STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 000	INITIAL COMMENTS A Complaint Investigation survey was conducted from 04/01/25 through 04/03/25. Event ID# IJ0C11. The following intakes were investigated NC0000228514 and NC0022827 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	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 Director interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #2 hit Resident #1 with a grabber-reacher tool (a tool that assists people reach something to pick it up) multiple times on the right hand, injuring his right 4th digit fingernail. This affected 1 of 4 residents reviewed for abuse (Resident #1).	F 600	1. Residents #1 and #2 were immediately separated by facility staff on 3/11/2025. Resident #1 was taken to his room for first aid to his right fourth finger. Resident #2 was assisted back inside his room and metal grabber/reacher was removed from his room by facility staff. Notification of local law enforcement agency and state agency was completed by the Director of Nursing on 3/11/2025.	4/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 1 The findings included: Resident #1 was admitted to the facility on 11/25/19 with diagnosis that included multiple sclerosis, psychosis, anxiety disorder and mood disorder due to known physiological condition. Resident #1's Minimum Data Set (MDS), dated 12/20/24, revealed he was cognitively intact and had no behaviors. He had impairment on both sides of his upper and lower extremities and was dependent on staff for his activities of daily living and independently operated his manual wheelchair. Resident #1's care plan, last revised 01/02/25, indicated Resident #1 had been care planned for manipulative behaviors and physical and verbal aggression towards staff and other residents related to his anger and poor impulse control. Interventions included education to the resident on the importance of avoiding known triggers that could lead to the escalation of retaliatory physical aggression towards other residents, or by other residents to himself. Resident #2 was admitted to the facility on 07/29/24 with diagnoses which included generalized anxiety disorder and dementia without behavioral disturbance. Resident #2's quarterly MDS, dated 01/29/25, revealed he was cognitively intact and had no behaviors. He had impairment on one side of his lower extremities, was dependent on staff for bed to chair transfers, and independently operated a manual wheelchair.	F 600	Both resident #1 and #2 care plans were reviewed and updated as needed. Resident #1 will continue to be monitored by staff for location while out of bed and staff will assist him to pass by resident #2 room when he wishes to access areas of the facility beyond resident #2 room. 1:1 sitter placed with resident #2 when he is out of bed to ensure no contact with resident #1. Neither resident #1 nor resident #2 are able to get out of bed without assistance of staff as both require use of a mechanical lift for transfers. Education provided to both residents by the Director of Nursing on avoiding each other, no physical contact, and acceptable behaviors. 2. Through interviews with residents #1 and #2, facility staff, psych providers, and medical director, it was determined this incident resulted from on-going animosity between resident #1 and #2. Resident #2 is alert and oriented x 3 with no cognitive impairment and denied any wishes or plans to harm other residents. No other residents were identified that may be affected. With resident #2 having a 1:1 sitter assigned to him the risk to other residents was removed. Sitters assigned to resident #2 are instructed to allow resident #2 to move about facility as he desires but he is not allowed to enter rooms or areas where resident #1 is present. Sitters will maintain visual contact with resident #2 at all times once he is out of bed until he is placed back in the bed in the evening. Nurses perform 15 minute checks on resident once he is returned to bed to validate his location	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 2 Resident #2's care plan, last revised 02/18/25, revealed Resident #2 had been care planned for his potential to be physically and verbally aggressive with staff and other residents and making false statements/accusations related to anger and poor impulse control. Interventions included de-escalation of the resident's physical and verbal aggression towards staff and other residents to ensure safety. An Initial Allegation Report for resident-to-resident abuse was completed on 03/11/25 after Resident #2 struck Resident #1 with a grabber-reacher tool and resulted in Resident #1 sustaining an injury to his right 4th digit fingernail. Notifications were made to the local law enforcement agency and