STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Rehabilitation Center	1212 Sunset Drive East Monroe, NC 28112

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and resident, resident representative, staff and physician interviews, the facility failed to protect a resident's right to be free from mental abuse and humiliation when Nurse Aide (NA) #1 continued to provide personal care to Resident #1 after Resident #1 was heard saying calmly leave me alone in an electronic video that NA #1 recorded with NA #1's personal cellular phone device while providing personal care to a resident (Resident #1). On the electronic video, Resident #1's chest area was observed exposed with no clothing or linens covering Resident #1's chest area. Resident #1's behaviors were observed escalating from a calm verbal tone to cursing and physically swinging her left arm at NA #1. This occurred for 1 of 3 residents reviewed for abuse (Resident #1). The reasonable person concept was applied to this deficiency as individuals would feel humiliated by the distribution of demeaning video recordings from personal cellular phone devices that included nudity of oneself.Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was moderately cognitively impaired and had exhibited verbal behaviors toward others 1 to 3 days for the seven-day look back period. The MDS further indicated Resident #1 required assistance with personal care. There were no physical behaviors toward others coded for Resident #1 on the MDS assessment.Resident #1's care plan last reviewed 6/24/2025 included a focus for activities of daily living, and interventions included one person assisting Resident #1 with bathing. Resident #1 was also care-planned for resisting care due to dementia. Interventions included providing opportunities for choice when providing personal care.An initial allegation report completed by the Administrator and dated 9/10/2025 at 2:59pm reported an allegation of abuse for Resident #1. The initial report documented that the Corporate Compliance Office received an allegation from Caller #1 that NA #1 had posted an electronic video on a social media site from her (NA #1's) personal cellular phone device of Resident #1 nude while NA #1 was providing personal care to Resident #1. The initial report further stated the local law enforcement agency was notified and the initial report was sent to the State Agency. On 9/10/2025 at 5:41pm, the Administrator played an undated electronic video that Caller #1 had emailed the facility on 9/10/2025. There was no audio (sound) on the electronic video, and the electronic video was divided into two parts. In part one of the electronic video, Resident #1 was observed lying supine (on the back) in the bed with a pink baby doll resting on her nude chest area. Resident #1 was observed swinging her left arm toward NA #1 as NA #1 reached toward Resident #1's left hand that was holding the pink baby doll up off Resident #1's chest area. Resident #1 was observed using her right hand to grab the pink baby doll to the right side of her body and swinging her left lower arm and hand toward NA #1. NA #1 was observed placing her right hand on Resident #1's left shoulder and her (NA #1) left hand on Resident #1's left elbow to turn Resident #1 before the video ended. In part two of the electronic video, NA #1 was observed setting up her personal cellular phone device to video record Resident #1 and returning to Resident #1's bedside. Resident #1 was observed lying supine in the bed dressed in a gown. Resident #1 was not observed moving in bed. The Administrator reported NA #1 had been suspended pending the investigation of the allegation of abuse for Resident #1.On 9/11/2025 at 10:30am, the electronic video emailed to the facility on 9/10/2025 of Resident #1 was observed with audio. In part one of the electronic video, NA #1 was heard telling Resident #1 she was going to get NA #1 in trouble. Resident #1 was heard telling NA #1 Get your ass out of here as she held a pink baby doll on her chest area with her left hand. NA #1 was heard saying, No, I'm trying to help you. Resident #1 was observed picking her left arm up in the air while holding the pink baby doll and NA #1 was observed reaching her left hand toward Resident #1's left hand that was up in the air holding the pink baby doll and NA #1's right hand was touching Resident #1's left elbow. Resident #1 was heard saying Somebody behind ya as Resident #1 swung her left arm toward NA #1 and grabbed the pink baby doll with her right hand and positioned on the right side of her body. Resident #1 was observed swinging her left hand toward NA #1 and NA #1 was heard telling Resident #1 Stop. Resident #1 was observed swinging her left lower arm and hand toward NA #1 two more times. NA #1 was heard telling Resident #1 to stop before NA #1 was observed placing her right hand on Resident #1's left shoulder area and NA #1's left hand was observed touching Resident #1's left elbow to turn Resident #1 toward her right side before the electronic video ended. In part two of the electronic video, Resident #1's head and upper body were visualized in the video and Resident #1 was dressed in a gown. NA#1 was observed

