| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Manokin Nursing and Rehab | 11974 Edgehill Terrace<br>Princess Anne, MD 21853 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on a review of complaint 2965994, observations during a dining experience, and interviews with facility staff, it was determined that staff failed to sit while feeding residents and failed to serve meals to all seated residents at the same time to provide a dignified dining experience. This was evident on 1 (Chase) of 2 nursing units observed during the dining experience of the complaint survey.The findings include:On 6/29/26 at 11:00 AM a review of complaint 2965994 was conducted regarding alleged concerns over resident care in the facility.On 6/29/26 at 12:38 PM observation on the dementia unit (Chase) noted residents eating lunch at the table adjacent to the nurse's station. Observation was made of Geriatric Nursing Assistant (GNA) #16 standing to feed Resident #9 and Resident #10. Licensed Practical Nurse (LPN) #7 was standing to feed Resident #11 and Unit Manager #8 was standing to feed Resident #12.On 6/30/26 from 8:27 AM to 8:46 AM a second observation of the dining experience during breakfast was made on the dementia unit.Observation was made of Resident #15 eating breakfast at the table while Resident #7 and Resident #16 watched until their breakfast came on the next food cart. Resident #10 ate at a separate table while Resident #17 waited for his/her breakfast tray. Resident #10 also had a fly flying around his/her head and the food while he/she was eating. It was also noted that while residents were eating, there were excessive crumbs, spills, pieces of food, and trash on the floor under their tables, by their feet, and adjacent to their tables. Six residents were sitting at a round table in front of the nurse's station for breakfast. Resident #18 had a breakfast tray and was eating. Resident #9 was fed breakfast by a staff member. Resident #19, #20, and #21 received their breakfast trays when Resident #18 and Resident #9 were done eating. Resident #22 sat there while all other residents at the table ate their breakfast. Resident #22 did not get his/her breakfast tray until 8:46 AM. GNA #11 was asked why Resident #22 did not get his/her breakfast tray until everyone else was done eating. GNA #11 stated, because [he/she] has to be fed.GNA #11 was asked why there was a delay in all of the residents getting their meal trays at the same time. GNA #11 stated that the kitchen does not send all the trays up at the same time because they have some residents that require feeding. GNA #11 was asked about the spills, crumbs, and trash on the floor in the dining area. GNA #11 stated that housekeeping leaves at 4 PM.On 6/30/26 at 10:05 AM the surveyor discussed the condition of the Chase dining area with the Nursing Home Administrator (NHA) and showed him pictures of the area. The NHA stated that someone should have cleaned up after dinner last night. The NHA was also informed of the dignity issues.On 6/30/26 at 10:51 AM an interview was conducted with the Director of Nursing (DON). The surveyor showed the DON the pictures of the Chase unit. The DON stated there was a mop, bucket, and a broom in the utility closet on that unit and someone should have cleaned up. The DON stated she agreed about the dignity issue with standing to feed the residents and the residents sitting at the tables and getting their food at the same time. The DON stated they would talk to the kitchen about when the food was delivered. |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints, observations, and interviews, it was determined that the facility failed to 1) provide maintenance services necessary to keep resident rooms and equipment sanitary and orderly and 2) ensure a resident's room was a safe, comfortable and homelike environment. This issue was observed on 3 of 5 nursing units reviewed for maintenance services and 1 of 4 resident rooms reviewed for safe, comfortable and homelike environment during a complaint survey.<br><br>The findings include:<br><br>1) On 6/29/26 at 12:20 PM the following environmental observations were made during a tour of the facility:<br><br>Ceiling Tiles in Disrepair: [NAME] water stains of various sizes were observed on ceiling tiles in rooms 106, 307, and room [ROOM NUMBER].<br><br>Plastic plumbing pipes were on the floor and in resident basins in rooms 107, 111, and room [ROOM NUMBER].<br><br>Toilet paper rollers were missing from toilet paper holders in rooms 303, 111, and room [ROOM NUMBER].<br><br>Bathroom exhaust fans were hanging down from the ceiling in rooms [ROOM NUMBERS].<br><br>Drywall was missing on the corner approximately 3 inches with the gray corner beading exposed by the bathroom door in room [ROOM NUMBER]. The drywall was also missing in the bathroom approximately 6 inches by 3 inches in room [ROOM NUMBER].