to the State Agency on 03/11/25. A Progress Notes note written by Nurse #1 on 03/11/25 at 5:45 PM. in Resident #1's medical record detailed the altercation on 03/11/25 (no time noted) between Resident #1 and Resident #2. The nurse wrote that Resident #2 had been observed by another resident (Resident #6) striking Resident #1 with his reacher-grabber tool which caused injury to Resident #1's right 4th digit fingernail. The nurse indicated that wound care had been provided to Resident #1's finger and stated that a local law enforcement officer came to the facility and took statements from residents involved in the altercation as well as statements from witnesses of the incident. A Progress Note written by Nurse #4 on 03/11/25 at 6:18 PM in Resident #2's Medical Record detailed the 03/11/25 altercation between Resident #2 and Resident #1. The nurse stated Resident #2 said he had been in his room, watching television, when Resident #1 went into	F 600	and no contact with resident #1. Neither resident #1 nor resident #2 are able to get out of bed without assistance of staff as both require use of a mechanical lift for transfers. Resident #1was educated on avoiding contact with resident #2 and staying away from areas or rooms where resident #2 is present. Staff will continue to monitor resident #1 location as per his care plan and redirect him away from areas where resident #2 is present. 3. Resident #2 was issued a 30-day Notice of Discharge on 3/14/2025 after notification of the Ombudsman and resident's daughter. Facility social worker will continue to work towards securing appropriate discharge location for resident #2 until alternate location is identified and arrangements made for transfer. 1:1 sitter will remain in place with resident #2 until he is discharged from the facility to ensure no further incidents occur with resident #1 or other residents. 30-day Notice of Discharge will be reissued upon expiration until discharge location is identified and transfer is scheduled. No need for systemic changes was identified as facility staff responded appropriately per facility abuse policy and this incident was isolated to resident #1 and resident #2 with both being alert and oriented. Both voice discontent only with each other. 4. Facility Social Worker will report on status of discharge location for resident #2 to the facility's QAPI committee monthly and more frequently if needed. The Director of Nursing will report to the facility's QAPI committee monthly on resident #2 behavior and adherence to his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 3 his room and started talking "s**t" to him and told him (Resident #2) that he (Resident #1) was going to "f**k him up" and that Resident #1 had swung at him. The nurse wrote that Resident #2 told her he had defended himself by hitting Resident #1 with his reacher-grabber tool. The Investigation Report, submitted on 03/14/25 by the Administrator, indicated she substantiated the allegation of resident-to-resident abuse after the investigation concluded. A summary of the incident details included, " ...All witness statement support incident occurring in hallway outside of [Resident #2's] room. Blood was noted on the floor in the hallway. [Resident #2] continued to state throughout the investigation that [Resident #1] kicked open his door, busted into his room, and asked him if he wanted to fight. None of the witness statements support this. [Resident #1] was in sight of staff in the hallway where they witnessed [Resident #2] hitting him with the reacher ..." The local law enforcement officer's Incident/Investigation Report, dated 03/11/25, indicated he had been dispatched to the facility and once there, took statements from Resident #1, Resident #2 and witnesses to the altercation. The officer reported Resident #1 informed him he had approached Resident #2 and told him he had a "big head" and then Resident #2 told him that he had a big head and then Resident #2 began to swing a reacher-grabber tool, hitting him (Resident #1) in his knee and cut his finger with the tool. The officer then spoke with Resident #2 who informed him that Resident #1 always called him names and threatened him. Resident #2 told the officer that Resident #1 had entered his room and told him that he was going to "mess" him up	F 600	care plan interventions. The Administrator and/or Social Worker will meet with resident #2 as needed to discuss any possible discharge locations willing to accept him for transfer. The Administrator will communicate with the Ombudsman as information is obtained regarding discharge location and The facility's QAPI committee will make further recommendations/revisions to current plan as need is identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 4	F 600		