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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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff and physician interviews, the facility failed to perform a physical assessment of a resident when Nurse Aide (NA) #3 reported to Nurse #2 and Nurse #3 on 9/2/2025 on the 3:00 pm to 11:00 pm shift the report of a fall and a change in Resident #2's self-transfer status from the wheelchair to the bed. Resident #2 was sent to the hospital on 9/3/2025 on the 7:00 am to 3:00 pm shift and admitted for a left hip fracture. This occurred for 1 of 1 resident reviewed for injury of unknown origin (Resident #2). Findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses including dementia, stroke and legal blindness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 was moderately cognitively impaired and required supervision for all mobility tasks including wheelchair to bed. The care plan last reviewed 6/19/2025 for Resident #2 included a focus for falls. Interventions included the following: bed in lowest position, use of non-skid footwear and post fall event skin checks and providing cues for safety awareness. Physician #2's progress notes dated 9/1/2025 recorded a regulatory visit was conducted with Resident #2 on 9/1/2025. Physician #2 recorded Resident #2 voiced no complaints of pain on 9/1/2025 and there was no documentation of Resident #2 having a recent fall. There was no nursing report dated for 9/1/2025 on the 7pm to 7 am shift reporting a fall for Resident #2. There was no nursing documentation in Resident #2's electronic medical record (EMR) for 9/1/2025 or 9/2/2025. A review of Resident #2's September 2025 Medication Administration Record recorded Resident #2's pain level as zero from 9/1/2025 to 9/3/2025. In an interview with NA #4 on 9/10/2025 at 3:13pm, she stated on 9/1/2025 from 11:00 pm to 7:00am, Resident #2 was up in his wheelchair in the hallway with her until 5:00 am when Resident #2 went to bed. She stated Resident #2 did not want to go to bed that night and she assisted him to the bathroom with no change in his mobility observed and Resident #2 voiced no complaints of pain with movement. In an interview with Nurse #4 on 9/10/2025 at 7:15 am, Nurse #4, who was assigned to Resident #2 on 9/1/2025 7:00 pm to 7:00am, stated she did not recall Resident #2 having a fall on 9/1/2025 or recently. In an interview with NA #5 on 9/10/2025 at 2:29 pm, she explained Resident #2 was able to move independently and used furniture arrangement in the room to touch when walking to the bathroom on 9/2/2025 from 7:00 am to 3:00 pm. She stated Resident #2 required supervision when walking to the bathroom and in his room and used the call bell to notify nursing staff for assistance. She stated on 9/2/2025, she assisted Resident #2 with his personal care and observed Resident #2 walking to the bathroom with no complaints of pain or change in his mobility. In a phone interview with Nurse #5 on 9/10/2025 at 9:41 am, she stated she was assigned to Resident #2 on 9/2/2025 on the 7:00 am to 7:00 pm shift and at the change of shifts at 7:00am, there was no report of Resident #2 experiencing a fall on 9/1/2025. She explained Resident #2 was at his baseline on 9/2/2025 sitting up in the wheelchair in the hallway at the nursing station with no complaints of pain verbalized. She stated Resident #2 was assisted with his personal care, assisted to the bathroom and repositioned in the wheelchair on 9/2/2025 and Resident #2 did not mention he had fell or voice complaints of pain during the shift.In an interview with Occupational Therapist on 9/10/5 at 2:30 pm, he stated Resident #2 could stand and transfer without assistance and the need for supervision was stressed Resident #2 when moving in his room. He stated Resident #2 would call at times for help and was not consistent in calling for help when up in his room. He explained when occupational therapy worked with Resident #2 on 9/2/2025, Resident #2 was observed changing positions per himself without assistance slower than normal from the wheelchair to standing and walking to the bathroom. He stated Resident #2 did not endorse any pain during therapy. He explained at baseline Resident #2's walked with his upper body leaned forward which decreased the speed of his movement and there were no acute concerns observed with Resident #2's left leg/hip area.In an interview with NA #3 on 9/10/2025 at 3:05 pm, she explained Resident #2 always required supervision with self-transfers from wheelchair to bed when preparing to go to bed. She stated on 9/2/2025 around 9:30 pm when Resident #2 stood up from wheelchair to turn to sit on the bed, Resident #2 could not turn and said, it's my hip and she had to help Resident #2 to shift his left leg back to sit on the bed. She explained Resident #2 moved his right and left legs onto the bed himself with no facial grimace or complaints of pain and she provided a little assistance in straightening his legs in the bed, which she normally would do for Resident #2. She stated when Resident #2 was in the bed he said, I believe it's my hip and asked NA #3 if his left hip was blue. She stated Resident was lying on his right side and there was no blue discoloration observed to

