STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215179	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manokin Nursing and Rehab	11974 Edgehill Terrace Princess Anne, MD 21853

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from physical and verbal abuse by staff for 1 (Resident #3) of 10 sampled residents reviewed for abuse. It was determined the non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, at a scope and severity of J.The IJ began on 02/05/2026 when the Administrator verbally and physically abused Resident #3.The survey team notified the Administrator and Director of Nursing of the IJ and provided the IJ template on 03/24/2026 at 2:17 PM. Beginning 02/12/2026 until 02/24/2026, the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past non-compliance was cited with a compliance date of 2/24/2026.Findings included:A facility policy titled, Abuse, Neglect and Exploitation, revised 03/25/2025, indicated, Policy: It is the policy of this facility to provide protections for the 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. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, 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 policy specified, Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment and Verbal Abuse mean the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.An admission Record revealed the facility admitted Resident #3 on 12/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of dementia, post-traumatic stress disorder, and generalized anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Per the MDS, Resident #3 used tobacco and did not exhibit any physical or verbal behaviors directed toward others during the assessment period. The Facility Reported Incident [FRI] Initial Report Form submitted by the Chief Nursing Officer (CNO) on 02/12/2026, revealed on 02/05/2026 a verbal exchange occurred during a resident smoke break that involved the Administrator and Resident #3. Per the FRI Initial Report Form, initial reports and observations indicated an interaction escalated and Resident #3 engaged in physical contact with the Administrator; however, subsequently Resident #3's resident representative (RR) reported an (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	allegation that the Administrator might have made physical contact with Resident #3 prior to the resident's physical response. The FRI Initial Report Form indicated this information was not known at the time of the initial observation, was received after the event, and the matter remained under investigation.During an interview on 03/17/2026 at 11:32 AM, Resident #3 stated on the day of the incident (02/05/2026), there was a resident smoke break and usually only four residents were allowed out at the smoke break at one time, but the Administrator made a mistake and let all the residents out who wanted to smoke at the same time. Resident #3 stated they were smoking and minding their own business when all of a sudden the Administrator started to call them racial slurs. Resident #3 stated they never got along with the Administrator because she always tried to start something with them. Resident #3 stated they were trying to get back in the building but the Administrator kept hitting them, so they choked the Administrator to get her out of their way. Resident #3 stated they did not want to hurt the Administrator, they just wanted her out of their way. According to Resident #3, there were multiple residents and staff that witnessed the incident.Contained within the facility's investigation file was Certified Nursing Assistant (CNA) #1's handwritten Witness Statement Form completed 02/05/2026, which indicated ?I [CNA #1] witnessed admin [Administrator] standing in front the door stopped [Resident #3] from coming in the building at which they asked for the code to open the door at which another aide open the door and administration [Administrator] pushed the door back closed and said no which amplified the situation and [Resident #3] had become aggressive after she [Administrator] kept pushing on [Resident #3].During an interview on 03/18/2026 at 2:07 PM, CNA #1 stated she was sitting at the nursing station when she heard an activity staff person yell for help. CNA #1 stated as she approached the door, she saw the Administrator standing in front of the door screaming no to Resident #3. CNA #1 stated she saw Resident #3 trying to get around the Administrator but the Administrator kept blocking the door and was not letting Resident #3 come in. CNA #1 stated she witnessed the Administrator push Resident #3 in their chest two times in an attempt to move the resident from the door, all while screaming no at the resident. CNA #1 stated then all of a sudden she saw Resident #3 grab the Administrator's neck and pressed her against the door. CNA #1 stated the activity aide (AA) was present and separated Resident #3 and the Administrator.During an interview on 03/23/2026 at 12:18 PM, AA #31 stated on 02/05/2026 as she walked by she saw Resident #3 and the Administrator both shoving each other. AA #31 stated she did not hear what was being said, but when she approached the door to put the code in so that the door would open, the Administrator screamed no and repeatedly stated do not open the door. AA #31 stated the next thing she saw was Resident #3 choking the Administrator. AA #31 stated she screamed for help and more staff came to help.Contained within the facility's investigation file was Resident #9's handwritten Witness Statement Form completed 02/09/2026, which indicated On Thursday [02/05/2026] at the smoke break, I [Resident #9] saw the administrator [Administrator] push [Resident #3] after [Resident #3] tried to come back in facility with cigarette [half] one. She [Administrator] pushed [Resident #3] back again then used the N word [a racial slur].After the N word was used [Resident #3] grabbed her [Administrator] by the throat.During an interview on 03/17/2026 at 2:00 PM, Resident #9 stated they witnessed the incident between Resident #3 and the Administrator. Resident #9 stated Resident #3 wanted to come in facility and the Administrator blocked Resident #3 from going in the facility because the resident had a cigarette. According to Resident #9, the Administrator wanted Resident #3's cigarette and would not let the resident in the facility. Resident #9 stated Resident #3 kept trying to get in and then after a few blocks, the Administrator pushed Resident #3 in their chest and the resident rocked back. Resident #9 stated Resident #3 tried to enter the code on the key pad again in an attempt to enter the facility. Resident #9 stated it was at that time, the Administrator called Resident #3 a racial slur and that set Resident #3 off and the resident choked the Administrator. Resident #9 stated Resident #3 did not put their hands on the Administrator until after the Administrator called Resident #3 a racial slur. A quarterly MDS, with an ARD of 01/06/2026, revealed Resident #9 had a BIMS score of 15, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which indicated the resident had intact cognition. Contained within the facility's investigation file was Resident #10's handwritten Witness Statement Form undated which indicated The administrator stopped [Resident #3] from going in the door to come back in. The administrator [Administrator] pushed [Resident #3] away from the door because [Resident #3] was bringing [his/her] cigarette back in. When the administrator pushed [Resident #3] she also used the N word when she put her hands on [Resident #3] & used the N word is when she was choked by [Resident #3].During an interview on 03/17/2026 at 2:13 PM, Resident #10 stated Resident #3 was trying to come in the facility from a smoke break. According to Resident #10, the Administrator stated Resident #3 had a cigarette in their hand, but the resident did not Resident #10 stated the Administrator shoved Resident #3 in chest real hard maybe three times and Resident #3 kind of fell against the door, but did not fall down. Resident #10 stated Resident #3 kept trying to put the code in on the key pad to open the door. Per Resident #10, the Administrator called Resident #3 a racial slur and Resident #3 got mad. A quarterly MDS, with an ARD of 11/05/2025, revealed Resident #10 had a BIMS score of 15, which indicated the resident had intact cognition. Contained within the facility's investigation file was Resident #11's handwritten Witness Statement Form completed 02/09/2026, which indicated [Resident #3] had half a cigarette [Resident #3] was trying to punch the code in to go inside. I yelled 2x [two times] & said [Resident #3] always keeps [his/her] own cigarette & lighter. She [Administrator] broke her own rule by taking every one out at one time instead of groups as she has stated before. The administrator pushed [Resident #3] 2x then used the N word. [Resident #3] then after that choked her.Contained within the facility's investigation file was Resident #16's Witness Statement Form completed by Social Services Director (SSD) #29 on 02/12/2026, which indicated [Administrator] gave [Resident #3] two cigarettes and [Resident #3] smoke one and then tried to come back in building. [Administrator] told [Resident #3] [he/she] couldn't go back in the building with the cigarette and to put it back in the drawer. [Resident #3] tried to put numbers in to open the door. [Administrator] blocked the door with her body and then threw her hand to block the key code. At that time voices became escalated and [Resident #3] and [Administrator] started verbally arguing with each other. Resident stated that they were all trying to tell [Administrator] that [Resident #3] always has a cigarette but she wasn't paying attention. [Resident #16] stated that someone tried to get [Administrator] inside but she refused and shut the door stating no. [Resident #3] told her [he/she] does this all the time and tried to get in again. Resident reports that [he/she] did see administrator shove [Resident #3] and [the resident's] hands at her neck, but was trying to get away and could not recall the order of those events.During an interview