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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH AND REHABILITATION	**345 MANOR ROAD , MARS HILL, North Carolina, 28754**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The survey team entered the facility on 08/25/25 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 08/26/25 and 08/27/25. Therefore, the exit date was 08/27/25. Event ID 1D5477-H1. The following intake was investigated: 2583137. One (1) of the one (1) complaint allegation resulted in deficiency. Past noncompliance was identified at 483.12 at tag F600 at scope and severity of G.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: 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	F0600	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0600 SS = G	Continued from page 1 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 08/07/25. This deficient practice occurred for 1 of 3 residents reviewed for abuse. Findings included: Resident #1 was admitted to the facility on 12/18/24 with diagnoses that included dementia, depression and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated 07/31/25 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 01/02/16 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 05/10/25 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	F0600		

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F0600 SS = G	Continued from page 2 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 soon as she knew NA #1 had Resident #1 on his side of the room, she and NA #2 went into the room and pushed Resident #2 out into the hall on his bed to safety. Once they had	F0600		

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F0600 SS = G	Continued from page 3 Resident #2 out in the hall, she noticed a bed pad had been placed over Resident #2's head and when it was removed, there was blood on his head and his neck was swollen. She stated Resident #2 opened his eyes when she talked to him but didn't provide any verbal responses. She stated Nurse #2 contacted Emergency Medical Services (EMS), she called the DON, NA #1 remained in the room with Resident #1 and NA #2 stayed with Resident #2 out in the hall until EMS arrived and transported both Resident #1 and Resident #2 to the hospital. Nurse #1 stated the entire incident was so traumatic for everyone involved and happened so quickly, she did not assess either resident nor interview them to find out what had happened or what Resident #1 used to inflict Resident #2's injuries. Nurse #1 stated earlier in the evening/shift, both Resident #1 and Resident #2 had been fine, and she was not sure what caused Resident #1 to assault Resident #2 as he had never displayed any aggression or behavior toward anyone prior to this incident. During a phone interview on 08/25/25 at 11:40 AM, NA #1 recalled it was toward the end of the shift on 08/04/25 at approximately 10:00 PM when he had just come back inside the building from taking out the trash when Nurse #1 let him know that Resident #1 had hit her and needed help. NA #1 stated when he went to Resident #1 and Resident #2's room, Resident #1 was sitting at the foot of Resident #2's bed with a call light cord in his hand. NA #1 stated when he asked Resident #1 if he would go back to his bed, Resident #1 started swinging the call light cord hitting him (NA #1) "but not hard" and then walked out into the hall swinging the call light cord at Nurse #1 who was standing in the hall. NA #1 stated he was able to get the call light cord from Resident #1 and redirected back into the room, Resident #1 then picked up his walker and tried to hit staff, but he (NA #1) just kept talking to Resident #1, was able to get him to put the walker back down and redirected him back to his bed. NA #1 stated he stayed with Resident #1 while Nurse #1 and NA #2 got Resident #2 out of the room. NA #1 stated he didn't specifically ask Resident #1 what had happened but did recall while trying to redirect Resident #1, he overheard Resident #1 tell NA #2 that he had "beat the crap out of [Resident #2]." NA #1 stated there had been no concerns with either resident when he had checked in on them earlier in the shift and was not sure what had caused Resident #1 to assault Resident #2. NA #1 stated prior to this incident, Resident #1 had never displayed any type of aggression or behaviors toward anyone. During a phone interview on 08/25/25 at 3:36 PM, NA #2 recalled sometime around 10:00 PM on 08/04/25 she was	F0600		

