

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365831	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Lincoln Knolls Health & Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 31 Maranatha Drive Youngstown, OH 44505	
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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to ensure newly hired staff received orientation and training on abuse prohibition upon hire. This had the potential to affect all 39 residents residing in the facility. Findings include: Review of the personnel files for Certified Nursing Assistant (CNA) #509 (date of hire 06/25/26), CNA #506 (date of hire 05/13/26), Certified Medication Assistant (CMA) #507 (date of hire 06/11/26), Housekeeper #512 (date of hire 07/06/26) and [NAME] #511 (date of hire 05/21/26) revealed no evidence of orientation and training on abuse upon hire. An interview with [NAME] #511 on 07/09/26 at 11:13 A.M. revealed they had received no training on abuse since hire. An interview with Human Resources (HR) #510 on 07/09/26 at 9:58 A.M. confirmed there was no abuse training on the forms in the personnel files to account for abuse training for new hires. HR #510 stated the Administrator checks new hires against the abuse registry and abuse training was done during the yearly in-service. An interview with the Administrator, Director of Nursing and HR #510 on 07/09/26 at 11:22 AM confirmed employee files for [NAME] #511, Housekeeper #512, CMA #507 and CNA #506 and #509 did not have abuse training records and confirmed they did not know if it was done since there was no record of it in the files. Review of the facility policy titled Abuse, Neglect and Exploitation, dated 2021, revealed under the section of Employee Training that all new employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. This deficiency represents non-compliance investigated under Complaint Number 3069121.		

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review and review of facility policy, the facility failed to ensure a thorough investigation was completed for an allegation of abuse. This affected one (Resident #9) of three residents reviewed for abuse. The facility census was 39. Findings include: Review of the medical record for Resident #9 revealed an admission date of 12/08/25 with diagnoses including malignant neoplasm of ovary, heart failure, bipolar disorder, and anxiety disorder. Resident #9 was her own responsible party. Review of the care plan for Resident #9 dated 03/11/26 revealed a behavior problem related to false beliefs and false statements regarding dietary, staff, other residents, herself and her belongings. Interventions included to give medications as ordered, caregivers to provide opportunities for positive interactions, discuss behaviors, and intervene as necessary. The care plan also revealed the resident was sexually active. Interventions included reduce opportunities that may increase risk of falls/fall related injuries and use best method of communication with resident to meet or anticipate needs. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/08/26, revealed the resident had intact cognition, was independent for bed mobility, transfers, and ambulation. Review of the facility document titled Grievance Complaint Report, dated 07/02/26 and received by the Administrator, revealed Resident #9 reported that she broke up with her boyfriend and did not want him coming to her room anymore. The Director of Nursing (DON), the Administrator and Social Service met with the boyfriend and he said ok. Both parties agreed to break off the relationship and the complaint was resolved on 07/02/26 and signed by Resident #9. The document also revealed on 07/03/26 an entry stating follow up with resident who stated it was a mistake, and they are back together. An interview with Certified Nursing Assistant (CNA) #500 on 07/08/26 at approximately 11:00 A.M. revealed she went into Resident #9's room in the morning on 07/01/26 to lay eyes on her and Resident #9 stated Resident #25 raped her. CNA #500 stated she immediately took Resident #9 to Registered Nurse (RN) #503 to inform the nurse and have Resident #9 checked. CNA #500 stated they were not asked to write a witness statement at any time. An interview with CNA #506 on 07/08/26 at 12:55 P.M. revealed on the morning of 07/01/26 she came out of a resident's room on the 400 hall and saw Resident #9 coming from Resident #25's room around 6:30 A.M. Resident #9 stated Resident #25 raped her by having oral sex, but Resident #9 seemed all over the place with her thoughts. CNA #506 stated the nurse it was reported to was RN #505 who took it very seriously. CNA #506 stated she was never asked to give a witness statement, and no one questioned her about it. An interview with Director of Nursing (DON) on 07/08/26 at 1:02 P.M. revealed when he spoke to Resident #9 she denied being raped. The DON stated Resident #9 stated she did not want to date Resident #25 anymore then changed her mind and wanted to continue the relationship. The DON confirmed allegations of abuse should be thoroughly investigated. The DON stated no abuse involving Resident #9 had been reported to him. An interview with the Administrator on 07/08/26 at 1:17 P.M. revealed she went to Resident #9 first thing in the morning on 07/02/26 and Resident #9 stated they didn't want to be in a relationship anymore and didn't want to be bothered by Resident #25 anymore. The Administrator stated it was reported to her by a nurse the day before that Resident #25 was bothering Resident #9 and no abuse was reported. The Administrator stated social services followed up with Resident #9 to address her concerns about the relationship. The Administrator confirmed no witness statements were obtained from staff who initially reported the concern to nursing on 07/01/26. An interview with RN #503 on 07/08/26 at approximately 1:30 P.M. revealed she got report from RN #505 about a rumor going around about Resident #9 and had passed it on to the DON so did not take it any further. RN #503 stated she was not asked to do a witness statement. A follow-up interview with the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator and Social Service Designee on 07/08/26 at 2:40 P.M. revealed after speaking to Resident #9 on 07/02/26, they determined abuse did not occur, so they filed a resident grievance concern to address it. An interview with Certified Medication Assistant (CMA) #507 on 07/08/26 at 3:48 PM revealed when she came back to work on 07/02/26 Resident #25 and Resident #9 were both on 15-minute checks. CMA #507 stated she was told it was because Resident #9 made a statement that Resident #25 had raped her. CMA #507 stated she was never interviewed about anything. An interview with RN #505 on 07/09/26 at approximately 9:00 A.M. revealed a CNA overheard Resident #9 talking to another resident about Resident #25 bothering Resident #9. RN #505 stated the CNA reported it to her so RN #505 called the Administrator to let them know Resident #25 was bothering Resident #9 and the Administrator stated to RN #505 they would look into it. An interview on 07/09/26 at 10:00 A.M. with Resident #9 revealed she had a bad dream because of her medication and thought she was being touched by her boyfriend (Resident #25) without her consent and told staff. Resident #9 stated she usually did not have bad dreams and chose to stay away from him after that for a couple of days. Resident #9 confirmed she filed a grievance on 07/02/26 then changed her mind because she wanted to see and be around Resident #25 and wished for him to come to her room again. An interview on 07/09/26 at 10:15 A.M. with Resident #25 revealed he was on good terms with Resident #9, but was told to stay away from Resident #9 on 07/02/26 which was after Resident #9 came to his room around 7:30 A.M. in the morning yelling at him but then later talked it out and everything was fine. Record review of policy titled Abuse, Neglect and Exploitation revealed an immediate investigation is warranted when there is suspicion of abuse or reports of abuse. All involved persons should be identified and interviewed including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. Complete and thorough documentation of the investigation should be provided. This deficiency represents non-compliance investigated under Complaint Number 3069121.		