DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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

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

(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 An unannounced complaint investigation was conducted from 3/4/26 through 3/5/26. (Event ID 1F2858-H1) The following intakes were investigated: 2749110, 2790979, 2790915, and 2784476. Four of the eight complaint allegations resulted in deficiency.	F0000		
F0580 SS = A	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when	F0580		03/31/2026

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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F0580 SS = A	Continued from page 1 there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and Responsible Party, the facility failed to notify the Responsible Party regarding an altercation that had occurred for a resident who was observed to have a bruised eye three days after the altercation for 1 of 3 sampled residents involved in 2 alleged abuse cases (Resident # 1). The findings included: Resident # 1 was admitted to the facility on 8/24/22 and had a diagnosis of dementia. Review of a facility investigative file revealed statements which showed that Resident # 1 was in an altercation with another resident on 2/14/26 (Saturday) during which two Nurse Aides allegedly saw that Resident # 1 was hit. On 2/17/26 the Director of Nursing documented on a skin audit report that Resident # 1 had a bruise below her left eye. Interview with Resident # 1's Emergency Contact # 2 revealed he was the closest relative to Resident # 1 and her Responsible Party but had Emergency Contact # 1	F0580		

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F0580 SS = A	Continued from page 2 listed as first person to contact in an Emergency in the resident's medical record because she lived locally and he did not. Emergency Contact # 2 further reported the following information. A resident called him on 2/15/26 (Sunday) and let him know that Resident # 1 had been hit by another resident. He in turn called Emergency Contact # 1 and she and another family member went to the facility on one of days following where they observed that Resident # 1 had a black eye. The facility had not called him or any of the other emergency contacts in the record prior to a resident telling him about the altercation or family members going to the facility and seeing the resident had a black eye. One of the family members called the police. It was confirmed with the Administrator on 3/5/26 at 3:00 PM that the Responsible Party and Emergency Contacts did not initially learn about the altercation from facility staff reporting the incident to them on 2/14/26 and they had initially learned about it from a source of whom she was not specifically aware.	F0580		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F0607	Address the corrective action for those residents found to have been affected by the deficient practice. On 2/17/26 the facility administrator notified the Rocky Mount Police Department that residents #1 and #2 were involved in an altercation where staff members reported bodily hits of residents. On 3/4/26 NA#1 was interviewed by facility administrator. NA#1 stated that she heard yelling and looked up and saw Resident #2 hitting Resident #1. On 3/4/26 NA#1 was provided education regarding Abuse and Neglect Prohibition policy specifically that the Administrator is to be notified immediately following a witnessed bodily hit between residents. On 3/5/26 the Regional Clinical Director provided education to the facility administrator and director of nursing regarding "Abuse & Neglect Prohibition" policy that included 1) the center will report allegations and substantiated occurrences of alleged abuse/neglect or misappropriation of resident property to state/federal agency and law enforcement officials as designated by state/federal law; 2) the center will complete a thorough investigation by ensuring that all witnesses are interviewed; 3) the facility administrator is to be notified immediately following an altercation witnessed bodily hit between residents as well as allegations or suspicions of such an occurrence. The administrator will serve as the facility abuse coordinator per the Abuse & Neglect Prohibition policy for NC, revised on 3/30/26. The center will report allegations, suspicions and actual occurrences of abuse, neglect, misappropriation or mistreatment immediately to the facility administrator.	03/31/2026

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F0607 SS = D	Continued from page 3 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with staff, the facility failed to implement their abuse policy when the facility failed 1) to report to the local law enforcement within 24 hours that Resident # 1 and Resident # 2 were involved in an altercation where staff members reportedly witnessed bodily hits of residents and 2) complete a thorough investigation by ensuring that all witnesses were interviewed. The facility also failed to ensure its “Abuse and Neglect Prohibition” policy, specified that the Administrator was to be notified immediately of allegations of abuse as required by federal regulations and failed to ensure that immediately following the altercation between Resident # 1 and Resident # 2 that it was clearly communicated to the Administrator that there had been witnessed bodily hits between the residents. This was for 1 of 2 alleged abuse cases reviewed involving Resident # 1 and Resident # 2. The findings included: Review of the facility’s “Abuse and Neglect Prohibition” policy, dated 10/24/22 and revised on 8/2023, revealed the following policy and procedures. “The center will investigate any alleged abuse/neglect or misappropriation of resident property in accordance with state or federal law.” Under “Reporting and Response,” the abuse policy listed 6 items which read, “1) The center will report all allegations and substantiated occurrences of abuse, neglect, and misappropriation of property to the state/federal agency and law enforcement officials as designated by state/federal law. 2)The center will assure that reporters are free from retaliation 3) The center will post a conspicuous notice of employees rights, including the right to file a complaint with the State Survey Agency if they believe the center has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. 4)The center will report to the corporate office in accordance with reporting procedures via Risk Guide. 5) The center will report any occurrences of abuse by registered or certified staff to the State Board as	F0607	Continued from page 3 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/5/26 the facility director of nursing completed an audit (last 30 days) of facility resident to resident altercations to ensure that each were reported timely/accurately, documentation of notifications to appropriate parties, including law enforcement, families/designated representatives and medical staff and thorough investigation was completed. No concerns were noted during this audit. Address what measures will be put in place or system changes made to ensure that the deficient practice will not recur. On 3/6/26 the corporate Director of Clinical Services in-serviced the administrator on the proper response to resident-to-resident occurrences, including recognizing the potential for abuse, response to an occurrence, thorough investigation of an occurrence, including proper interview strategies and review of statements and interviews, reporting requirements including law enforcement, corporate, and state/federal requirements, designated representatives and medical personnel. On 3/18/26, the Administrator provided education to the interdisciplinary team (Director of Nursing, clinical leadership, activity director, social worker, rehab, dietary and business office managers) on the proper response to resident to resident occurrences, including recognizing the potential for abuse, response to an occurrence, thorough investigation of an occurrence including proper interview strategies and review of statements and interviews, reporting requirements including corporate, law enforcement and state/federal requirements, designated representatives and medical personnel. On 3/18/26 education was again initiated for all employees by the Administrator, DON and department leadership regarding Abuse &Neglect Prohibition policy with emphasis on the response to an allegation, suspicion of or actual incident with accurate and timely (immediate) reporting of information to the administrator, DON. medical personnel and resident's designated representative. Staff identified as not receiving the education will be scheduled to receive the education prior to working the next shift. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The administrator/designee will audit incident reports Monday -Friday for 12 weeks to identify any new resident to resident allegations or occurrences to ensure consistency with policy implementation including a thorough investigation, involved party statements and or interviews, documentation of appropriate	