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F0600 SS = G	Continued from page 4 called to Resident #1 and Resident #2's room to help Nurse #1. NA #2 stated when she got to the room, NA #1 was in the room trying to calm Resident #1 down and Resident #2 was lying on his bed with his head covered but she wasn't sure with what at that point. She stated once NA #1 got Resident #1 redirected back to his bed, she and Nurse #1 immediately went into the room and they both pushed Resident #2 and his bed out of the room and a little way down the hall to safety. NA #2 stated Resident #2 had a bed pad covering his head and when it was removed, the top of his head was bleeding, but she was not sure what other injuries he had. NA #2 recalled just before she and Nurse #1 were getting Resident #2 out of the room, Resident #1 stated he had "beat the crap out of [Resident #2]" but never said why. NA #2 stated everything happened so fast and the entire incident was so traumatic, she didn't ask Resident #2 what had happened or notice what Resident #1 may have used to cause Resident #2's injuries. She stated her focus at that time was to keep talking to Resident #2 to make sure he stayed awake until EMS arrived. NA #2 stated she stayed out in the hall with Resident #2 while NA #1 stayed in the room with Resident #1 and while waiting on EMS to arrive, she monitored Resident #2's vital signs which remained stable, he never lost consciousness and he did not complain of any pain. The Emergency Department (ED) progress note dated 08/04/25 revealed Resident #2 presented for evaluation following an alleged assault by his roommate at the nursing facility. Upon initial evaluation, Resident #2 was noted to be hypotensive (low blood pressure) and did not complain of pain. Resident #2 had contusions, superficial abrasions and lacerations to the left side of the head and left posterior shoulder, a superficial scalp laceration requiring staple repair and a CT scan of the neck/head revealed Resident #2 had a 4mm left temporal subdural hematoma with no significant mass effect and no midline shift (displacement of the brain's midline structures from their normal position). A repeat CT scan completed 6 hours after the initial CT scan showed stabilization of the head bleed, and no further treatment was required. Resident #2 remained at the hospital for monitoring and was discharged back to the facility on 08/07/25. During an observation and interview on 08/25/25 at 10:11 AM, Resident #1 was sitting in his wheelchair in his room watching TV. Resident #1 was well-groomed, calm with a confused affect and displayed no behaviors. Resident #1 was unable to recall the name of his former roommate or the incident involving Resident #2 on 08/04/25.	F0600		

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F0600 SS = G	Continued from page 5 During an observation and interview on 08/25/25 at 11:55 AM, Resident #2 was lying in bed on his right side and covered with a sheet. He had faded circular bruising below the left eye, side of his face and neck and multiple small, round, scabbed abrasions on the top of his head, and scabbed abrasion in the hairline of his scalp with no signs of swelling or redness. When asked about the incident involving Resident #1 on 08/04/25, Resident #2 stated he couldn't recall when it happened or a lot of the details but did remember that Resident #1 came over to his side of the room one evening and hit him twice on the left side of the face and once on the right. Resident #2 stated he had no idea why Resident #1 had hit him, and he wished he knew what had "set him off." Resident #2 stated it had "shocked him" that Resident #1 had acted that way as they had never had any issues or altercations prior. Resident #2 stated he hadn't seen Resident #1 since the incident, and he felt safe at the facility. Review of the facility's investigation report dated 08/08/25 completed by the Administrator revealed both Resident #1 and Resident #2 were treated at the hospital and neither resident was able to recall the events of the incident. It was noted Resident #1 and Resident #2 had been roommates since 01/27/25 and had always gotten along. The summary of the facility's investigation revealed in part, the allegation of abuse was unsubstantiated based on the findings of the investigation as well as "Resident #1 lacking the mental capacity to recall the events; however, out of an abundance of caution, the facility developed and implemented a proactive plan to mitigate the risk of similar incidents in the future." During an interview on 08/25/25 at 4:32 PM, the DON recalled it was sometime around 10:00 PM when Nurse #1 called to let her know that Resident #1 was being aggressive, had hit Nurse #1 and Nurse #1 was concerned Resident #1 might hurt someone else. The DON stated Nurse #1 was on the phone talking to her (the DON) while standing out in the hall by Resident #1 and Resident #2's room while NA #1 was in the room with Resident #1 and Resident #2. The DON stated at first, they didn't realize Resident #2 was hurt so she instructed Nurse #1 to call the on-call provider to get orders and start the paperwork to send Resident #1 to the hospital for evaluation because the behavior he was displaying was so unlike his normal character. The DON stated she then overheard someone state that Resident #2 was hurt but it was so chaotic no one knew the extent of his injuries, just that there was blood on his pillow. She then told Nurse #1 to get the residents	F0600		

