 denied any pain or distress at the time. R35 skin assessment contained no bruising, tears or swelling.</p> <p>Record review of R35 provider note dated 10/21/2024 revealed the provider note documented R35 was seen for an acute visit as R35 struck a nursing Aide in the face yesterday. The nursing Aide then struck R35 back. The patient did not have any recollection of the events and denied experiencing any pain. R35 noted to be agitated at times. Plan of care revealed the following plan: 1. The patient seems to have suffered no significant injuries or was struck by a staff member. The facility is taking appropriate steps to address this issue.</p> <p>Review of GNA 37 personnel file revealed the license was up to date, and the criminal background check was completed prior to GNA 37 employment at the facility. The report revealed GNA 37 had no history of crime.</p> <p>During an interview on 06/18/2025 at 11:42 AM, the Nursing Home Administrator (NHA1) revealed she was not employed at the facility in October 2024. She reported that her expectation was for staff at the facility to protect the residents and GNA37 should not have slapped R35. She also added that the abuse training was done regularly at the facility.</p> <p>During an interview on 06/19/2025 at 2:38 AM, Director of Nursing (DON) 2 stated that staff at the facility were regularly in-serviced on different types of abuse. DON 2 reported other staff members reported hearing GNA37 slapping R35. She stated GNA37 was suspended and then terminated after the outcome of the investigation. She reported that other staff members were all in serviced after the abuse incident on 10/20/2024. DON 2 all the residents who could have been potentially affected by abuse were interviewed, and they all reported they did not have concerns related to abuse at the facility.</p> <p>LPN 36 was no longer employed at the facility and did not return the phone call.</p> <p>GNA 37 was no longer employed at the facility and did not return the phone call.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews, observations and record review, the facility failed to maintain an environment that was free from staff-to-resident abuse for two residents (Resident R10 and R35) of ten residents sampled for abuse. Specifically, Maintenance Assistant (MA) 39 slapped a R10 in the face and Geriatric Nurse Aide (GNA)35 hit R35 in the face. The facility census was 101.</p> <p>The findings include:</p> <p>Record review of the facility's abuse, neglect and exploitation policy dated 02/02/2024, and last revised on 3/25/2025 showed the following:</p> <p>The facility is to provide protection for health, welfare and rights of each Resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse means, the willful infliction of injury, unreasonable confinements, Intimidation, or punishment resulting from physical harm, pain or mental anguish, which can include staff to Resident abuse, and certain Resident to Resident altercations. Instances of abuse include all Residents, irrespective of any mental or physical condition that cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. The covered individual is anyone who is an owner, operator, employee, manager, agent, or contractor of the facility. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. The facility will designate an abuse prevention coordinator, who is responsible for reporting allegations of suspected abuse, neglect, or exploitation to the state survey agency. And other officials in accordance with state law. The facility will have written procedures. That includes immediately, but not later than two hours after the allegation is made; it should be reported to the State Survey agency.</p> <p>1. Record review of R10s face sheet showed his admission date was dated 06/28/2023; diagnoses included Spinal Stenosis, Bipolar Disorder and Chronic Systolic Congestive Heart failure. Record review of R10s Care Plan initiated on 6/28/2023 documented. R10 was dependent on staff to meet emotional, intellectual, physical, and social needs due to physical limitations. R10 had chronic pain related to contractures/ decreased mobility.</p> <p>Record review of R10s written statement dated 3/23/2024 revealed that on 3/22/2024, R10 documented he/she was at the nurse's station when MA 39 angrily approached using profane language and hit him/her on the back of the head and poked him/her on the shoulder.