<br><br>Resident #13's left wheelchair armrest was missing the front 3 inches of foam padding and the vinyl on the left armrest was cracked throughout.<br><br>The door to the bathroom in room [ROOM NUMBER] had (2) 1-inch holes.<br><br>The light bulb was burned out at the sink in room [ROOM NUMBER].<br><br>The nightstand drawer in room [ROOM NUMBER] was missing the third drawer.<br><br>In the Chase (dementia unit) observations were made of the floor in the TV room where a majority of the dining tables were located. There were spills on the floor, crumbs, pieces of paper towels, plastic cups, and pieces of food. In the alcove was trash on the floor including a plastic cup, napkins, and newspaper ads from circulars.<br><br>On 6/29/26 at 12:55 PM a tour was conducted Infection Control Preventionist (IP) #5 and she confirmed the maintenance concerns in the resident rooms. IP #5 stated that she informed the maintenance director, and he informed her to put the concerns in the TELS system. The TELS system is an electronic system to report maintenance concerns.<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/29/26 at 1:47 PM an interview was conducted with Director of Maintenance (DOM) #9. DOM #9 stated that he had 1 assistant that has been at the facility for the past 2 months. Previously the DOM was by himself for a short time. DOM #9 stated that staff were supposed to put any maintenance issues or repairs in TELS. DOM #9 stated, we have a hard time getting them to do that. I tell them that no matter what the size of the issue is to put it in TELS. I do room audits once a week. Regarding the brown ceiling stains, DOM #9 stated there were certain spots on the roof that get a lot of water and there has been a lot of rain. DOM #9 stated, I have been playing catch up today changing ceiling tiles because of the rain we had this weekend. On [NAME] the air conditioning unit was leaking, and I shop vacuumed that out. DOM #9 stated, once a week they will take the wheelchairs out of the unit and we will clean them and they are supposed to report the issues like wheelchair armrests.<br><br>On 6/30/26 at 8:46 AM Geriatric Nursing Assistant (GNA) #11 was shown the trash and crumbs on the floor in the Chase unit. GNA #11 stated that housekeeping leaves at 4 PM.<br><br>On 6/30/26 at 10:05 AM the surveyor discussed the condition of the Chase dining area with the Nursing Home Administrator (NHA) and showed him pictures of the area. The NHA stated that someone should have cleaned up after dinner last night. The NHA was also informed of the other maintenance issues.<br><br>On 6/30/26 at 10:51 AM an interview was conducted with the Director of Nursing (DON). The surveyor showed the DON the pictures of the Chase unit. The DON stated there was a mop, bucket, and a broom in the utility closet on that unit and someone should have cleaned up.<br><br>2) The facility staff failed to ensure a resident's room was a safe, comfortable and homelike environment.<br><br>Review of Resident #6's medical record on 6/29/26 revealed the Resident was admitted to the facility in February 2026 with a diagnosis to include Dementia. Dementia is an umbrella term for a decline in memory, thinking or reasoning skills that is severe enough to impair a person's ability to perform everyday activities.<br><br>Observation of Resident #6's room on 6/29/26 at 12:00 PM revealed the Resident was not in his/her room and there was no sheet on the Resident's bed.<br><br>Observation of Resident #6's room on 6/29/26 at 1:00 PM revealed the Resident was in his/her bed and the bed still did not have a sheet on it. At that time the Surveyor observed Ant and Roach spray can on the Resident's bedside table.<br><br>The Surveyor went with the Unit Manager (UM) #8 on 6/29/26 at 1:29 PM to Resident #6's room. At that time UM #6 confirmed the Ant and Roach spray at the Resident's bedside and stated it was brought in by the Resident's family and she would remove it immediately. UM #6 also stated the facility staff had cleaned the Resident's bed earlier that day, hadn't had a chance to put a sheet on it and the Resident had placed him/herself in the bed without the staff knowing.<br><br>The observations for Resident #6's room were shared with the Administrator on 6/30/26 at 10:14 AM. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on review of facility reported incident 3044296, documentation review, and interviews, it was determined the facility failed to report an alleged abuse immediately to the Nursing Home Administrator and within 2 hours to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #3) of 2 residents reviewed for 2 facility reported incidents during a complaint survey. The findings include:On 6/29/26 at 11:00 AM a review of facility reported incident 3044296 was conducted and revealed Resident #3 alleged that Certified Medicine Aide (CMA) #17 refused to give Resident #3 his/her breakfast tray until Resident #3 took his/her medication. On 6/15/26 at 2:30 PM Resident #3 was interviewed by the Nursing Home