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F0600 SS = G	Continued from page 6 separated and assessed and she (DON) would call the Administrator to let her know what was going on. The DON stated when staff were able to get Resident #2 out of the room, they reported there was blood on his head, and his ear was rather bruised. The DON stated since Resident #2 was agreeable to going to the hospital, she told Nurse #1 just to contact EMS to get Resident #1 and Resident #2 both sent out to the hospital as soon as possible. The DON explained they tried to determine a root cause as part of the investigation into the incident but were not able to definitively determine what could have caused Resident #1's behavior or what he could have used to cause Resident #2's injuries. She stated they tried talking to both Resident #1 and Resident #2 when they returned from the hospital but neither resident could recall what had happened. She recalled Resident #2 had stated Resident #1 had never been aggressive to him before, they were buddies, and he didn't know why Resident #1 had hit him. During an interview on 08/25/25 at 5:02 PM, the Administrator stated on 08/04/25 sometime around 10:00 PM or shortly thereafter she received a call from the DON informing her of the incident involving Resident #1 and Resident #2. The Administrator stated she went to the ED on 08/04/25 to see Resident #2 to try and get a grasp on what had happened, but he was sleeping so she went to the hospital lobby to start the paperwork for the initial report to submit to the State Agency. The Administrator stated when she saw Resident #1 in the ED, he had lacerations to the left side of head and there was swelling and bruising but she did not know at that point he had a subdural hematoma. She stated when she got to the facility later that morning (08/05/25), they tried to do a root cause but since the incident was unwitnessed, it was tough for them to determine what actually happened or what Resident #1 had used to cause Resident #2's injuries and when she was able to finally talk with both residents, neither were able to recall the incident. The Administrator stated Resident #1 and Resident #2 had been roommates for a long time, got along good with one another with no issues and then this incident happened "out of the blue." She stated Resident #1 had never displayed any type of aggression or behaviors prior to the incident on 08/04/25 and felt it was an isolated and unexplainable event. She stated since returning from the hospital, neither resident was able to recall the incident, Resident #2 was a little more tired but able to answer appropriately when spoken to and Resident #1 was moved to a private room on the opposite side of the facility away from Resident #2 and had displayed no further behaviors. The Administrator explained they had an ad-hoc QAPI meeting on 08/05/25 to discuss the incident and it was decided to focus on	F0600		

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F0600 SS = G	Continued from page 7 roommate compatibility when developing a plan to prevent something like this from happening in the future even though Resident #1 and Resident #2 appeared to be compatible roommates. She stated they immediately started implementing the corrective action plan and in-service education on abuse and roommate compatibility was provided to all facility staff on 08/05/25. During a phone interview on 08/26/25 at 8:39 AM, the MD stated Resident #1's injuries which included a subdural hematoma, scalp lacerations and bruising were significant but required no surgical intervention. The MD explained the subdural hematoma had resolved and the lacerations and bruising were healing. He stated prior to the incident on 08/04/25, Resident #2 was totally dependent on staff for all activities of daily living, bed mobility and transfers which did not change or diminish following the incident and other than the subdural hematoma, bruising and lacerations that were all healing, Resident #2 had slowly returned to his baseline with no latent effects medically or physically. The MD stated Resident #1's behavior was totally out of character as he was always mild-mannered with no episodes of behaviors or aggression. The MD stated the hospital did diagnosis Resident #1 with a urinary tract infection (UTI) that was treated with antibiotics, but it was hard to determine what caused his outburst or if the UTI was the contributing factor. He stated he had not known someone to display the type of aggressive behavior Resident #1 had as a result of a UTI. The facility provided the following corrective action plan with a completion date of 08/07/25: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On August 4, 2025, at approximately 10:05 p.m., Resident #1 hit Nurse #1 in the hallway outside the door of his room. Nurse #1 immediately requested additional assistance from Nurse Aide (NA) #1 and NA #2. NA #1 entered the resident's room, while NA#2 and Nurse #1 waited outside at the door. Upon entering the room, Resident #1 was sitting at the bottom of Resident #2's bed with a call light cord in his hand. Resident #1 exhibited agitation with all staff members, but NA #1 was able to retrieve the call light cord and get Resident #1 into his bed. At this time, Resident #1 stated he had injured Resident #2, and staff observed Resident #2 with an underpad over his head. Upon removing the underpad, staff identified Resident #2 was	F0600		