so he began to hit Resident #1 because he had been scared for his safety. The report indicated the officer also took a statement from Resident #6 who had informed the officer he had observed both of the residents talking in the hallway before Resident #2 hit Resident #1 with his reacher-grabber tool. The officer acknowledged in his report that he had closed the report as "closed by exception, victim refused to cooperate."

An interview was conducted with Resident #6 on 04/02/25 at 12:58 PM. Resident #6 was coded as being cognitively intact on his 02/01/25 quarterly MDS. Resident #6 explained that on 03/11/25 he had observed Resident #1 in his wheelchair approach Resident #2 who had been sitting in his wheelchair outside of his room in the hall and in front of the doorway to Resident #2's room. As he continued to observe the two residents, Resident #6 described how Nurse #2 approached him as he sat in the hall and said he pointed to the two residents (Residents #1 and Resident #2) in the hall. He said Nurse #2 walked towards both of the residents and then the next thing he (Resident #6) knew, Resident #2 swung his reacher-grabber tool and struck Resident #1 with it and observed Resident #1 swinging his arms. Resident #6 indicated he thought Resident #1 had done that in self-defense from Resident #2. Resident #6 indicated that he did not hear any of the conversation between the two residents but could hear Resident #1 "hollering."

An interview was conducted with Nurse #2 on 04/02/25 at 2:55 PM. Nurse #2 confirmed she had worked from 3:00 PM until 11:00 PM on 03/11/25. Nurse #2 stated she had been walking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 5	F 600		

down the Skilled A and B hall when Resident #6 stopped her and said, "hey, they're fighting" and pointed towards Resident #1 and Resident #2. She stated she looked in the direction of the two residents who were outside of Resident #2's doorway, in the hall. Nurse #2 explained Resident #1 was observed sitting in his wheelchair and facing Resident #2 who had been sitting in his wheelchair in the hallway, outside of his room's doorway. Nurse #2 further explained she immediately began walking towards the two residents and before she could get to them, Resident #2 began hitting Resident #1 with his reacher-grabber tool and that Resident #1 was observed trying to back up, holding his arms in a way to deflect the blows. Nurse #2 stated by the time she reached the residents, Resident #2 struck Resident #1 three to four more times with his reacher-grabber tool. She explained she pulled Resident #1's wheelchair away from Resident #2 and started to take him to his room when she noticed he was bleeding from his finger. Nurse #2 explained Resident #1's nurse provided treatment to his injured finger. Nurse #2 stated she did not know how the argument had started. Nurse #2 stated she provided a statement to the local law enforcement officer when he arrived at the facility. When asked about the residents' level of care required to perform their activities of daily living (ADL), the nurse stated Resident #1 was totally dependent on staff for his ADL and stated Resident #2 required extensive assistance with his ADL. She stated both of the residents were able to operate their wheelchairs independently after being placed in the wheelchairs using a mechanical lift. Nurse #2 confirmed both residents were alert, oriented and able to make their needs known. She stated both residents were known to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 6	F 600		

argumentative with each other, as well as with other residents and staff.

An observation and interview were conducted with Resident #1 on 04/02/25 at 10:27 AM. Resident #1 explained that on 03/11/25, around 4:00 PM, he had started rolling down the hall in his wheelchair to visit another resident. Resident #1 further explained he rolled up to Resident #2 who had been sitting in his wheelchair in the hall, outside the door to his room, and told him, "you have a big head." Resident #2 responded by saying to him, "you have a big head." Resident #1 then asked Resident #2 if he wanted to fight and stated Resident #2 said no. Resident #1 stated Resident #2 then grabbed his reacher and started hitting him with it and he had tried to block Resident #2's blows with his arms. When asked about his relationship with Resident #2, Resident #1 declared that he did not like Resident #2 because he always starts trouble and that he had never liked him. When asked how he felt after being hit by Resident #2, Resident #1 said, "I ain't scared of that boy." When asked about the injury he sustained during the incident, Resident #1 held up the fingers on his right hand and said they were fine and could not remember which finger had been injured. An observation of the fingers on his right hand revealed no outward signs of a healing/healed injury to any of the fingers on his right hand.