Administrator (NHA) and the Unit Manager (UM). According to the facility report, Resident #3 stated that the incident happened the previous Saturday or Sunday. Review of a written statement from Physical Therapy Assistant (PTA) #14 documented that he went to see Resident #3 on 6/14/26 at 2:00 PM and the resident informed him that CMA #17 withheld the resident's lunch because the resident would not take his/her medicine and today, 6/15/26 at 12:30 PM the resident told him that the same thing happened at breakfast. Review of an email dated 6/17/26 from Geriatric Nursing Assistant (GNA) #18 documented that the resident told her that he/she reported it on 6/4/26 to the nurse at the desk. Review of Licensed Practical Nurse (LPN) #15's statement documented that the pulmonary nurse practitioner (NP) reported to her that Resident #3 made accusations that staff had twisted the resident's arm and legs and that everyone was aware. LPN #15 documented that she went to interview the resident and the resident stated that he/she reported it on 6/11/26 to the nurse. On 6/30/26 at 3:27 PM an interview was conducted with PTA #14 who stated that Resident #3 had reported to him that he/she did not have breakfast because CMA #17 told the resident if he/she did not take the medications that he/she would not receive breakfast. He said the resident stated that it happened 2 times. PTA #14 stated he saw the resident on 6/14/26 at 2:00 PM and that is when Resident #3 told him that his/her breakfast was withheld that day and when he went back to see the resident on 6/15/26 at 12:30 PM the resident told him the same thing happened again. PTA #14 was asked if he reported it to anyone on 6/14/26 and he said, I did not tell my supervisor on 6/14/26, so I forgot to tell my supervisor until the next time [he/she] said the same thing again. I told my director and that was it. We received education after that but if you forget you forget. The surveyor read the statement back to PTA #14 with another surveyor in the room and he confirmed the statement. PTA #14 stated, [his/her] leg was not turned, it was just that [his/her] breakfast was withheld. On 6/30/26 at 3:40 PM an interview was conducted with Resident #3. Resident #3 stated that he/she was not going to take a silly pill so she (CMA #17) put her hands under my blanket and wrenched my knee cap. It was the first time. I went to report her. That night she told everyone to withhold my food. I called the police and told them that she was holding my food back. It happened more than 1 day with [name of CMA #17]. I told someone at the desk and they wrote it down. I asked them to report it to the director. The surveyor asked Resident #3 if his/her food was withheld more than 1 day and he/she replied, yes.On 7/1/26 at 8:24 AM the Director of Rehabilitation (DOR) #13 was interviewed and stated that she did have a conversation with PTA #14 about reporting immediately to the nurse. The DOR stated, for us we should report it to the nurse. I don't work on Sundays. You tell the closest nurse in management. He did say he forgot after it happened the first time.On 7/1/26 at 8:40 AM the NHA was informed of the surveyor's findings of facility staff not reporting timely. The NHA stated he found out from rehab, and he was putting a plan in place. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on medical record review and interview, it was determined the facility staff failed to administer medications timely. This was evident for 1 (Resident #6) of 4 residents reviewed during a complaint survey. The findings include:Review of Complaint 2988557 was conducted on 6/29/26 regarding the timeliness of administration of medications for Resident #6.Review of Resident #6's medical record on 6/29/26 revealed the Resident was admitted to the facility in February 2026 with a diagnosis to include Dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.Review of Resident #6's physician medication orders revealed the Resident was ordered on 2/27/26 Pantoprazole Sodium 40 mg give in the morning for GERD (Gastroesophageal Reflux Disease) and Synthroid 75 mcq one time of day for thyroid. Review of Mayo Clinic guidelines on administration of Pantoprazole and Synthroid revealed they are recommended to be given at least 30 minutes before a meal.Review of Resident #6's June 2026 Medication Administration Audit Report on 6/30/26 with the Director of Nursing revealed the Resident was scheduled to receive Pantoprazole and Synthroid daily at 6 AM. Further review revealed the Resident did not receive those medications timely on the following dates:6/2/26 Administered at 9:48 AM6/3/26 Administered at 8:26 AM6/11/26 Administered at 12:37 PM6/20/26 Administered at 8:21 AM6/24/26 Administered at 8:10 AM6/27/26 Administered at 10:52 AM6/28/26 Administered at 9:19 AMInterview with the Director of Nursing on 6/30/26 at 2:30 PM confirmed the facility staff failed to administer Pantoprazole and Synthroid to Resident #6 timely in June 2026. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on medical record review and staff interview it was determined the facility failed to provide treatment/services to prevent/heal pressures ulcers as ordered for a resident. This was evident for 1 (Resident #4) of 3 residents reviewed during a complaint survey. The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II ( superficial loss of skin such as an abrasion, blister or shallow crater), Stage III ( full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed).Review of a Complaint 3017918 was conducted on 6/29/26 regarding the care of Resident #4.Review of Resident #4's medical record on 6/29/26 revealed the Resident was admitted to the facility in February 2026 with a diagnosis to include muscle wasting and atrophy. Muscle wasting is the wasting or thinning of your muscle mass, often from aging or inactivity. 1) The facility staff failed to provide treatment as ordered to prevent pressure ulcersReview of Resident #4's physician orders revealed on 3/31/26 the Resident was ordered skin prep two times a day for boggy heels. A boggy heel is typically caused by excess fluid and can be an early indicator of a developing heel pressure injury. Review of Resident #4's April and May Treatment Administration Records revealed the facility staff failed to administer the skin prep on the following dates at 10:00 PM: 4/8, 4/19, 4/22, 4/24, 5/4, 5/7 and 5/14/2026.Interview with the Regional Nurse on 6/30/26 at 1:46 PM confirmed the facility staff failed to administer skin prep to Resident #4's heels as ordered.2) The facility staff failed to provide treatment as ordered for a pressure ulcer.Further review of Resident #4's medical record revealed the Resident was assessed by the Wound NP (Nurse Practitioner) on 5/22/26 for an unstageable pressure ulcer. At that time the Wound NP ordered the facility staff to administer the following treatment twice daily: cleanse with wound cleanser/normal saline. Medical grade honey. Skin prep surrounding tissue or periwound. Bordered dressing. The Resident was assessed by the Wound NP on 5/29/26. At that time the Wound NP ordered the facility staff to administer the following treatment twice daily: cleanse with wound cleanser/normal saline. Medical grade honey. Zinc oxide paste to periwound. Bordered dressing.Review of Resident #4's May 2026 Treatment Administration Record revealed the facility failed to change the sacrum wound treatment orders until 5/30/26 and at that time was only doing once a day instead of twice a day as ordered. During interview with the Regional Nurse on 6/30/26 at 1:46 PM confirmed the facility staff failed to administer the Wound NP's 5/22/26 sacral pressure treatment orders until 5/30/26 and failed to administer the treatments twice daily. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on medical record review and interview, it was determined the facility staff failed to assess and monitor a resident's nutritional needs and intervene in a timely manner. This was evident for 1 (Resident #4) of 4 residents reviewed for nutrition during a complaint survey. The findings include:Review of a Complaint 3017918 was conducted on 6/29/26 regarding the care of Resident #4.Review of Resident #4's medical record on 6/29/26 revealed the Resident was admitted to the facility in February 2026 with a diagnosis to include muscle wasting and atrophy. Muscle wasting is the wasting or thinning of your muscle mass, often from aging or inactivity. Further review of Resident #4's medical record revealed the facility staff documented Resident #4's weight on admission 2/18/26 was 164 pounds, 3/6/26 173.4 pounds and 4/9/26 178.6 poundsFurther review of Resident #4's weights revealed the facility staff documented the Resident's next weight on 5/20/26 and it was 156.6 pounds.On 5/22/26 the Resident was seen by the Dietitian who documented: Resident has fair to good PO (by mouth) intake, he/she is triggering for significant weight loss, reweight requested, will assess change after re-weight is obtained.Further review of Resident's medical record revealed the Resident was not reweighed until 6/2/26, 13 days later, with a documented weight of 153 pounds. The Resident was not seen by the Dietitian after the documented re-weight on 6/2/26 and transferred out of the facility on 6/9/26.Interview with the Dietitian on 6/30/26 at 11:43 AM, the Dietitian stated weights should be weekly on admission times 4 then monthly and no further interventions were put in place for the Resident after the 5/20/26 documented weight loss.Review of the facility's Weight Monitoring policy implemented on 2/15/24 revealed it stated: A weight monitoring schedule will be developed upon admission for all residents: Newly admitted residents-monitor weekly for 4 weeks. All others-monitor weight monthly.Interview with the Regional Nurse on 6/30/26 at 1:15 PM confirmed Resident #4 was not weighed weekly on admission times 4 and no additional nutritional interventions were put in place after the documented 5/20/26 weight loss. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility reported incident 3044296, complaints 3044605, 3017702, 2980425, medical record review, and interviews, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 3 (Residents #3, #5, #7) of 8 residents reviewed for 9 intakes reviewed on a complaint survey.<br><br>The findings include:<br><br>A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.<br><br>1) On 6/29/26 at 11:00 AM a review of complaint 3044605 and facility reported incident 3044296 were conducted regarding an abuse complaint from Resident #3. Review of complaint 3044605 alleged that Resident #3 stated on 6/8/26 Certified Medicine Aide (CMA) #17 physically assaulted Resident #3. Resident #3 refused to take his/her medication and Resident #3 threw an inhaler at CMA #17 and then CMA #17 grabbed Resident #3's wrist and twisted it. Resident #3 stated that on 6/11/26 he/she again refused to take his/her medication and CMA #17 grabbed and twisted the resident's leg while in bed and again in the evening of that same day Resident #3 refused to take medication, so his/her dinner/food was withheld because he/she had not taken his/her medication. Resident #3 claimed there were injuries, however there were no obvious signs of injuries to the right wrist, but there was a large bruise on the back of the resident's hand by the thumb. However, the resident claimed that bruise resulted from him/her accidentally getting his/her hand caught between the bed frame and the wheelchair.<br><br>Review of facility reported incident #3044296 documented that the social worker was notified by the ombudsman on 6/15/26 at 11:15 AM that there was a complaint that came in about Resident #3 regarding abuse.<br><br>Review of both the complaint and the facility reported incident documented that police were notified and came to interview the resident. There was no documentation found in the medical record that the police ever came to interview Resident #3 and there was no documentation found in the medical record about the allegations that the resident made.<br><br>Review of Resident #3's medical record revealed a 6/7/26 change in condition note that documented the nurse noted a small spot of bleeding on top of Resident #3's right hand discoloration that per the resident occurred in the dining room on Wednesday.<br><br>Review of a 6/9/26 alert note documented a new skin condition: a large bruise to the right top of the hand, which the resident stated he/she hit on the footboard.<br><br>Review of a 6/12/26 physician's note documented that the resident was found on the floor and questioned whether he/she fell out of bed, but he/she was found sitting on the floor at the bedside. The resident did not have any injuries but was noted several days ago to have an injury to the right hand that the resident blamed on the wheelchair apparatus. It was simply a bruise on the anterior surface of the resident's right hand, and it was healing well.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | No further documentation was found regarding any allegations of meals being withheld or accusations of abuse.<br><br>On 6/30/26 at 9:17 AM Nurse Practitioner (NP) #10 was interviewed and stated that Resident #3 would tell her about people that have predeceased the resident and that the resident was waiting for them to come see him/her. NP #10 stated that Resident #3 cannot make difficult decisions and had mild cognitive impairment. NP #10 stated, I am not aware of any assault and I saw [him/her] the next day and [he/she] did not report any of this to me. NP #10 stated that Resident #3 will occasionally mention delusions about the opposite sex. NP #10 stated that she would put in for a psych (psychiatry) evaluation. NP #10 reviewed Resident #3's medical record with the surveyor and questioned why there was no documentation in the medical record about Adult Protective Services (APS) coming out and the Sheriff. NP #10 stated that if she had known the Sheriff had come out that she would have gone right in to see the resident.<br><br>Further review of the medical record failed to produce a psych note. There was a typed note in the documentation with facility reported incident #3044296 that was not dated and not signed and was assumed to be from psych.<br><br>On 7/1/26 at 8:40 AM the Nursing Home Administrator (NHA) stated he was aware that there was no documentation in the medical record about the police coming to the facility to see Resident #3. The NHA stated the undated and unsigned note was from psych and the psych note was not put in the medical record timely.<br><br>2) A review of Complaint 3017702 was conducted on 6/30/26 regarding Resident #5's fall on 5/17/26.