on 03/17/2026 at 3:28 PM, Resident #16 stated Resident #3 was trying to get inside the facility, but they had a lit cigarette and the Administrator stood in front of the resident with her hand out asking for the cigarette. Resident #16 stated Resident #3 would not give the cigarette to the Administrator and the Administrator blocked the key pad so that Resident #3 could not press the code to enter the facility. Per Resident #16, Resident #3 got pissed and kept trying to enter the facility. Resident #16 stated both Resident #3 and the Administrator started to push each other, but the Administrator pushed Resident #3 in their chest with both of her hands really hard. Resident #16 stated both Resident #3 and the Administrator were screaming at each other and the next thing they knew, Resident #3 started to choke the Administrator. An admission MDS, with an ARD of 01/14/2026, revealed Resident #16 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.A review of the facility plan of correction revealed the facility initiated corrective actions on 02/12/2026 to remove the immediate jeopardy and correct the failed practices as follows:The Administrator was suspended pending investigation of the abuse allegation on 02/12/2026.On 02/12/2026, a quality assurance (QA) meeting was held with the Assistant Administrator, Maintenance Director, Infection Preventionist, Social Services Director (SSD), Director of Nursing (DON), Assistant Dietary Director, Admissions Director, Minimum Data Set Coordinator, Central Supply Coordinator/Transportation Clerk, unit managers, Activity Director, Scheduling Coordinator, Business Office Manager, and Human Resource (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director. The QA team reviewed the case findings for Resident #3. The QA committee developed, reviewed, and approved a corrective action plan, to include auditing progress notes, grievances, behaviors, and risk management.On 02/12/2026 - 02/24/2026, 148 employees were provided an in-service by the Chief Nursing Officer (CNO). The in-service education included but was not limited to abuse policy, smoking policy, and resident rights.On 02/12/2026, a performance improvement plan (PIP) audit worksheet was implemented for any residents admitted to the facility, to ensure they were able to exercise their right to smoke without potential for abuse and accurate investigation of abuse allegations. The PIP audit worksheet was to be completed by DON, CNO, Regional Director of Operations (RDO), or designee daily for seven days, with results of the PIP audit worksheet to be reported to the QA committee for determination of the need for ongoing formal monitoring.On 02/16/2026, the facility conducted interviews with residents who were members of Resident #3's smoking group. These interviews were conducted to determine if the resident was abused, had witnessed abuse, or informed a staff member of abuse.On 02/16/2026, the facility conducted observations of residents who were members of Resident #3's smoking group. These observations were made to determine how the residents were being treated by staff, other residents, or anyone else visiting the facility.On 02/19/2026, the RDO and corporate Human Resource Manager provided in-service education to the Administrator, including de-escalation techniques, smoking policy, abuse prevention, and residents' rights.The facility's alleged date of compliance was 02/19/2026 however, all staff education was not completed until 2/24/26.The survey team reviewed the facility's corrective action plan, in-service education records, monitoring tools, the facility's investigation file, and interviewed residents and staff which revealed the facility implemented corrective actions from 02/12/2026 to 02/24/2026.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, document review, and facility policy review, the facility failed to ensure an allegation of resident abuse was reported to the state survey agency (SSA) within two hours for an allegation involving 1 (Resident #3) of 10 sampled residents reviewed for abuse. Findings included:A facility policy titled, Abuse, Neglect and Exploitation, revised 03/25/2025, indicated, Policy: It is the policy of this facility to provide protections for the 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. The policy further revealed, VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia, for example], law enforcement when applicable) within specified timeframes; a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. An admission Record revealed the facility admitted Resident #3 on 12/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of dementia, post-traumatic stress disorder, and generalized anxiety disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Per the MDS, Resident #3 used tobacco and did not exhibit any physical or verbal behaviors directed toward others during the assessment period. A Physical Aggression Initiated incident report, completed by Licensed Practical Nurse (LPN) #12 on 02/05/2025, revealed a Nursing Description of the incident