F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
	245220				С
	345339	B. WING		0	5/06/2025
ROVIDER OR SUPPLIER					
REHABILITATION AN	ID HEALTHCARE CENTER				
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
INITIAL COMMEN	TS	F 00	0		
on 5/6/2025. Even	ID # QHHC11. The following				
deficiency.	-				
		F 60	0		5/19/25
Exploitation The resident has the neglect, misappropriation as includes but is not corporal punishme any physical or che	he right to be free from abuse, oriation of resident property, or defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to				
§483.12(a) The fac	sility must-				
physical abuse, co involuntary seclusi This REQUIREME	rporal punishment, or on;				
Based on record r family interview, th resident's right to b (Resident #1) of th physical abuse. Re cognitively impaire by a family member marks on her left u	e facility failed to protect the be free from abuse for one ree residents reviewed for esident #1, a severely d resident, was hit with a belt er resulting in three whip-like pper thigh and abdomen. A		 facility. Resident #1 was removed the presence of the abuser after the initial episode of Law enforcement was informed an abuser was arrested. 2. All residents have the ability to b 	from f abuse. nd the pe	
	ROVIDER OR SUPPLIER REHABILITATION AN SUMMARY (EACH DEFICIE REGULATORY O INITIAL COMMENT A complaint invest on 5/6/2025. Event intakes were invest NC00230076. One of the two alled deficiency. Free from Abuse a CFR(s): 483.12(a)(1) §483.12 Freedom Exploitation The resident has th neglect, misapprop and exploitation as includes but is not corporal punishme any physical or che treat the resident's §483.12(a)(1) Not physical abuse, co involuntary seclusion This REQUIREME by: Based on record r family interview, th resident's right to b (Resident #1) of th physical abuse. Recognitively impaired by a family member marks on her left u	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345339 RCHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint investigation survey was conducted on 5/6/2025. Event ID # QHHC11. The following intakes were investigated NC00229764 and NC00230076. One of the two allegations resulted in a deficiency. 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345339 B. WING	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345339 B. WING REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET Tage STREET ADDRESS, CITY, STATE, ZIP CODE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS F 000 A complaint investigation survey was conducted on 5/6/2025. Event ID # QHHC11. The following intakes were investigated NC00229764 and NC00230076. F 000 One of the two allegations resulted in a deficiency. F 600 Free from Abuse and Neglect CFR(s): 483.12 (a)(1) F 600 S483.12 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. 1. Resident #1 continues to resided facility. Resident #1 continues to resided facility. Resident #1 continues to resided facility. Resident #1 as everely contilvey impaired resident, was hit with a belt by a family member resulting in three whip-like marks on her left upper thigh and abdome. A 1. Resident #1 continues to reside facient by the deficient practice	CORRECTION IDENTIFICATION NUMBER: A BUILDING COV 345339 B: WING TREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET WINDS OR, NC 27963 REHABILITATION AND HEALTHCARE CENTER SUMMARY STREET OF DECODENCES POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION READULATORY OR LSC DENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INITIAL COMMENTS F 0000 POWDERS PLAN OF CORRECTION POWDERS PLAN OF CORRECTION INTER STAINTON TO RECOMENT ADDREDUPAL PLAN OF CORRECTIONS POWD

Electronically Signed

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.