An interview was conducted with Resident #2 on 04/01/25 at 3:10 PM. Resident #2 was observed sitting in his wheelchair in his room. Also present at this time was Nursing Assistant #2 who was providing a one-to-one observation. Resident #2 acknowledged he did not like Resident #1 and said that Resident #1 had told him that he hated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 7	F 600		

white people. Resident #2 explained that on 03/11/25, at some time in the late afternoon, he had been napping while seated in his wheelchair in front of the TV in his room. He said Resident #1 "kicked his door in", came into his room and began to fight with him. Resident #2 stated Resident #1 did not say anything to him and remained adamant he had struck Resident #1 with his grabber-reacher tool as a means of self-defense. When Resident #2 was informed that witness accounts of the incident placed both residents out in the hallway, Resident #2 maintained his story that Resident #1 kicked the door to his room open, entered the room and began to fight with him. Resident #2 stated he had witnesses that saw this and said to talk with Nursing Assistant (NA) #1. Resident #2 indicated that he was not afraid of Resident #1 and he had just been trying to protect himself after Resident #1 came into his room.

An interview was conducted with NA #1 on 04/02/25 at 3:23 PM. NA #1 confirmed that she had worked from 3:00 PM until 11:00 PM on 03/11/25. NA #1 explained she had been walking towards the Nurses' Station on the Skilled A and B halls when she observed Resident #1 rolling down the hall in his wheelchair and headed towards where Resident #2 was seated in his wheelchair, outside of the doorway to his room. She thought Resident #1 would go on past Resident #2 but then she observed Resident #1 stop and begin to roll backwards, towards Resident #2. NA #1 stated she knew the two of these residents did not get along and started walking towards the two of them to prevent an altercation. Before she could get to them, she said she observed Resident #2 grab his reacher-grabber and swing at and strike Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 8	F 600		

#1. NA #1 stated by the time she got to them, Nurse #2 had also arrived and explained that between the two of them, they got the two residents separated. As Nurse #2 pushed Resident #1 to his room, NA #1 said she told Resident #2 that he could not hit people and said he (Resident #2) told her that he could not help it because Resident #1 had told him he was going to "beat his a**." She stated she then observed some blood on one of Resident #2's hand, assumed it had been from the altercation, and left him to inform a nurse. At the Nurses' Station, she spoke with the Unit Manager, Nurse #3.

An interview was conducted with Nurse #3, on 04/02/25 at 1:45 PM. Nurse #3 confirmed that she was the Unit Manager for the Skilled A and B halls. Nurse #3 explained on 03/11/25 she became aware of the incident between Resident #1 and Resident #2 when she came out of her office located behind the Nurses' Station desk and heard yelling down the hall. Nurse #3 stated when she looked towards the commotion, she saw both residents in the hall, outside of Resident #2's room. She explained she observed Resident #2 swat Resident #1 repeatedly with his grabber-reacher as Resident #1 was trying to shield himself from the blows. She explained that Resident #1 did not have full control of his upper extremities because of his medical diagnosis. She described that Resident #1 sat in a semi-reclined position in his wheelchair and how he would not have been able to hit Resident #2 in retaliation if he wanted to. Nurse #3 described both residents as alert and oriented and stated how neither of them could get up out of their beds without the total assistance of staff using a mechanical lift to do so. She said that Resident #1 often rolled himself via wheelchair to other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 9	F 600		

areas of the facility and enjoyed visiting with other residents and went to therapy and activities, all of which were located past Resident #2's room. Nurse #3 described Resident #2 as more stationary and said he often sat outside of the door to his room or outside in the smoking courtyard. Nurse #3 said Resident #2 had been known to make racist or disrespectful remarks to other residents and staff and would often not tell the truth when asked about incidents he may have been involved in. She also said that while Resident #2 hit Resident #1 during this incident, Resident #1 could be the instigator during arguments with residents and staff and stated that he sometimes "feeds off" being the victim as well and that he was not always truthful. Nurse #3 indicated that Resident #2's reacher-grabber tool had been removed from him by the Human Resources Director and he (Resident #2) had been placed on a one-to-one observation while out of his bed for his safety as well as the safety of other residents.