</p> <p>Record review of R48s written statement dated 3/23/2024 revealed that on 3/22/2024, R48 documented he/she was at the nurses' station when he/saw saw MA 39 poking R10 on the shoulder and documented he/she could smell the breath of alcohol from MA 39's breath. R48 concluded MA 39 dropped a bottle of alcohol on the floor, where he was working at the nurse's station.</p> <p>Record review of R10s progress notes dated 03/22/2024 at 09:17 PM, Licensed Practical Nurse (LPN) 10 documented a Late Entry and wrote, R10 approached him/her and called the LPN to his/her room and stated the drunk maintenance guy, Maintenance Assistant (MA) 39 slapped him/her on the back of the neck while he/she was in the Day Room and R10, stated, everybody in the day room heard it. R10 stated that he/she does not want MA 39 to lose his job.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a written statement dated 3/23/2024, the Maintenance Director (MD7) documented on 3/22/2024 that he asked MA 39 to leave the facility three times and MA 39 refused. On 3/23/2024 when MD7 reported to work in the morning, he asked MA 39 to leave the facility and MA 39 walked out.</p> <p>Record review of the quarterly Minimum Data Set (MDS), a federal mandated data assessment form dated 7/28/2024, revealed R10 had a BIMS score of 15/15, which indicated the resident was cognitively intact.</p> <p>Record review of the discharged MDS, a federal mandated data assessment form dated 8/11/2024, revealed R10 was discharged with no anticipated return.</p> <p>During an interview on 6/13/2025 at 10:49 AM former, Licensed Practical Nurse (LPN) 10 stated, on 3/22/2024 at approximately 7:00 PM, R10 approached him and stated the MA 39 slapped him/her on the face, he went to investigate and found MA 39 drunk and disorderly, and he told the MA 39 he was calling the police. At that point according to LPN 10, MA 39 ran through the back door. LPN 10 stated the police were outside the parking lot for two hours waiting for MA 39. LPN 10 stated he notified the former Director of Nursing (DON) 4 and former Nursing Home Administrator (NHA) 3.</p> <p>During an interview on 6/16/2024 at 10:01 AM, the Assistant Director of Nursing (ADON)11 stated she remembered sometime in March 2024, MA 39 came into the building while he was intoxicated and physically struck R10. ADON 11 stated that the former NHA 3 and DON 4 were made aware immediately.</p> <p>During an interview with on 6/16/2025 at 11:15 AM, the Maintenance Director (MD7) revealed in March 2024, he was the transitional MD. MD7 stated on 3/22/2024 at approximately 12:00 PM he observed, MA 39 exhibited unusual behavior. According to MD 7, on the same day at approximately 1:30 PM, he found MA 39 sleeping in the storage room and smelling alcohol. MD 7 stated he spoke to MA 39 a second time at approximately 3:00 PM and directed MD 39 to go home as he was intoxicated and MA 39 refused. According to MD 7, at approximately 3:30 PM, he offered MA 39 a ride to his home since he had no transportation. MD 7 further revealed at approximately 4:30 PM he walked MA 39 out of the building and told him to go home. Later on, he was told MA 39 left the building and returned to the facility and was more intoxicated. He also learned that MA 39 hit R10 while intoxicated. MD 7 stated the next day on 3/23/2024 at approximately 7:30 AM when he reported to work, R10 told him MA 39 physically assaulted R10 and struck him/her on the head and R10 stated he/she was afraid of MA 39 and wanted someone to talk to him.</p> <p>During an interview on 6/16/2024 at 11:30 AM the former DON 4 stated she remembered MA 39, a former employee, was intoxicated on duty, and he hit another resident (R10) while he was under the influence. According to the former DON 4, the resident declined to press charges.</p> <p>During an interview on 6/16/2025 at 12:30 PM, the former NHA 3 revealed, on 3/22/2024, R10 stated, MA 39 hit him/her on the head while he/she was in the day room. R10 stated MA39 was drunk.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to provide adequate supervision and implement intervention to prevent multiple falls for one Resident (R31) of 3 sampled residents who was at high risk for falls.