05/21/2025

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/03/2025 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345339	B. WING _				C / 06/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOD		HEALTHCARE CENTER		13	306 SOUTH KING STREET		
WINDSON	REHABILITATION AND	HEALTHCARE CENTER		W	/INDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 1	F	500			
	Resident #1 was adm 9/27/2024 and had di intellectual disability a Documentation on a o (MDS) assessment d Resident #1 was seve and was dependent of daily living. Resident any moods or behavin assessment. Documentation on a o 11/04/2024 revealed of daily living, self-can relative to muscle we neuroleptic syndrome reaction to the use of One of the intervention was Resident #1's tot repositioning and turn There were no focus care plan for Resident Documentation in a n 4/23/2025 at 7:18 PM "This nurse was stand of [readmission] patie standing there, I over This nurse then overh hitting someone, and #1] yelling again. This (the) unit manager of Nurse #2 was intervie PM. Nurse #2 confirm	hitted to the facility on agnoses of a genetic-related and a neurological condition. quarterly Minimum Data Set ated 1/20/2025 revealed erely cognitively impaired on staff for all activities of #1 was not coded as having ors on the MDS care plan dated as initiated Resident #1 had an activity re performance deficit akness and malignant e, a rare and life-threatening antipsychotic medication. ons under this focus area tal dependence on staff for hing in bed. areas for behaviors on the t #1 before 4/23/2025. ursing progress note dated I written by Nurse #2 stated, ding in (the) hallway in front ent room. As this nurse was heard [Resident #1] yelling. heard the sound of someone then I overheard [Resident a nurse then went to inform, what was going on."			or higher. Audit questions include: De know about abuse? Do you know who to report abuse to? Do you feel safe in the faci Do you have any concerns about abuse including visitors (phys verbal, emotional, sexual, financial?) assessments were conducted for all other residents for signs of abuse, i.e, welts, bruises of unknown origin. 3. All staff including nurses, certified nursing assistants, agency/contract s all ancillary staff, and all newly hired employees were educated on the Abuse Prevention Po by the Director of Nurses/Assistant Director of Nurses 5/19/2025. This education included 1 and group training sessions. The Administrator/design will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff and all newly h employees will be educated. No staff will work after 5/19/2025 until education is received. 4. The Dirctor of Nurses/Assistant Director of nurses weekly audits x 4 th monthly x 2 months with residents with a BIM's score of 11 ch higer for any concerns or allegations abuse. Skin checks will be conducted on all other reidents. checks will be conducted weekly x 4 weeks then monthly x 2 months. Results of these audits will	lity? sical, Skin taff, blicy by 1 ee ired hen r of Skin	
	Resident #1 on 4/23/2	2025 for the 7:00 AM to 7:00			presented to the Quality Assurance		

Facility ID: 922993

		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		10. 0938-03 FE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· /)		MPLETED
						С
		345339	B. WING		0	5/06/2025
NAME OF P	ROVIDER OR SUPPLIER	•	· 1	STREET ADDRESS, CITY, STATE, ZIP C		
				1306 SOUTH KING STREET		
WINDSOF	REPADILITATION AND	HEALTHCARE CENTER		WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From nor	- 2				
F 000			F 60			
	PM shift. Nurse #2 pr	5		and Performance Improv	· · ·	
	information. Nurse #2			Committee for three month	S IOF REVIEW	
		vith another resident when te someone was being hit		and, if warranted, further action.		
w N ay N		eone calling out in pain.		5. Alleged Date of Complia	nco: Moy 10	
	· ·	listen, and she heard it		2025	nce. May 19,	
		sound and a cry of pain.		2025		
		to the hallway, and she saw				
		aides (NA #1 and NA #2)				
		resident rooms they were in.				
		wo nurse aides if they had				
		#2 then heard the whipping				
		ain coming from Resident				
		time. One of the nurse aides				
		Resident #1's room but then				
		ed around and went back to				
		nts. Nurse #2, without going				
		om, went down the hall to get				
		Irse #2 found the Unit				
		r Resident #1 was "getting				
	•	stated she let the Unit				
	· ·	situation because she knew				
	_	family member in the room.				
		the Unit Manager spoke with				
	Resident #1's family	member and the family				
	-	the room to be escorted off				
	the premises. Nurse	#2 entered Resident #1's				
	room and assisted th	e Unit Manager with a skin				
		nt #1 was lying on her right				
		s on her left hip. Nurse #2				
	completed a pain ass					
		2 explained the red raised				
		treatment and Resident #1				
		in pain. Nurse #2 explained				
		ediately go into Resident #1's				
	room when she hear					
		family member in the room.				
		ained that she had been a				
	I nurse for a long time	and had numerous training				