<br><br>Review of Resident #5's medical record on 6/30/26 revealed the Resident was admitted to the facility in 2024 with a diagnosis to include Dementia. Dementia is an umbrella term for a decline in memory, thinking or reasoning skills that is severe enough to impair a person's ability to perform everyday activities.<br><br>Further review of Resident #5's medical record revealed the Resident had an unwitnessed fall on 5/17/26. Review of a nurse's note on 5/17/26 at 4:30 AM stated: Patient found on floor at bedside. Head to toe assessment performed. 2 cm laceration to right brow. Provider notified who recommended first aide and fall protocol.<br><br>During interview with the Regional Nurse on 6/29/26 at 4:08 PM, the Regional Nurse stated for an unwitnessed fall the facility staff would be expected to perform neuro checks on the Resident.<br><br>A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination.<br><br>Further review of Resident #5's medical record revealed no neuro checks in the medical record.<br><br>On 6/30/26 at 10:49 AM the Director of Nursing (DON) presented the Surveyor the neuro checks for Resident #5 for 5/17/26. At that time the DON stated the neuro checks were not in the Resident's medical record but in a file in her office to be uploaded into the medical record. The DON added she has not had time yet to upload them.<br>(continued on next page) |

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| | 215179 | A. Building<br>B. Wing | 07/01/2026 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) Review of Resident #7's medical record on 6/29/26 revealed the Resident was admitted to the facility on [DATE]. Review of the Resident's hospital discharge summary revealed it stated the Resident's cognition and memory are impaired.<br><br>Observation of Resident #7 on 6/29/26 at 12:45 PM revealed the Resident is on the locked Dementia unit.<br><br>Further review of Resident #7's medical record revealed the facility assessed the Resident on 5/12/26 to have a BIMS (Brief Interview for Mental Status) of 5 of 15, indicating severe cognitive impairment.<br><br>Further review of Resident #7's medical record revealed the facility staff assessed the Resident's elopement risk on 6/4 and 6/29/26 and scored the Resident a 0 indicating the Resident is not an elopement risk.<br><br>Interview with the Administrator on 6/30/26 at 7:48 AM, the Administrator was asked why the Resident was on the locked Dementia unit. The Administrator stated the Resident was trying to leave the facility and can be very confused.<br><br>During interview with the Regional Nurse on 6/30/26 at 4:18 PM, she confirmed the 6/4 and 6/29/26 Elopement Risk Evaluations were inaccurate assessments and Resident #7 is an elopement risk. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint 2965994, observation, and staff interview, it was determined the facility failed to follow infection control practices and guidelines to prevent the development and transmission of disease. This was evident for 3 of 5 nursing units observed during the complaint survey.The findings include: On 6/29/26 at 11:00 AM a review of complaint 2965994 alleged that a visitor to the facility observed dirty meal trays, a dirty towel on the floor with a brown liquid on it and a puddle of dried brown liquid on the floor, a stained pillow, and dried food all over the floor that appeared to have been there for some time. The worker was concerned with the cleanliness of the rooms in the facility. On 6/29/26 at 12:20 PM a tour of the facility was conducted with the Infection Preventionist (IP) #5. The following infection control concerns were observed:room [ROOM NUMBER]: bathroom: There was 1 gray and 1 pink basin lying on the floor under the sink. The basins were not labeled and were not in plastic. There also was an elbow piece of plumbing pipe sitting in the pink basin.room [ROOM NUMBER]: In the bathroom there was a fly sitting on the toilet rim. There was no toilet paper roller, and the toilet paper was sitting on the back of the toilet. There was a gray bedpan on the floor by the toilet that was not labeled or in plastic. There was 1 gray basin on the floor with a scrunched up brown soiled washcloth inside the basin. There was 1 gray basin sitting on top of the plastic drawers under the sink. The basins were not labeled or in plastic.room [ROOM NUMBER]: There was no toilet paper roller, and the toilet paper was sitting on the back of the toilet. There was a gray basin sitting on the back of the toilet that was not in plastic or labeled.room [ROOM NUMBER]: There was a white basin that appeared to go with a bedside commode sitting on the floor under the sink along with a white toilet urine collection hat. Neither item was labeled or wrapped in plastic.room [ROOM NUMBER]: There was a white urine collection hat on the floor by the door that was upside down. There was 1 gray fracture pan and 1 pink basin sitting on the floor under the sink along with 2 gray basins sitting inside of each other. There were 2 gray basins sitting in each other on the back of the toilet. None of the items were labeled or