STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mount Rehabilitation Center	160 S Winstead Avenue Rocky Mount, NC 27804

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, record review, and interviews with staff, the facility failed to implement their abuse policy when the facility failed 1) to report to the local law enforcement within 24 hours that Resident # 1 and Resident # 2 were involved in an altercation where staff members reportedly witnessed bodily hits of residents and 2) complete a thorough investigation by ensuring that all witnesses were interviewed. The facility also failed to ensure its Abuse and Neglect Prohibition policy, specified that the Administrator was to be notified immediately of allegations of abuse as required by federal regulations and failed to ensure that immediately following the altercation between Resident # 1 and Resident # 2 that it was clearly communicated to the Administrator that there had been witnessed bodily hits between the residents. This was for 1 of 2 alleged abuse cases reviewed involving Resident # 1 and Resident # 2.The findings included:Review of the facility's Abuse and Neglect Prohibition policy, dated 10/24/22 and revised on 8/2023, revealed the following policy and procedures. The center will investigate any alleged abuse/neglect or misappropriation of resident property in accordance with state or federal law. Under Reporting and Response, the abuse policy listed 6 items which read, 1) The center will report all allegations and substantiated occurrences of abuse, neglect, and misappropriation of property to the state/federal agency and law enforcement officials as designated by state/federal law. 2)The center will assure that reporters are free from retaliation 3) The center will post a conspicuous notice of employees rights, including the right to file a complaint with the State Survey Agency if they believe the center has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. 4)The center will report to the corporate office in accordance with reporting procedures via Risk Guide. 5) The center will report any occurrences of abuse by registered or certified staff to the State Board as required by state law. 6) Policies and procedures will be analyzed and modified as necessary by the QA & A/QAPI Committee (Quality Assurance and Performance Improvement) to meet the full intent of the law. There was no specific policy or procedure referenced in the 8/20/23 revised Abuse and Neglect Prohibition policy which noted what Risk Guide to the Corporate Office entailed, and the Abuse and Neglect Prohibition policy did not specify that the Administrator was to be notified immediately of alleged abuse.On 2/17/26 the facility submitted to the state agency an Initial Allegation Report of alleged abuse which according to the facility's report to the state agency occurred on 2/17/26 and of which they became aware on 2/17/26. In the facility's initial report to the state agency, the facility submitted that Resident # 1 alleged that Resident # 2 swung at her on 2/17/26.Review of the facility's investigative file revealed statements which indicated alleged abuse occurred on 2/14/26 and not on 2/17/26. On 2/22/26, the Administrator signed she completed a five-day Investigation Report which included corrected information and which was submitted to the state agency. The Administrator indicated the following on the five-day investigation report. There had been an altercation between Resident # 1 and Resident # 2 which had occurred on 2/14/26 and the facility became aware of the incident on 2/17/26. The facility's investigation showed that Resident # 2 made contact with Resident # 1's shoulder/chest. Resident # 1 had a bruise on her cheek. There had been no witness that Resident # 1's face had been contacted, but it was thought that the altercation had led to Resident # 1's eye being bruised.Review of statements obtained by the (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility regarding the alleged abuse between Resident # 1 and Resident # 2 revealed the following statements.Nurse Aide (NA # 1) wrote the following information in a statement which was dated 2/14/26. She saw Resident # 1 watching television in the activity room. Then she saw Resident # 3 enter the Activity room and sit next to Resident # 1. Then a few minutes later she saw Resident # 2 enter the Activity Room and sit on the other side of Resident # 1. Then she heard yelling and looked up and saw Resident # 2 hitting Resident # 1 and she also heard Resident # 3 saying hit her again. Then Resident # 2 swung at Resident # 1 again. She (NA # 1) entered the activity room with NA # 2 and tried to get Resident # 1 out of the Activity Room, but NA # 2 put Resident # 2 at another table. On 3/4/26 there was an update on the statement by Nurse Aide # 1 which read before [Resident # 1] went to bed she told [Resident # 2] hit her in her eye.NA # 1 was interviewed on 3/4/26 at 5:15 PM and reported the following information. On the evening of 2/14/26 she had been sitting at the nursing desk and had a direct view into the activity room. Resident # 1 entered the activity room first. Resident # 3 then entered the activity room and sat close to Resident # 1. Resident # 2 then entered and sat close to both Resident # 1 and # 3. They were all watching television. Then she heard Resident # 1 yelling, Stop. Leave me alone. She heard Resident # 3 yell, Hit her again. As she (NA # 1) was entering the activity room, she saw Resident # 2 hit Resident # 1 with his fist. He hit her in the face. Resident # 1 was backing away from him. Resident # 2 swung to hit Resident # 1 again but Resident # 1 put her arm up to block his hit. Nurse Aide # 2 was right behind her and entered also. She (NA # 1) never saw Resident # 1 provoke Resident # 2 or hit Resident # 2. She (NA # 1) tried to take Resident # 1 out of the room but Resident # 1 did not want to leave. Resident # 2 was taken and put at a different table. After a few minutes, Resident # 1 wheeled in her wheelchair out of the activity room and left. At the time, Resident # 1 did not have any marks on her face or outward signs of injury. Before Resident # 1 went to bed that night, NA # 1 heard Resident # 1 say, he hit me. She was not assigned to care for Resident # 1 or Resident # 2 on the evening of the incident. NA # 2 had been the assigned Nurse Aide on the residents' hall and therefore NA # 2 had spoken to the Nurse. She did not know what NA # 2 told the nurse regarding what had happened. She (NA # 1) had not spoken to a nurse. She had been asked to write a statement that night and put it under the Administrator's door. She had done so. A couple days later she noticed that Resident # 1 had a black eye. No one had asked her about the incident after the incident occurred until the current day when she was talking to the surveyor. The surveyor was the first person to talk with her about the incident. Resident # 3, who she heard tell Resident # 2 to hit Resident # 1 again during the incident, had always started things. Resident # 3 would tell other residents that Resident # 1 was crazy and other negative remarks about the resident. She had reported Resident # 3's remarks to nurses but had not reported them to the Administrator. The Administrator had not talked to her about the 2/14/26 incident.Review of NA # 2's statement in the facility's investigative file revealed NA # 2 wrote the following information. She (NA # 2) was sitting at the nursing station charting when she heard a loud commotion in the Activity Room. When she got in there to find out what was going on, NA # 1 had separated Resident # 1 and Resident # 2 who were in the middle of a physical altercation. NA # 1 pulled Resident # 1 away and she (NA # 2) asked Resident # 2 to go to another table and he did. She (NA # 2) did not see who passed the first lick but they were both hitting each other.NA # 2 was interviewed on 3/4/26 at 4:45 PM and reported the following information which included differing details of the incident regarding what she heard to prompt her to go into the activity room on 2/14/26 and what she saw. NA # 2 reported the following specific details. She and NA # 1 were at the nursing desk together on the evening of 2/14/26. Resident # 1, # 2, and # 3 were all in the activity room watching television. She did not recall that there were any other residents with them. She heard Resident # 3 yell, They are fighting. They are fighting. She entered with NA # 1 and saw that both Resident # 1 and Resident # 2 were hitting each other but she did not recall where the blows were on each of the resident's bodies. She did not know who had struck the first blow. Neither resident reported how it had started. NA # 1 took Resident # 1 back to her room. Resident # 2 stayed in the activity room. She had not known (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	either resident to fight before and it was a surprise to her that it had occurred. NA # 1 told whoever the nurse on duty was what had occurred. She did not recall which nurse that was. She (NA # 2) was assigned to Resident # 2 but not to Resident # 1. That night Resident # 1's eye was okay but in a couple of days it turned black.Nurse # 1 was interviewed on 3/5/26 at 9:50 AM and reported the following information. On the 3:00 to 11:00 PM shift on 2/14/26, she was the assigned nurse for Resident # 1 and Resident # 2. A Nurse Aide told her that Resident # 1 and Resident # 2 were in an altercation and that Resident # 1 had started hitting Resident # 2. Resident # 2 did not hit back at first and then he did. She did not recall which Nurse Aide had told her about the incident. The incident occurred in the Activity Room. She checked the residents and they had no marks. It was a very busy night, and she did not call the Administrator but knew she should have done so.The Scheduler was interviewed on 3/4/26 at 4:25 PM and reported the following information. She was the Administrator on Duty for the weekend of 2/14/26. She had been in the facility on the evening of 2/14/26 when she heard NA # 1 at the nursing station talking to someone else saying that Resident # 2 had hit Resident # 1. She did not clarify where Resident # 1 had been hit. She went to talk to the nurse on the hall and found out that the nurse was aware of the incident. She went to look at Resident # 1 and did not see any marks on the resident. Resident # 1 told her (the Scheduler) that a man had hit her and described a physical feature of the male resident. She talked to Resident # 2 who said he did not know what she was talking about. She (the Scheduler) called the Administrator and referred to Resident # 1 and Resident # 2 and told the Administrator that Resident # 2 may have hit Resident # 1. Resident # 1 had been assessed and there were no marks. The Administrator told her (the Scheduler) to have NA # 1 write a statement and put it under her door. She made sure the residents were separated. During an interview with the local police department on 3/5/26 at 12:17 PM, it was confirmed that they did not receive a report of alleged assault until 2/17/26 at 12:17 PM.The DON (Director of Nursing) was interviewed on 3/5/26 at 12:15 PM and reported she had been off on 2/14/26 through 2/16/26 and no one had reported any alleged abuse to her. The Scheduler had reported to her on 2/16/26 that Resident # 1's eye was dark underneath the eye. At the time she became aware, the Administrator had already noticed the darkened area also. During interviews with the Administrator on 3/4/26 at 2:00 PM, 3/5/26 at 8:00 AM and 3/5/26 at 11:20 AM, the Administrator reported the following information. The Scheduler had called her at home on the evening of 2/14/26 and told her there was a resident-to-resident altercation