Facility ID: 922993

If continuation sheet Page 3 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DAT	E SURVEY PLETED
		345339	B. WING			05	C 5/ 06/2025
NAME OF PF	OVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	she had never encour hitting a resident. NA #1 was interviewe NA #1 confirmed she during the evening m she heard clapping at she went out into the noise was and along Resident #1's room. N was pulled so she con the first bed but saw to assumed was a family #1 reiterated she did happening, so she rei resident with eating. NA #2 was interviewe NA #2 stated she was Resident #1 for the 3: 4/23/2025. NA #2 stat next door assisting a evening meal when s clapping sound. NA # head out of the room sound and looked into #1's room. NA #2 said Resident #1's family re curtain and looked at Nurse #2 in the hallwa thought the family me Resident #1. NA #2 s next door to assist the NA #2 revealed she do from Resident #1's roo did not know that the Resident #1 was cons	ut she was in shock, and ntered a family member ed on 5/6/2025 at 12:42 PM. was in a resident's room ealtime on 4/23/2025 when nd hollering. NA #1 stated hallway to see what the with NA #2 peaked into NA #1 indicated the curtain uld not see Resident #1 in the back of what she y member in the room. NA not know what was turned to assisting another ed on 5/6/2025 at 1:54 PM. s assigned to care for :00 PM to 11:00 PM shift on ted she was in the room resident in eating the he heard a smacking or :2 indicated she stuck her because it was an unusual of the doorway of Resident d the curtain was pulled but member peaked around the her. NA #2 said she saw ay and Nurse #2 said she ember was spanking aid she reentered the room e other resident with eating. Id not hear any more noises iom. NA #2 confessed she	F	600			

Facility ID: 922993

If continuation sheet Page 4 of 18

	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING	·		
		245220	B. WING			С
		345339	B. WING			5/06/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983		
			I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 600	Continued From pag	le 4	F 60	0		
1 000			FOU	8		
		walls of the facility. NA #2 #1 sometimes resisted care				
but in The f interv mem Some mem herse who o to go	but in general she w					
	Satin general she w					
	The family member of	of Resident #1 was				
		025 at 3:01 PM. The family				
		e following information.				
	Someone from the fa	acility called the family				
	member and told her	r Resident #1 was exposing				
	-	nember did not want to reveal				
		family member did not plan				
		hat day, but she went to the				
	• •	Resident #1. The family				
		the hit Resident #1 with her				
		es. The Assistant Director of				
		plained to the family member she was not allowed to do that				
		mily member stated she did				
	-	ng and considered abuse. If				
		ad known disciplining				
	Resident #1 with a b					
		ing the police called, it				
		ned. The family member				
		viewed by the police and				
		at she loved Resident #1,				
	•	ry medical appointment, and				
		e hospital when she almost				
	-	nber said she told the police				
		urt Resident #1, but she				
		ehavior of undressing. The				
		sorry it happened, but she felt				
		bline Resident #1 when she				
		d found her with her arm out				
	-	nily member confirmed Nurse ent #1's room, asked her what				
		requested she leave. The				
		d other family members have				
	nanning member state			I. I		1
	-	nt #1 but that she would not				

Facility ID: 922993

If continuation sheet Page 5 of 18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	E SURVEY PLETED
		345339	B. WING		05	C 5/06/2025
	ROVIDER OR SUPPLIER	HEALTHCARE CENTER	13	REET ADDRESS, CITY, STATE, ZIP CODI 06 South King Street Indsor, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	have supervised visit that. Documentation in the dated 4/23/2025 at 7 stated, "This nurse w by the floor nurse that member] was whoop immediately went to [observed [Resident # on her right side and member] standing be on her hips and a bel immediately asked w [Resident #1's family me by repeating what asked her if she was with the belt that she #1's family member] the (Resident #1) was act then proceeded to tel member] that she can while she is here in th is our responsibility. I family member] what and [Resident #1] had too naked in the bed. I as member] to step out of walked to the nursing (Director of Nursing) informed to tell [Resid leave and to call 911.	med she was told she could s, but she did not want to do a nursing progress notes 12 PM by the Unit Manager as notified around 6:00 PM t [Resident #1's family ing her. This nurse Resident #1's] room and 1] laying in the bed, kind of [Resident #1's family side the bed with her hands t in her left hand. I hat was going on and member] responded back to t I had just asked her. I then hitting her (Resident #1) was holding and [Resident responded that she ting out with behaviors. I I [Resident #1's family not beat/hit her and that his facility, she (Resident #1) then asked [Resident#1's behaviors she is referring to mily member] stated that ok her gown off and was sked [Resident #1's family of the room and then I I station and called my DON and Administrator and was dent #1's family member] to	F 600			