An interview was conducted with the Human Resources Director on 04/02/25 at 2:39 PM. The Human Resources Director confirmed she had worked on 03/11/25 and stated the incident between Resident #1 and Resident #2 had occurred just prior to her clocking out for the day around 5:30 PM. The Human Resources Director stated after she clocked out and started walking back to her office, she heard Nurse #3 say, "Oh my God, Resident #2 is hitting Resident #1." The Human Resources Director explained that she did not see the interaction between the two residents. She said she told Nurse #3 that someone needed to get Resident #2's reacher-grabber tool away from him. She stated she walked down to his (Resident #2's) room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 10	F 600		

asked him to let her have it. She stated that before he gave it to her, he told her, "he started it." The Human Resources Director said she removed the grabber-reacher without incident and told him to stay in his room until everything got sorted out.

An interview was conducted with the facility's Medical Director on 04/03/25 at 9:25 AM. The Medical Director explained he had been made aware of the 03/11/25 incident that involved Resident #1 and Resident #2. After talking with the residents, he felt that Resident #1 was the instigator of this incident, and Resident #2 the aggressor. He further explained that both residents lacked the appropriate coping mechanisms for handling a situation when anger and aggression were triggered. He stated Resident #2 had very little threshold for controlling his anger and impulsivity, and he believed Resident #2 was not a danger to himself or others provided he remain on the one-to-one observation. The Medical Director stated it was his expectation the facility provide a safe environment for all the residents who reside there and thought as long as Resident #2 remained on a one-to-one observation when he was out of his bed, that the facility was providing that safe environment.

An interview with the Administrator was conducted on 04/03/25 at 10:54 AM. The Administrator stated that since the incident between Resident #1 and Resident #2 on 03/11/25, Resident #2 remained on a one-to-one observation until he went to bed at night. She explained that Resident #2 could not get out of bed by himself and therefore the one-to-one observation was not continued while he was in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 11	F 600		

bed. She explained nursing staff did safety checks of him every 15 minutes. The Administrator further explained staff would continue to monitor Resident #1 and would assist him past Resident #2's room when he wanted to visit friends or attend therapy or activities, all of which were located past Resident #2's room. When asked how she thought this incident might have occurred, the Administrator stated no one could really say. She explained Resident #1 told her that he had planned on visiting his friend who resided across the hall from Resident #2, and she believed Resident #2 had been waiting in his doorway to confront Resident #1 because he thought he (Resident #1) was out to "get him." The Administrator stated they tried to keep Resident #1 from any opportunity for him to antagonize Resident #2 as well as trying to keep him safe from Resident #2's aggression. The Administrator explained she put a Plan of Correction (POC) in place after meeting with her Interdisciplinary Team and provided a copy of it for consideration. She stated monitoring for this POC included keeping Resident #2 on a one-to-one observation for the duration of his stay at the facility and it would be reviewed in their monthly Quality Assurance and Performance Improvement (QAPI) meetings. The Administrator explained she did not include a facility-wide in-service training on their Abuse policy as she felt strongly it did not occur because of staff error. She also felt the staff executed their Abuse policy and procedures as they should have after the incident occurred. The Administrator explained she had issued Resident #2 a 30-day notice of discharge on 03/14/25 and discussed the incident between the two residents at an Ad Hoc QAPI meeting on 03/11/25. She had plans to continue to bring the situation to their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345267	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLADEN EAST HEALTH AND REHAB, LLC	804 S POPLAR STREET ELIZABETHTOWN, NC 28337

(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
F 600	Continued From page 12 monthly QAPI meetings until a safe discharge location for Resident #2 could be arranged. The facility provided a corrective action plan that was not acceptable to the State Agency as it did not include the following required components: address how the facility will identify other residents having the potential to be affected by the same deficient practice; address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	F 600		