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F0600 SS = G	Continued from page 8 bleeding about the head. Nurse #1 went to the desk and instructed Nurse #2 to call 911 while NA #1 and #2 stayed in the room. With assistance, NA #2 immediately removed Resident #2, while still in bed, into the hallway to get him away from Resident #1. NA #1 remained with Resident #1 until Emergency Management arrived. This altercation resulted in both Resident #1 and Resident #2 requiring additional medical attention beyond first aid at the facility. Both Resident #1 and Resident #2 were immediately separated by nursing staff at approximately 10:10 p.m. on August 4, 2025. Resident #1 was placed with one-to-one supervision by NA #1 immediately upon separation until departure from the facility. The facility notified emergency management via 911 at approximately 10:13 p.m. on August 4, 2025. Emergency Management Services arrived at the facility at 10:27 p.m. on August 4, 2025. Resident #1 and Resident #2 left the facility with Emergency Management personnel at 10:40 p.m. on August 4, 2025. Resident #1 and Resident #2 were taken to the hospital for further evaluation on the night of August 4, 2025. The Facility Administrator arrived at the hospital at 11:55 p.m. Resident #2 was interviewed by the Administrator on August 4 and August 6, 2025, and reported no recollection of the incident. Resident #1 was interviewed by facility staff on August 4, 2025, and again while hospitalized on August 6, and likewise did not recall any incident occurring at the facility. Medical Director notified of incident 8/4/25 by the Director of Nursing. Per regulation, a 24-Hour abuse allegation report was filed by the Administrator on 8/5/25. On August 5, 2025, the dedicated Interdisciplinary Team (IDT) including the Minimum Data Set (MDS) Nurse, two Nurse Unit Managers, Social Services Director, and Admissions Director reviewed all active residents for roommate compatibility to ensure all roommates were compatible without any recent signs for concern.	F0600		

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F0600 SS = G	Continued from page 9 Criteria included in consideration of roommate compatibility included: similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of mental, physical, psychosocial impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. The Interdisciplinary Team also considered roommate compatibility may be determined by resident's environmental preferences such as lighting, noise levels, temperatures, and clutter within the living space. They took signs of incompatibility into consideration during this audit. Considerations of roommate incompatibility included verbal bickering; complaints of inability to complete normal tasks; evidence of residents' withdrawal from others, or desire to stay out of his or her room. No roommates were determined to be incompatible at the time of this meeting on August 5, 2025; however, staff did provide one resident with some additional questioning and offer an alternative room due to his verbal expression of not wanting to be in his current temporary room. All results were reviewed with the Administrator by the Social Services Director on August 5, 2025. Beginning August 5, 2025, all room changes or roommate selections, including new admissions, will be documented following the already occurring group decision amongst the Interdisciplinary Team with input from floor staff, including but not limited to licensed nurses, nurse aides, housekeeping, and other members of administration. Criteria included in consideration for roommate compatibility will include similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of physical, mental, psychosocial impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff were also educated that roommate compatibility may be determined by residents' environmental preferences such as lighting, noise levels, temperatures, and clutter within the living space. The Administrator will sign off with her final approval on all room changes or roommate selections that are being documented beginning August 5, 2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Assistant Director of Nursing reviewed all Nursing Notes for active and inactive residents over the past thirty (30) days on August 5, 2025. This included the current residents and discharged residents who were at the facility during the dates of July 5, 2025-August 5, 2025. The review monitored for behavior charting or	F0600		