If continuation sheet Page 6 of 18

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	E SURVEY
			A. BUILDIN	G		
		345339	B. WING			С
		343339				5/06/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	JDE	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETIO
F 600	Continued From page	e 6	F 60	00		
		appening on the evening of				
		Manager was coming up to				
the nursing static		om another hallway when				
		d her at the nursing station				
		nember] is whopping her."				
	The Unit Manager wa	as confused and asked				
	Nurse #2 who and whether the second s	nat was going on. Nurse #2				
		1's location and that it				
		nt #1 was being "whopped."				
		o the Unit Manager she did				
	not go into the room l					
		hit Manager went down the				
		ident #1's room to see the				
	-	er hands on her hips and hands. The Unit Manager				
		nber what was going on and				
		sponded by repeating what				
	•	anager asked the family				
		itting Resident #1 and the				
		nded that Resident #1 was				
		Manager explained to the				
	family member of Re	sident #1 that although they				
		s, she was not allowed to hit				
		facility because the residents				
		e. The Unit Manager asked				
		Jnit Manager observed that				
		ner right side in bed and				
	-	own there were raised red				
		it with a belt. The family				
		hallway and the ADON was hit Manager then called the				
	-	e Director of Nursing, who				
		ng. The Administrator told				
		nform the family member of				
	-	the building and to call 911.				
		d the ADON walk the family				
	-	#1 to the front door and				
		urn to the building until the				
		0	1	1		1

	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345339	B. WING				C / 06/2025
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	came to the building to Nurse #2, NA #1, NA #1's family left the fact arrived. The police to on Resident #1. The full by the family member assumed she hit her yn noise described by Ne stated this was an un- family member and she before this that she w Resident #1. The ADON was interv PM. The ADON stated overheard someone to the family member of Resident #1 with a be went down the hallwa family member what he by the family member a belt to discipline her had to explain that she in the facility and walk so she could leave. An attempt to intervie 5/6/2025 at 12:36 PM to express her recolled 4/23/2025. Documentation on a w dated 4/23/2025 at 6: as assessed as havin whip-like marks to fro	o conduct interviews with #2, and herself. Resident ility before the police ok pictures of the red marks Unit Manager was not told of Resident #1, but it was with her belt because of the urse #2. The Unit Manager expected action from the he had never indicated ould do anything like this to riewed on 5/6/2025 at 12:50 d on 4/23/2025 she alking in the hallway about Resident #1 whipping eff. The ADON revealed she y and saw the family y. The ADON asked the happened, and she was told of she was spanking her with r. The ADON revealed she e was not allowed to do that sed her to the building door w Resident #1 was made on . Resident #1 was not able ction of the events of weekly skin assessment 54 PM revealed Resident #1 g "Slight redness and nt of left thigh. Small, red t upper abdomen area."	F	600			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345339	B. WING				C 106/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	 4/23/2025 at 7:04 PW in no pain and had no Documentation in a no 4/23/2025 at 8:35 PW practitioner was made Resident #1 and requerered at an and the dated 4/24/2025 at 4: [#1] left the facility via 4/23/25 and returned [9:50 PM] with no new by the writer noted to break in skin. Residen Pleasant mood. No d Documentation in Reupdated on 4/23/2025 potential for harm injuction of the cognitive loss and be goal was for Resident to harm from others at environment through intervention was super member in a common present. An interview was con Worker on 5/6/2025 at Worker revealed Ress was very involved in Imedical appointments plan conferences. Th was shocked when stafamily member hit here 	I revealed Resident #1 was o indicators of pain. ursing progress note dated I revealed the nurse e aware of the incident with tested she be sent out to the evaluation. nursing progress notes 04 AM stated, "Resident a stretcher at [8:50 PM] on to the facility by stretcher at w orders. Skin assessment be [within normal limits]. No int alert and oriented. istress noted." sident #1's care plan was 5 with the focus area for the ury from others relative to haviors of undressing. The t #1 to have no injuries due and will remain in a safe	F	600			

Facility ID: 922993

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	S FOR MEDICARE &	MEDICAID SERVICES		CONSTRUCTION		RM APPROVE NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		345339	B. WING		0	5/06/2025
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DE	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER				
				INDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
F 600	Continued From pag	e 9	F 600			
		only be allowed to have				
		Resident #1 for a period of				
		rker indicated that to her				
		#1's family member had not				
	been back to the fac	liity.				
	An interview was cor	nducted with the facility				
		/2025 at 1:36 PM. The facility				
		ed that Resident #1 tried to				
		on without understanding				
		because she had a childlike ator indicated the family				
		#1 would say things jokingly				
		she would stop Resident #1				
	-	family dynamics were not				
		e Administrator explained				
	-	member, who struck her with ring Resident #1's young				
		ty to visit her. The police and				
		to Resident #1 after the				
	• •	ily member would not be				
		or a while. Resident #1				
		e on the day of the event				
		it meant she would not be hter and the family member				
	-	inistrator confirmed the				
	-	the family member to notify				
	her she would only b					
		n Resident #1 until it was				
		e. The Administrator stated				
		Iff to intervene immediately if e facility no matter the				
	source or situation.	o radinty no matter the				
F 607 SS=G	Develop/Implement	Abuse/Neglect Policies)-(5)(ii)(iii)	F 607			5/19/25
	§483.12(b) The facili	-				
	implement written po					