in plastic.room [ROOM NUMBER]: There was 1 gray basin sitting on the floor sitting inside a pink basin. They were not labeled or in plastic.room [ROOM NUMBER]: There was no toilet paper roller in the toilet paper holder. The toilet paper was sitting on top of the hand rail.In the rooms identified in the 100 hallway and the 300 hallway, the bathrooms were shared between 2 rooms of residents.room [ROOM NUMBER]: In a room that housed 4 residents there was a gray basin sitting on the floor under the sink with no label and not in plastic.On 6/30/26 at 8:27 AM observations were made of the floor in the TV room of the Chase Unit (dementia) where a majority of the dining tables were located. There were numerous spills on the floor, crumbs, pieces of paper towels, plastic cups, and pieces of food on the floor. In the alcove was trash on the floor including a plastic cup, napkins, and newspaper ads from circulars.On 6/29/26 at 12:55 PM an interview was conducted with IP #5. IP #5 was asked what the policy was for storage of urinals, basins, fracture pans, and toilet collection hats. IP #5 stated, for residents they should be dated with the patient's room number or last name. The basins, fracture pans, and toilet collection hats should be put in a bag to store them. IP #5 confirmed the surveyor's findings while on a tour with the surveyor and stated she would have to look for the policy. On 6/29/26 at 1:45 PM IP #5 came back to the surveyor and stated that they did not have a policy. IP #5 stated that Regional #19 said that they were cited previously for this back in December 2025 and they did not have a policy then and they still did not have a policy.On 6/30/26 at 10:05 AM the Nursing Home Administrator (NHA) was informed of the findings. He was shown the pictures of the Chase Unit, and he agreed with the surveyor's findings.On 6/30/26 at 10:51 AM the Director of Nursing (DON) was informed of the findings. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaint 2965994, observations, interviews, and documentation review, it was determined that the facility failed to maintain an effective pest control program, evidenced by numerous flies throughout the facility. This was evident on 2 of 2 days observed during a complaint survey.The findings include: On 6/29/26 at 9:35 AM a review of complaint 2965994 alleged concerns regarding the facility's environment.On 6/29/26 at 9:48 AM a tour of the facility was conducted. Observation was made on the dementia unit (Chase) of a fly on the baby doll's head that Resident #14 was holding. There was a fly in the back dining area of the unit and in the 500 hallway.On the 100 hallway in room [ROOM NUMBER] there was a fly buzzing around in the resident's room and a fly sitting on the toilet seat in the resident's bathroom.On 6/29/26 at 12:55 PM a tour was conducted with Infection Preventionist (IP) #5. IP #5 confirmed the facility had a fly problem as there were several flies observed on the tour and in resident bathrooms.On 6/29/26 at 1:08 PM flies were observed around resident food in the A/B day room where residents were eating lunch.There were flies in the conference room where the surveyors were located.On 6/30/26 at 8:45 AM Resident #10 had a fly flying around his/her head and food while eating breakfast in the dementia unit.On 6/30/26 at 8:52 AM an interview was conducted with Director of Maintenance (DOM) #9 who stated that the pest control company comes to the facility every 2 weeks. DOM #9 stated they were here last week, but he was unsure of what they had been treating. DOM #9 stated they have pest control books at the nurse's station and the staff would put concerns in the book. DOM #9 stated he had noticed they were having a fly problem, and he noticed it was bad yesterday. DOM #9 stated that the supervisor from the pest control company would come out to the facility. He stated that the pest control company was backed up and would be out after the holidays. DOM #9 stated that when the pest control company was here last week he asked about the flies and they said they would ask the supervisor about adding on a treatment.The pest control logs and pest control invoices were reviewed with DOM #9. Review of the pest control logs documented flies at the nurse's station and in multiple resident rooms on the Chase unit on 3/17/26 and 3/19/26. Another pest control log documented on 5/18/26 there were flies throughout the whole building.Review of the 6/25/26 pest control invoice documented that the service technician checked in with the facility staff on duty and looked at log books and reports and there were no concerns. Review of the invoice dated 5/28/26 documented, verbal report of fly activity throughout the building. DOM #9 confirmed the findings.On 6/30/26 at 10:05 AM the fly concerns were discussed with the Nursing Home Administrator (NHA). The NHA stated he was aware of the issue and that he called the pest control company to talk to a supervisor. |