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, and staff, Contracted Pest Control Company Technician, and Wildlife Department Technician interviews, the facility failed to implement an effective pest control program to maintain a pest free living environment after the first sighting of a snake in the building on 8/15/2025 for 110 of 110 residents residing in the building. Findings included: On 9/9/2025 at 1:05 pm, the front entrance of the building was observed with two glass swinging doors. When the two glass swinging doors where closed, there was a half inch opened space area observed between the doors on the lower part of the doors that extended approximately six inches from the bottom of the doors. This opening between the two doors provided an entrance for a snake to enter the building. Upon entering the building, there was a receptionist office observed on the right side and the admission's office was observed across the hall on the left. There was a one-inch open space between the admission's office doors and the floor. A review of the maintenance logs from July 2025 to September 2025 that were located at each nurse's station for the three resident halls recorded no sightings of snakes in the building. In an interview with Nurse #1 on 9/10/2025 at 11:40 am, she stated a small six inch baby snake with diamond shapes on the skin was observed entering the building through the front entrance doors and entering the admissions office one night shift (8/15/2025) in August 2025. Nurse #1 explained the admission's office door was locked and she did not have a code to enter the admission's office. She stated she sent a group text to the Administrator and the Director of Nursing (DON) informing them of the snake in the admissions office. Nurse #1 stated she did not text or notify the Maintenance Director. She stated she did not observe any other sightings of the snake that night. Nurse #1 explained she was unable to provide exact date of the sighting of the snake because her text messages automatically deleted. The distance from the admission's office to the closest room with a resident residing in the room was measured at 192 feet. In an interview with the Director of Nursing (DON) on 9/10/2025 at 4:39 pm, the DON stated Nurse #1, who was working a 7:00 pm to 7:00am night shift on 8/15/2025, had reported in a group text message to the Administrator and DON on 8/16/2025 at 12:00am there was a snake in the admission's office and Nurse #1 was going on break. The DON stated she did not see the group text until 8/16/2025 at 4:44 am and replied to Nurse #1 asking if it was a big snake. The DON stated on 8/16/2025 at 6:42 am, Nurse #1 replied to her text describing the snake as a small tan and black snake and it was in the office (admission's office) across the hall from the receptionist office. The DON stated on 8/16/2025 at 6:48 am she texted Nurse #1 asking if the Maintenance Director was aware because she was going in there (the building) and she was not a snake fan. The DON stated she informed the Maintenance Director and the Administrator of the snake in the admission' office and they conducted an exterior and internal sweep of all areas for other snakes. The DON further stated since beginning employment at the facility in April 2025, she had not observed mice in the building. In an interview with Housekeeper #1 on 9/10/2025 at 11:51 am, she explained she usually reported to work at 7:00 am and cleaned the front entrance area first. She stated one morning in August 2025 (exact date unknown) while cleaning the admission's office, she observed a 6 inch grayish colored snake behind the couch. She stated she called the Maintenance Director, who removed the snake out of the admission's office. In an interview with the Maintenance Director on 9/11/2025 at 12:32 pm, he stated upon reporting to work on the morning of 8/16/2025, he removed a 3-to-4-inch black snake that the housekeeping staff observed out of the admission's office. He explained it was not a copperhead snake because the snake did not have a yellow tail (copperheads have a distinct bright yellow or green tail which they keep for roughly a year). The Maintenance Director reported there had been no issues with mice in the building prior to the sighting of the snake. He explained he conducted an external rounding of the building with no further snakes observed. In a follow up interview on 9/11/2025 at 3:10 pm, the Maintenance Director stated since snake repellent material were obtainable from the local hardware store, the facility did not maintain snake repellent materials at the facility. The Maintenance Director stated that he went to obtain snake repellent material at the local hardware store on 8/16/2025 and the hardware store did not have any snake repellent material. In an interview with the Administrator on 9/10/2025 at 3:17 pm, he stated he did not see the group text message Nurse #1 sent on 8/16/2025 at 12:00 am until waking up that morning. He stated the Maintenance Director had captured and removed the snake from the admission's office upon his arrival to the building.In a follow up interview on 9/11/2025 at 12:35 pm, the Administrator explained he conducted an interior observation of all resident rooms, offices, departments and resident care areas with no further sightings of a snake identified. The Administrator stated he didn't know why he did not email the facility's