Facility ID: 922993

If continuation sheet Page 10 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345339	B. WING				06/2025	
	ROVIDER OR SUPPLIER	HEALTHCARE CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 306 SOUTH KING STREET VINDSOR, NC 27983	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	e 10	F	607				
	§483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re	ion of residents and						
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and						
	§483.12(b)(3) Include paragraph §483.95,	e training as required at						
	§483.12(b)(4) Establi QAPI program require	sh coordination with the ed under §483.75.						
	facilities in accordance Act. The policies and	e reporting of crimes funded long-term care with section 1150B of the procedures must include the following elements.						
		ting a conspicuous notice of lefined at section 1150B(d)						
	retaliation, as defined (2) of the Act. This REQUIREMENT	hibiting and preventing I at section 1150B(d)(1) and is not met as evidenced						
	interviews, the facility identify abuse and re- a resident from physi- delayed intervention	spond to intervene to protect cal abuse. Facility staff when Resident #1, a			 Resident #1 was removed from the presence of the abuser after the initial episode of abuse. Law enforcement was informed and the abuser was arrested. 			
	with a belt by a family whip-like marks on he abdomen and a visit	mpaired resident, was hit r member resulting in three er left upper thigh and to the emergency room. I to notify the state agency			2. All residents have the ability to be affected by the deficient practice.			

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		345339	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/06/2025	
				1306 SOUTH KING STREET			
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER		WINDSOR, NC 27983			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		CTION OULD BE PROPRIATE	(X5) COMPLETIC DATE	
F 607		a 11	E 60	7			
F 607	 within two hours of pl in the facility. This oc 3 residents reviewed policies and procedur investigations. Findin a. Documentation on policies and procedur heading of identificati exploitation, "the facil occurrences, patterns constitute: Abuse: unreasonable confine punishment with resu- mental anguish." Documentation on the policies and procedur "When suspicion of a reports of abuse/negl following procedure v where applicable will: the resident and prote- incident." Resident #1 was adm 9/27/2024 and had di intellectual disability a Documentation on a 0 (MDS) assessment d Resident #1 was seviand was dependent of 	hysical abuse that occurred curred for 1 (Resident #1) of for adherence to abuse res during physical abuse gs included: the undated facility abuse res revealed under the ion of abuse, neglect, and lity will identify events, s, and trends that may The willful infliction of injury, ement, intimidation, or ilting physical harm, pain, or e undated facility abuse res also revealed in part, buse/neglect/exploitation or lect/exploitation occurs, the vill be initiated: All staff, the Respond to the needs of ect him/her from further hitted to the facility on iagnoses of a genetic-related and a neurological condition. quarterly Minimum Data Set ated 1/20/2025 revealed erely cognitively impaired on staff for all activities of #1 was not coded as having	F 60	 3. All staff including nurses, cert nursing assistants, agency/contract staff, all ancill and all newly hired employees will be educated or Abuse Prevention Policy. The policy describes the right for ret to be free from abuse, negelect, exploitation or mistre and their obligation under state and federal law to report by the Administrator or designee. This will include sig abuse, reporting timeframes. All education will be completed Director of Nurses/Assistant Director of Nurses or designee 5/19/2025. This education will include 1:1 and group training The Administrator/designee will be the person who will ensilicensed nurses, certiied nursing assistants agency/com staff, all ancillary staff and newly hired employees will be educated. No staff will work afte date util education has been received. The Administrator was is serviced by the V.P of Clinical 5/8/2025 on the state and federal timeframes for reportin abuse and suspected abuse. New hires will receive training hire. 	ay staff in the esidents eatment abuse ins of d by the e by sessions. eure all tract r n- s on g actual		
	assessment. Documentation in a n	ursing progress note dated 1 written by Nurse #2 stated,		 The Administrator or designed conduct Weekly audits x 4 then monthly audits x 2 to assess s understanding of the what 			