between Resident # 1 and Resident # 2. She was told that it was a verbal altercation which was non-physical and no one had been hurt. She was aware that Resident # 1, who was cognitively impaired, had a history of telling other residents things like where they could sit in the common area. She had assumed Resident # 2 was the aggressor in the verbal altercation and told the Scheduler to make sure he was monitored. On 2/15/26 (Sunday) she called and talked to a nursing staff member, who validated Resident # 1 and Resident # 2 were being kept apart, monitored, and there were no problems. On Monday (2/16/26) Resident # 1 was gone for most of the day for dialysis and therefore she did not get an opportunity to talk to her. She did not look at NA # 1's statement until Tuesday (2/17/26). She did not talk to NA # 1 on 2/17/26 and first talked to NA # 1 on 3/4/26 and had her update her statement. On Tuesday (2/17/26) she talked to Resident # 1 and noticed that her eye was darker underneath. She asked her what had happened and Resident # 1 initially told her that a branch had hit her on the way to dialysis. (She had gone to dialysis the previous day). She asked Resident # 1 to think and see if there was anything else that she recalled that might have caused the dark area under her eye. Resident # 1 then said that there was a guy who was going to beat her up. The guy would not do what she asked him to do and then he pushed her. Resident # 1 had pointed to her right anterior shoulder when she said the guy had pushed her. She (the Administrator) then talked to Resident # 2 on 2/17/26 and he said he did not have a problem with anyone. Resident # 2 reported he had not hit anyone, and he wanted to be left alone. Then she had talked to Resident # 3 who had been the only resident who had witnessed the incident. Resident # 3 was cognitively intact, but she (the Administrator) could not voice an opinion on whether the resident (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was credible or not. Resident # 3 had told her (the Administrator) that Resident # 1 started hitting Resident # 2 when he would not do what she wanted him to do. Resident # 2 had backed up and pushed her away in a defensive manner but had not hit Resident # 1 at all. She (the Administrator) called the police to report the alleged assault on 2/17/26 and found that the family had become aware of the resident's bruising below her eye by someone other than a staff member and had already called the police themselves that day a very short time period before she had done so. She knew there had been different stories told by different individuals and she had not been able to substantiate that abuse had occurred. The Administrator did validate that the incident was not reported to her (as the Administrator) as abuse initially in order that the report to the police and state agency report be initiated per their policy. She also validated that the investigation into the alleged abuse did not begin until 2/17/26 because details had not been communicated clearly to her and she had been busy and not read NA # 1's statement when she returned to work on Monday (2/16/26).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and Physician Assistant, the facility failed to ensure the medical record was complete regarding altercations that had occurred and a Physician Assistant's assessment following an altercation. This was for 2 of 2 sampled residents whose records were reviewed related to an altercation (Residents # 1 and # 2). The findings included:1a. Resident # 1's was admitted to the facility on [DATE] and Resident # 2 was admitted on [DATE].Review of a facility investigative file into alleged abuse which occurred during an altercation on 2/14/26 between Resident # 1 and Resident # 2 revealed written statements from witnesses regarding details of what transpired in the altercation. A review of Nurse Aide (NA #1's) statement revealed she witnessed Resident # 2 hit Resident # 1. A review of NA # 2's statement revealed Resident # 1 and Resident # 2 were both hitting each other.Nurse # 1 had been assigned to care for Resident # 1 and Resident # 2 on 2/14/26. During an interview with Nurse # 1 on 3/5/26 at 9:50, Nurse # 1 reported she did not recall which Nurse Aide had informed her about an altercation, but she had been told that Resident # 1 hit Resident # 2 and then Resident # 2 hit Resident # 1 back. Nurse # 1 further reported she had been very busy, checked the residents, saw no injuries or marks, but did not document in the medical record the altercation or her assessment of the residents.During an interview with the Administrator on 3/5/26 at 3:45 PM, the Administrator reported Nurse # 1 should have made a notation in each resident's record that the residents had been involved in an altercation.1b. On 2/17/26 Resident # 1 was documented on a skin audit report as having bruising to the cheek area below her left eye. Physician Assistant # 1 was interviewed on 3/5/26 at 1:10 PM and reported the following information. She recalled assessing Resident # 1 after Resident # 1 had been involved in an altercation on 2/14/26 and after Resident # 1 was identified to have a bruise below her eye. She did not recall for sure which day this had been but knew it had been after the bruise and altercation had been reported to her from staff. Resident # 1's eye was not painful or shut. Resident # 1 did not have vision problems. Resident # 1 had reported she had been hit in another room and did not give details. She (PA # 1) reported she did not make a notation about her assessment of Resident # 1 in Resident # 1's medical record.During an interview with the Administrator on 3/5/26 at 3:45 PM, the Administrator reported PA # 1 should have made a notation in Resident # 1's record about her assessment of Resident # 1 when she evaluated her for the bruised eye following the altercation.