that indicated Resident #3 was physically aggressive toward a staff member (Administrator). The section of the report for the Resident Description of the incident indicated Resident #3 stated that they were outside smoking and once done, they threw their cigarette down in the snow, at which time the staff member (Administrator) instructed them to pick it up. The report indicated that Resident #3 reported that they declined to pick up the cigarette, and the staff member began pushing them. Per the report, the resident reported that they also had an unlit cigarette with them, and the Administrator asked that the resident hand it over, and the resident again refused and informed the Administrator they had always kept their cigarettes in their possession. The resident alleged the Administrator then started pushing them again while saying the resident was not listening, so Resident #3 choked the Administrator. The incident report included statements from two staff members, Certified Nursing Assistant (CNA) #1 and CNA #33. CNA #33's attached statement indicated that around 4:15 PM, she responded to a request for help, and upon her arrival, Resident #3 was trying to get into the building, but the Administrator was blocking the door, and the Administrator and Resident #3 were shoving each other back and forth. Per the statement, CNA #33 opened the door to let Resident #3 or the Administrator inside in an attempt to deescalate the situation, but the Administrator slammed the door back closed with her body and hollered, No, which triggered the resident further. Per CNA #33's statement, the Administrator shoved the resident back again, and the resident then choked the Administrator. CNA #1's statement indicated she witnessed the Administrator standing in front of the door blocking Resident #3 from reentering the building, and another CNA (CNA #33) opened the door, but the Administrator pushed the door back closed and said no, which amplified the situation. CNA #1's statement further indicated Resident #3 became aggressive after she [Administrator] kept pushing on [the resident].A Facility Reported Incident [FRI] Initial Report Form, dated 02/12/2026, revealed the Chief Nursing Officer (CNO) submitted an initial report for the 02/05/2026 incident involving Resident #3 and the Administrator to the SSA on 02/12/2026 at 3:50 PM. During an interview on 03/18/2026 at 8:16 AM, LPN #12 stated staff were to report any witnessed or alleged resident abuse immediately, within two hours. She stated she was the nurse working on 02/05/2026 when the incident occurred (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between Resident #3 and the Administrator. She further stated that CNA #33 reported to her that following a smoke break, the Administrator provoked Resident #3. LPN #12 stated that she also interviewed Resident #3, who reported the Administrator yelled at them and pushed them. Per LPN #12, she notified Resident #3's family, the local police, the Director of Nursing (DON), and the Medical Director (MD). During an interview on 3/25/2026 at 10:27 AM, the Regional Director of Admissions (RDOA) stated that any abuse should be reported immediately. The RDOA then reviewed CNA #1's statement from 02/05/2026 and confirmed the information did represent an allegation of abuse and should have been reported immediately. The RDOA stated he did not know why the initial report was not submitted on 02/05/2026. During an interview on 03/27/2026, the Regional Administrator stated that the facility should submit initial reports of abuse within two hours of receiving an allegation.A review of the facility's plan of correction revealed the facility initiated corrective actions on 02/12/2026 as follows:On 02/12/2026, a quality assurance (QA) meeting was held with the Assistant Administrator, Maintenance Director, Infection Preventionist, Social Services Director (SSD), Director of Nursing (DON), Assistant Dietary Director, Admissions Director, Minimum Data Set Coordinator, Central Supply Coordinator/Transportation Clerk, unit managers, Activity Director, Scheduling Coordinator, Business Office Manager, and Human Resource Director. The QA team reviewed the case findings for Resident #3. The QA committee developed, reviewed, and approved a corrective action plan, to include auditing progress notes, grievances, behaviors, risk management, timely reporting of abuse, and collection of witness statements.On 02/12/2026 - 02/24/2026, 148 employees were provided an in-service by the Chief Nursing Officer (CNO). The education included but was not limited to the facility's abuse policy. The education included information about mandatory reporters and the facility's responsibility to ensure timely internal reporting as well as external reporting to the SSA for all allegations of abuse.The survey team reviewed the facility's corrective action plan, in-service education records, monitoring tools, the facility's investigation file, and interviewed residents and staff which revealed the facility implemented corrective actions from 02/12/2026 to 02/24/2026.