STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation	345 Manor Road Mars Hill, NC 28754

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident, staff and Medical Doctor interviews, the facility failed to protect a resident's (Resident #2) right to be free from physical abuse when a resident (Resident #1) with moderate cognitive impairment and no previous history of behaviors or aggression, hit Resident #2 in the face, head and neck causing injuries. Resident #1 continued to show aggression toward staff members until Nurse Aide (NA) #1 was able to get him redirected back to his bed at which point Resident #1 stated he had injured Resident #2. Resident #2 was immediately removed from the room and sent to the hospital for further evaluation. Hospital records dated 8/4/25 noted Resident #2 had contusions (superficial injury where small blood vessels are damaged), superficial lacerations and abrasions to the left side of the head and left posterior shoulder and a superficial scalp laceration requiring staple repair. A computed tomography (CT) scan of Resident #2's head identified a small 4 millimeters (mm) left temporal subdural hematoma (collection of blood between the skull and scalp) without mass effect (displacement or compression of brain or midline structures caused by bleeding). A repeat CT head scan completed 6 hours following the initial CT head scan showed stabilization of the brain bleed and no further treatment was required. Resident #2 remained at the hospital for monitoring and was discharged from the hospital and returned back to the facility on [DATE]. This deficient practice occurred for 1 of 3 residents reviewed for abuse.Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included dementia, depression and cognitive communication deficit.The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #1 with moderate cognitive impairment. Resident #1 required supervision or touching assistance with transfers and ambulation and displayed no physical or other behaviors during the MDS look-back period. Review of Resident #1's medical record revealed no documentation of behaviors or aggression prior to the incident on 08/04/25. Resident #2 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (group of disorders that affect the ability to move and maintain balance and posture), scoliosis (abnormal curving of the spine), and quadriplegia-incomplete (spinal cord injury that results in some but not total paralysis of the arms, legs and torso).The quarterly MDS assessment dated [DATE] assessed Resident #2 with intact cognition. Resident #2 had impairment on both sides of the upper and lower extremities and was dependent on staff assistance with all self-care tasks, bed mobility and transfers. Review of the August 2025 medication administration records revealed Resident #2 was not prescribed an anticoagulant (blood thinner) medication.A staff progress note dated 08/04/25 at 11:15 PM written by the Director of Nursing (DON) revealed in part, Resident #1 was noted displaying sudden, increased agitation and combative behaviors. The Medical Doctor (MD) was notified, and Resident #2 was sent to the hospital for evaluation and treatment.A staff progress note dated 08/04/25 at 11:15 PM written by the Director of Nursing (DON) revealed in part, Resident #2 was observed with discoloration and bruising to the head and neck. The Medical Doctor (MD) was notified, and Resident #2 was sent to the hospital for evaluation and treatment. Review of the facility's initial allegation report (24-hour report) completed by the Administrator revealed on 08/04/25 at 10:30 PM the facility became aware of a resident-to-resident altercation involving Resident #1 and Resident #2. It was noted Resident #2 was found with a laceration to his head, both residents were immediately separated and Resident #1 was put on one-to-one supervision.During a phone interview on 08/25/25 at 7:34 PM, Nurse #1 confirmed she was Resident #1 and Resident #2's assigned nurse on 08/04/25. Nurse #1 recalled at around 10:00 PM on 08/04/25 she had parked her medication cart in the hall by Resident #1 and Resident #2's room and she went up the hall to another resident's room. When she walked back to her medication cart a few minutes later, she noticed Resident #1 standing in the doorway of the room wearing a shirt and no pants, which was unusual because the door had previously been closed, and she immediately knew something was wrong. She stated when she walked up to Resident #1, he had a wild look in his eyes and when she asked him what was wrong, he stated this man is keeping me awake, makes me crazy and won't let me sleep. Nurse #1 stated she assumed Resident #1 was referring to his roommate, Resident #2, and as she tried to redirect Resident #1 back to his bed, Resident #1 hit her in the chin with a closed fist. Nurse #1 called for Nurse Aide (NA) #1 to come assist and when NA #1 arrived at the room, Resident #1 had sat down at the foot of Resident #2's bed and had a call light cord in his hand that he was swinging at staff. Nurse #1 recalled NA #1 was hit as well but was able to get the call light cord away from Resident #1 and was eventually able to get Resident #1 redirected back to his bed. Nurse #1 stated as