Facility ID: 922993

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		A. BUILDING				
						С
		345339	B. WING			05/06/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1306 SOUTH KING STREET		
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER		WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	- 10				
F 007	Continued From page		F 60			
		ding in (the) hallway in front		constitues abuse and the im	meidate	
		ent room. As this nurse was		interventions that staff should		
		heard [Resident #1] yelling.		take in the event that abuse		
		heard the sound of someone		wittnessed. The Administrator		
		then I overheard [Resident		designee will conduct month	ily audits of	
		s nurse then went to inform,		incidents reports and	the then	
	(the) unit manager of	what was going on.		investigations for three mon quarterly, to ensure that all	ins, then	
	Nurso #2 was intonvid	ewed on 5/6/2025 at 12:02		reports are logged, investigation	tod	
		ned she was assigned to		promptly and reported to	lieu	
		2025 for the 7:00 AM to 7:00		appropriate agencies as req	uired The	
	PM shift. Nurse #2 pr			results of these		
	information. Nurse #2	-		audits will be reported to the	Quality	
		with another resident when		Assessment and Performance	Quality	
		ke someone was being hit		Improvement (QAPI) Comm	ittee for	
		eone calling out in pain.		three months for review and, if		
		listen, and she heard it		warranted, further action.		
		ound and a cry of pain.		,		
		to the hallway, and she saw		5. Alleged date of Compliance	: Mav 19.	
		aides (NA #1 and NA #2)		2025.	,	
		resident rooms they were in.				
	Nurse #2 asked the t	wo nurse aides if they had				
		#2 then heard the whipping				
	sound and a cry of pa	ain coming from Resident				
	#1's room for a third t	time. One of the nurse aides				
	stuck their head into	Resident #1's room but then				
	both nurse aides turn	ed around and went back to				
		nts. Nurse #2, without going				
		om, went down the hall to get				
	-	irse #2 found the Unit				
	-	r Resident #1 was "getting				
		stated she let the Unit				
	•	situation because she knew				
		family member in the room.				
		the Unit Manager spoke with				
	-	member and the family				
		the room to be escorted off				
	-	#2 explained that she did not				
	inmediately go into h	Resident #1's room when she				

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				E CONSTRUCTION		O. 0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	· · ·	E SURVEY IPLETED		
			A. DOILDING			С
		345339	B. WING		05/06/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1306 SOUTH KING STREET		
WINDSOF	K REHADILITATION AND	HEALTHCARE CENTER		WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 13	F 60	7		
		ound because there was a	1 00			
		e room. Nurse #2 further				
	•	ad been a nurse for a long				
	time and had numerous training sessions on					
		n shock, and she had never				
		member hitting a resident.				
		hat if she saw or heard				
	she would have gone	pping Resident #1 with a belt				
	intervened immediate					
	NA #1 was interviewe	ed on 5/6/2025 at 12:42 PM.				
		she was not assigned to				
		on the evening shift on				
	4/23/2025. NA #1 co					
		ng the evening mealtime on heard clapping and hollering.				
		nt out into the hallway to see				
		and along with NA #2 peaked				
		om. NA #1 indicated the				
	curtain was pulled so	she could not see Resident				
		t saw the back of what she				
		ly member in the room. NA				
	#1 reiterated she did	not know what was eturned to assisting another				
	resident with eating.	sumed to assisting another				
	NA #2 was interviewe	ed on 5/6/2025 at 1:54 PM.				
		s assigned to care for				
		8:00 PM to 11:00 PM shift on				
		ated she was in the room				
	-	resident in eating the she heard a smacking or				
		#2 indicated she stuck her				
		because it was an unusual				
	sound and looked int	to the doorway of Resident				
	#1's room. NA #2 sai	d the curtain was pulled but				
		member peaked around the				
	curtain and looked at	t her. NA #2 said she saw				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345339	B. WING				06/2025	
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
F 607	Nurse #2 in the hallway thought the family me Resident #1. NA #2 s next door to assist the NA #2 revealed she do from Resident #1's ro did not know that the Resident #1 was con- later told that it was co- happened within the w The family member of interviewed on 5/6/20 member revealed the Someone from the fa- member and told her herself. The family me the facility that day, b discipline Resident #7 confirmed she hit Resi to five times. The Assi (ADON) explained to Resident #1 that she the facility. The family know disciplining Resi wrong and considered The Unit Manager wa 11:20 AM. The Unit M following events as ha 4/23/2025. The Unit M the nursing station fro Nurse #2 approached stating, "Her [family m The Unit Manager wa Nurse #2 who and wh described Resident # sounded like Resident	ay and Nurse #2 said she ember was spanking aid she reentered the room e other resident with eating. Id not hear any more noises om. NA #2 confessed she family member hitting sidered abuse. NA #2 was onsidered abuse. NA #2 was onsidered abuse because it walls of the facility. f Resident #1 was 25 at 3:01 PM. The family following information. cility called the family Resident #1 was exposing ember did not plan to go to ut she went to the facility to 1. The family member sident #1 with her belt three istant Director of Nursing the family member of was not allowed to do that in member stated she did not ident #1 with a belt was	F	607				