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F0600 SS = G	Continued from page 10 other forms of documentation which may indicate signs of resident-to-resident altercations, signs of roommate incompatibility, or signs and symptoms of abuse. The audit found one incident of a resident expressing differences of preference in room temperature on July 26, 2025. Follow-up identified this resident was moved following her requested attempt to give the situation a couple of days. The resident was moved to another room on July 29, 2025. Nurse Notes are reviewed by nurse management seven days per week. Nurse management will continue to observe signs of resident incompatibility, aggression, agitation, or signs of abuse and neglect. All active residents with a BIMS score of 12 or higher were interviewed by the Social Worker on August 5, 2025. These interviews were conducted to ensure everyone felt safe, didn't have concerns or any reports of abuse, were comfortable in their room, and being treated well. None of the residents interviewed had concerns about their safety, felt uncomfortable in their room, or felt mistreated. All results were reviewed with the Administrator by the Social Services Director on August 5, 2025. All active residents with a BIMS score of 0–11 were given a head-to-toe skin inspection by the Bachelor of Science in Nursing (BSN), Treatment Nurse on August 5, 2025, to ensure there were no signs or symptoms of unreported abuse or resident-to-resident altercations such as bruising, scratches, lacerations, etc. Results of this audit concluded that no residents were determined to have unreported or suspicious bruising, scratches, or lacerations. Results were reviewed with the Director of Nursing on August 5, 2025. On August 6, 2025, the Activity Director individually provided all residents with a copy of the Resident Bill of Rights. This information was provided with the regularly scheduled delivery of the Daily Newsletter. An ad hoc Quality Insurance and Performance Improvement (QAPI) was held on August 5, 2025, with members of the QAPI Team that included: Administrator, Director of Nursing, Medical Director, Social Worker, Wound Nurse, Director of Rehab, Assistant Director of Nursing, Nurse Aide, Pharmacist, and Dietary Manager. It was on this date the QAPI Team finalized the plan for staff education, audits and monitoring tools and their frequencies. The Facility Pharmacist completed a medication review Resident #1 and noted all medications were appropriate at this time. Pharmacy note can be found through medical records. On August 5, 2025, letters were mailed to all	F0600		

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F0600 SS = G	Continued from page 11 responsible parties to reaffirm residents' rights and to share the facility's ongoing efforts to ensure compatible roommate placements. The letter also included contact information for individuals who can be reached should there be any concerns or suggestions to help the facility provide the most suitable cohabitation arrangements for their loved ones. Staff interviews were conducted by the Administrator, Business Office Manager, Therapy Director, Activity Director, Environmental Services Director, Dietary Manager, and Nurse Management between August 5, 2025, and August 6, 2025. The interviews were completed to ensure no one had witnessed any previous resident altercations, signs or symptoms of abuse and/or neglect, or concerns for resident safety. Staff interviewed includes administration, licensed nurses, nurse aides, dietary, therapy, activities, and environmental services. No reports of concern for resident safety, observed altercations, or signs and symptoms of abuse were reported. Results and completion of the interviews were reviewed between the Administrator and Regional Operations Manager on August 6, 2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All staff, including but not limited to licensed nurses, nurse aides, dietary, housekeeping, administration, therapy, activities, and clerical support, were in-serviced between August 5, 2025, and August 6, 2025. In-services were conducted by the Director of Nursing and Assistant Director of Nursing. The in-service included a reminder of the room change process, recognizing signs and symptoms of abuse and neglect, preventing resident abuse, resident-to-resident altercations, recognizing and reporting signs or symptoms of resident-to-resident altercations, reporting abuse/neglect/resident-to-resident altercations to facility management, managing and de-escalating agitated residents, and identifying signs of roommate incompatibility. Considerations of roommate incompatibility included: verbal bickering; complaints of inability to complete normal tasks; evidence of residents' withdrawal from others; or desire to stay out of his or her room. Managing or de-escalating residents with aggressive or agitated behaviors; this included residents with a dementia diagnosis but was not limited to. Any active staff determined not to receive the in-service prior to August 6, 2025, will receive in-servicing by the Director of Nursing,	F0600		