</p> <p>Findings included:</p> <p>Record review of R31's face sheet showed an original admission was dated 12/13/2018; diagnoses included severe intellectual disabilities, major depressive disorder, restlessness, and agitation. R31's Minimum Data Set (MDS) dated [DATE] indicated that the resident had severely impaired cognitive skills for daily decision-making. R31's functional limitation in range of motion was impaired on both sides of upper extremity and lower extremity. The resident was dependent on staff with toileting hygiene and personal hygiene. R31 care plan initiated 04/04/2019 documented the resident was at risk and had potential for falls due to limited mobility, cognition decline due to severe Intellectual Disability (ID). The care plan directed the staff to place a bed against wall-per guardian preference, bed in lowest position when occupied, ensure proper body posture while in bed to ensure safety, floor mats beside bed when the resident is in bed and perimeter mattress applied to bed.</p> <p>Review of MD00203104 and the un-witnessed fall form dated 02/18/2024, Licensed Practical Nurse (LPN)29 documented, Geriatric Nurse Aide (GNA) alerted her that R31 was on the floor when she entered to provide care. R31 was found lying in a curled-up position (Baseline position) on the floor directly next to the bed. The bed was in the lowest position. It documented R31 rolled over the edge. The report indicated R31 was unable to give a statement. The report indicated a full assessment, Vital signs were obtained, R31 was safely assisted back to bed and wound care to small laceration to above left eye. The report revealed no injury was observed at the time of the incident. Further review of the incident report revealed no intervention was put in place after the fall incident.</p> <p>Review of the un-witnessed fall form dated 02/27/2024, RN (Registered Nurse)28 documented she was called to room about R31 being on the floor. When RN28 entered the room, R31 was on the floor. After the R31 assessment, the resident was assisted by two staff members to the bed. No apparent injury was noted at the time. R31 was unable to give a description. Further review of the form revealed no intervention was put in place after the R31 fall.</p> <p>Record review of R31 nurse's notes dated 03/31/2024 at 9:43PM, LPN #30, documented that R31 was observed laying on his/her Right side, on the floor mat beside the bed. His/Her head was towards the foot end of the bed. R31 was assessed for injuries, and injuries were noted. R31 appeared agitated when staff put him/her back into bed and was rubbing the skin on his/her arms. As needed pain medication was given for pain R31 may have been experiencing. Neuro checks have started. R31 was assisted back in bed. Notification was made for Medical Doctor, Director of Nursing (DON) and social workers. Neuro checks were within normal limits (WNL). Further review of the incident report revealed no intervention was put in place after the fall incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2025 at 4:08 PM, Minimum Data Set Coordinator (MDSC) 30 revealed she was not employed at the facility when R31 had the falls in 2024. She reported reviewing R31's care plan completed in February 2024 and March 2024 and did not find the interventions for the falls 02/18/2024, 02/27/2024 and 03/31/2024. MDSC 30 reported that the facility has an Interdisciplinary Team (IDT) meeting in the mornings that discusses the residents' falls. MDSC 30 stated the IDT comes up with the root cause of a fall, and the care plan was updated with new interventions.</p> <p>During an interview on 06/18/2025 at 11:38 AM, the Nursing Home Administrator (NHA1) revealed that she was not employed at the facility when R31 had the falls. She stated she could not find any documentation on R31's records indicating the interventions that were put in place after the falls that happened on 02/18/2024, 02/27/2024 and 03/31/2024. NHA1 stated that when R31 had the falls, the interventions should have been put in place and the care plan updated.</p> <p>During an interview on 06/18/2025 at 11:40 AM, the Director of Nursing (DON)2 revealed she was not employed at the facility when R31 had fallen. She added that the interventions should have been put in place after each fall that happened on 02/18/2024, 02/27/2024 and 03/31/2024.</p> <p>LPN30 was no longer employed at the facility and did not return phone calls.</p> <p>LPN29 was no longer employed at the facility and did not return the phone call.</p> <p>RN 28 was no longer employed at the facility and did not return the phone call.</p>		