Facility ID: 922993

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/03/2025 APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		345339	B. WING _			-		C 06/2025		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE				
WINDSOR REHABILITATION AND HEALTHCARE CENTER			1306 SOUTH KING STREET							
WINDSOR REHABILITATION AND HEALTHCARE CENTER				W	/INDSOR, NC 27983					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE		
F 607	hall and entered Resi family member with h her belt in one of her asked the family mem the family member res she said. The Unit Ma member if she was hi family member respon "acting out." The Unit family member of Res were family members her with a belt in the f were under their care her to step out of the observed that Reside in bed and when she raised red marks like Unit Manager was no of Resident #1, but it with her belt because Nurse #2. The ADON was interv PM. The ADON stated overheard someone t the family member of Resident #1 with a be went down the hallwa member in the hallwa family member what h by the family member a belt to discipline her had to explain that sh in the facility and walk so she could leave.	but described what it it Manager went down the dent #1's room to see the er hands on her hips and hands. The Unit Manager aber what was going on and sponded by repeating what anager asked the family tting Resident #1 and the nded that Resident #1 was Manager explained to the sident #1 that although they , she was not allowed to hit acility because the residents . The Unit Manager asked room. The Unit Manager nt #1 was on her right side lifted her gown there were she was hit with a belt. The t told by the family member was assumed she hit her of the noise described by riewed on 5/6/2025 at 12:50 d on 4/23/2025 she alking in the hallway about Resident #1 whipping dt. The ADON revealed she y and saw the family y. The ADON asked the happened, and she was told she was spanking her with r. The ADON revealed she e was not allowed to do that sed her to the building door	F	507		EFICIENCY)				
	Documentation on a v	veekly skin assessment								