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F0600 SS = G	Continued from page 12 Administrator, or designee prior to working. Education was added to the general orientation after 8/5/25. Any new staff will be educated before working by the Payroll Coordinator during general orientation. The Administrator will track to ensure all new employees have been educated. All staff, including but not limited to: Administrator, Administration, Nurses, Nurse Aides, Environmental Services, Therapy, Activities, and Dietary employees were in-serviced between August 5, 2025–August 6, 2025, by the Director of Nursing and Assistant Director of Nursing regarding roommate compatibility, assisting with selecting compatible roommates, recognizing signs or symptoms of roommate non-compatibility, and reporting procedures if roommates show evidence of non-compatibility. Staff were given examples of roommate compatibility, which included: similar sleeping patterns, toileting needs, ability to vocalize needs, similar routines, and examples of impairments that may cause conflicts, activity preferences, social preferences, and religious compatibility. Staff were also educated that roommate compatibility may be determined by residents' environmental preferences such as lighting, noise levels, temperatures, and clutter within the living space. The staff was provided with examples of roommate incompatibility, which may also be considered abuse. These examples were: verbal bickering; complaints of inability to complete normal tasks; evidence of residents' withdrawal from others; or desire to stay out of his or her room. These in-services included reporting procedures for staff should the event occur off hours. Any active staff determined not to receive the in-service prior to August 6, 2025, will receive in-servicing by the Director of Nursing, Administrator, or designee prior to working. All education included in the plan was added to the general orientation after 8/5/25. Any new staff will be educated before working by the Payroll Coordinator during general orientation. The Administrator will track to ensure all new employees have been educated. On August 5, 2025, the Regional Operator educated the Administrator and the Director of Nursing on conducting random daily observations of resident-to-resident interactions and staff to resident interactions for any sign of incompatibility or abuse. The Administrator added observations of resident compatibility to the Daily Rounding form to be completed by the Interdisciplinary Team to be discussed at morning meeting. On August 5, 2025, the Administrator educated the IDT on the new observations on the rounding form.	F0600		

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F0600 SS = G	Continued from page 13 Indicate how the facility plans to monitor its performance to make sure solutions are sustained: To ensure quality assurance, the Administrator, Director of Nursing, or designated member of management will randomly interview 5 staff members per week for two weeks, 3 staff members per week for two weeks, and 2 staff members per week for an additional month. The interview will consist of the following questions: Have you had any observations that indicate signs of abuse, resident-to-resident altercations, or signs of roommate incompatibility? Any necessary follow-up or education will be provided immediately and documented. Results of these interviews will be presented in the QAPI Committee Meeting for a minimum of two consecutive meetings, at which time a need for additional monitoring will be determined. To ensure quality assurance, the Social Worker or designated member of management will interview five residents per week for four consecutive weeks. The interview will ensure the residents feel safe, don't have unresolved concerns, are comfortable in their current room setting, and are being treated well. Any necessary follow-up will be reported to the Director of Nursing, Social Worker, or Administrator. Findings of these interviews will be presented in the upcoming QAPI Committee Meeting following completion of the four consecutive weeks. The committee will review and determine the need for further monitoring. Any room changes initiated as a result of roommate incompatibility will be reviewed for three consecutive QAPI Committee Meetings to ensure resolution and identify any trends. The date of compliance is August 7, 2025. On 08/25/25 and 08/26/25, the facility's corrective action plan was validated by the following: Staff interviews revealed they had received in-service education related to abuse, resident-to-resident altercations, how to manage difficult behaviors, and roommate compatibility. Staff were able to verbalize signs and symptoms of abuse as well as what signs to observe for that would indicate potential roommate concerns that could lead to potential altercations such as residents bickering or arguing with one another, complaining about one another and to immediately report any concerns to their immediate supervisor, DON and/or Administrator. Review of the staff attendance sign-in sheets revealed education was provided to all staff/all departments and was completed on 08/06/25. A letter dated 08/05/25 and signed by the Administrator was sent	F0600		

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F0600 SS = G	Continued from page 14 to the families of residents explaining the facility was conducting roommate compatibility assessments, the signs and symptoms that would indicate potential concerns and contact numbers for the Social Worker, Administrator and Director of Nursing to report any concerns the families may have. Skin assessments were conducted on all cognitively impaired residents with no concerns identified. Alert and oriented residents were interviewed who all reported they felt safe at the facility and had no concerns of abuse. Staff interviews were completed with all staff/departments on 08/06/25 with no concerns of abuse reported. Audits and monitoring tools were reviewed for the period 08/05/25 through 08/22/25 with no identified concerns noted and were completed as outlined in the facility's corrective action plan. The corrective action plan's completion date of 08/07/25 was validated.	F0600		