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345339	B. WING			0	5/06/2025
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 607	as assessed as havin whip-like marks to the red whip-like marks to the red whip-like marks to area." Documentation in a m 4/23/2025 at 8:35 PM practitioner was made Resident #1 and reque emergency room for a Documentation in the dated 4/24/2025 at 4: #1 was transported to 8:50 PM on 4/23/2029 evaluation and return on 4/23/2025 with no assessment performed facility revealed Resid broken or open skin a Documentation in the dated 4/24/2025 at 4: [#1] left the facility via 4/23/25 and returned [9:50 PM] with no new by the writer noted to break in skin. Reside Pleasant mood. No d An interview was con Administrator on 5/6/2 Administrator on stated s intervene immediately facility despite the sol	54 PM revealed Resident #1 g "Slight redness and e front of left thigh. Small, b the left upper abdomen ursing progress note dated I revealed the nurse e aware of the incident with lested she be sent out to the evaluation. nursing progress notes 04 AM indicated Resident b the emergency room at 5 via a stretcher for ed to the facility at 9:50 PM new orders. A skin ed upon her return to the dent #1 did not have any areas. nursing progress notes 04 AM stated, "Resident a stretcher at [8:50 PM] on to the facility by stretcher at v orders. Skin assessment be [within normal limits]. No nt alert and oriented. istress noted." ducted with the facility 2025 at 1:36 PM. The she expected the staff to y if abuse occurred in the	F	607	7		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETE C NAME OF PROVIDER OR SUPPLIER 345339 B. WING 05/06/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET WINDSOR, NC 27983 1306 SOUTH KING STREET WINDSOR, NC 27983 VINDSOR CORRECTION		RTMENT OF HEALTH AN ERS FOR MEDICARE & I				FO	ED: 06/03/2025 RM APPROVED NO. 0938-0391
345339 B. WING 05/06/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET WINDSOR REHABILITATION AND HEALTHCARE CENTER III 1306 SOUTH KING STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA		(X3) DA	ITE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINDSOR REHABILITATION AND HEALTHCARE CENTER 1306 SOUTH KING STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			345339	B. WING			05/06/2025
WINDSOR REHABILITATION AND HEALTHCARE CENTER WINDSOR, NC 27983 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	NAME OF PI	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, Z		
	WINDSOR	OR REHABILITATION AND	HEALTHCARE CENTER				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE) CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 607 Continued From page 17 F 607 Director of Nursing, Administrator, or designee will inolify the appropriate agencies within specified timeframes: Immediately, but no later that a 2 hours after the allegation involve abuse or result in serious bodily injury," Documentation on an initial allegation report revents that cause the allegation involve abuse or result in serious bodily injury," Documentation on an initial allegation report revealed the facility became aware of an incident of abuse on 4/23/2025 with the allegation details, "It was alleged by staff that [Resident #1's family member], [F-mily Member Name], physical Detained where, "Resident #1] sustained whelps to her lower extremity as a result of the incident." The faxed initial allegation report was sent to the state agency on 4/24/2025 at 10:41 AM. An interview with the facility Administrator was conducted on 56/2025 at 3:14 PM. The Administrator tated she was not in the facility when she was called by the Unit Manager notifying the ro the allegation Resident #1's family member hit Resident #1's family member hit Resident #1 was allogation or partitle the obligation of notifying the lacel police department immediately fulfilled the obligation of notifying the appropriate agencies within 2 hours. </td <td>F 607</td> <td>Director of Nursing, A will notify the appropri- specified timeframes: than 2 hours after the events that cause the result in serious bodif Documentation on an revealed the facility b- of abuse on 4/23/202 "It was alleged by star member], [Family Me abused her by beating the physical or menta "[Resident #1] sustain extremity as a result of initial allegation repor agency on 4/24/2025 An interview with the conducted on 5/6/202 Administrator stated s when she was called notifying her of the all member hit Resident Administrator thought department immediat notifying the appropria The Administrator adm facility the next day, 4 agency of the abuse a Resident #1. The Adm attempt to contact the</td> <td>dministrator, or designee iate agencies within Immediately, but no later allegation is made if the allegation involve abuse or y injury," initial allegation report ecame aware of an incident 5 with the allegation details, ff that [Resident #1's family mber Name], physically g her with a belt." Details of I injury/harm were, ned whelps to her lower of the incident." The faxed t was sent to the state at 10:41 AM. facility Administrator was 25 at 3:14 PM. The she was not in the facility by the Unit Manager egation Resident #1's family #1 with a belt. The notifying the local police ely fulfilled the obligation of ate agencies within 2 hours. mitted she came into the k/24/2025, to fax the state allegation regarding ninistrator confirmed her first e state agency was on</td> <td>F 607</td> <td></td> <td></td> <td></td>	F 607	Director of Nursing, A will notify the appropri- specified timeframes: than 2 hours after the events that cause the result in serious bodif Documentation on an revealed the facility b- of abuse on 4/23/202 "It was alleged by star member], [Family Me abused her by beating the physical or menta "[Resident #1] sustain extremity as a result of initial allegation repor agency on 4/24/2025 An interview with the conducted on 5/6/202 Administrator stated s when she was called notifying her of the all member hit Resident Administrator thought department immediat notifying the appropria The Administrator adm facility the next day, 4 agency of the abuse a Resident #1. The Adm attempt to contact the	dministrator, or designee iate agencies within Immediately, but no later allegation is made if the allegation involve abuse or y injury," initial allegation report ecame aware of an incident 5 with the allegation details, ff that [Resident #1's family mber Name], physically g her with a belt." Details of I injury/harm were, ned whelps to her lower of the incident." The faxed t was sent to the state at 10:41 AM. facility Administrator was 25 at 3:14 PM. The she was not in the facility by the Unit Manager egation Resident #1's family #1 with a belt. The notifying the local police ely fulfilled the obligation of ate agencies within 2 hours. mitted she came into the k/24/2025, to fax the state allegation regarding ninistrator confirmed her first e state agency was on	F 607			

Facility ID: 922993

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