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F0607 SS = D	Continued from page 4 required by state law. 6) Policies and procedures will be analyzed and modified as necessary by the QA & A/QAPI Committee (Quality Assurance and Performance Improvement) to meet the full intent of the law." There was no specific policy or procedure referenced in the 8/20/23 revised "Abuse and Neglect Prohibition" policy which noted what "Risk Guide" to the Corporate Office entailed, and the "Abuse and Neglect Prohibition" policy did not specify that the Administrator was to be notified immediately of alleged abuse. On 2/17/26 the facility submitted to the state agency an Initial Allegation Report of alleged abuse which according to the facility's report to the state agency occurred on 2/17/26 and of which they became aware on 2/17/26. In the facility's initial report to the state agency, the facility submitted that Resident # 1 alleged that Resident # 2 swung at her on 2/17/26. Review of the facility's investigative file revealed statements which indicated alleged abuse occurred on 2/14/26 and not on 2/17/26. On 2/22/26, the Administrator signed she completed a five-day Investigation Report which included corrected information and which was submitted to the state agency. The Administrator indicated the following on the five-day investigation report. There had been an altercation between Resident # 1 and Resident # 2 which had occurred on 2/14/26 and the facility became aware of the incident on 2/17/26. The facility's investigation showed that Resident # 2 made contact with Resident # 1's shoulder/chest. Resident # 1 had a bruise on her cheek. There had been no witness that Resident # 1's face had been contacted, but it was thought that the altercation had led to Resident # 1's eye being bruised. Review of statements obtained by the facility regarding the alleged abuse between Resident # 1 and Resident # 2 revealed the following statements. Nurse Aide (NA # 1) wrote the following information in a statement which was dated 2/14/26. She saw Resident # 1 watching television in the activity room. Then she saw Resident # 3 enter the Activity room and sit next to Resident # 1. Then a few minutes later she saw Resident # 2 enter the Activity Room and sit on the other side of Resident # 1. Then she heard yelling and looked up and saw Resident # 2 hitting Resident # 1 and she also heard Resident # 3 saying "hit her again." Then Resident # 2 swung at Resident # 1 again. She (NA # 1) entered the activity room with NA # 2 and tried to get Resident # 1 out of the Activity Room, but NA # 2	F0607	Continued from page 4 notifications and proper interventions.	

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F0607 SS = D	Continued from page 5 put Resident # 2 at another table. On 3/4/26 there was an update on the statement by Nurse Aide # 1 which read “before [Resident # 1] went to bed she told [Resident # 2] hit her in her eye.” NA # 1 was interviewed on 3/4/26 at 5:15 PM and reported the following information. On the evening of 2/14/26 she had been sitting at the nursing desk and had a direct view into the activity room. Resident # 1 entered the activity room first. Resident # 3 then entered the activity room and sat close to Resident # 1. Resident # 2 then entered and sat close to both Resident # 1 and # 3. They were all watching television. Then she heard Resident # 1 yelling, “Stop. Leave me alone.” She heard Resident # 3 yell, “Hit her again.” As she (NA # 1) was entering the activity room, she saw Resident # 2 hit Resident # 1 with his fist. He hit her in the face. Resident # 1 was backing away from him. Resident # 2 swung to hit Resident # 1 again but Resident # 1 put her arm up to block his hit. Nurse Aide # 2 was right behind her and entered also. She (NA # 1) never saw Resident # 1 provoke Resident # 2 or hit Resident # 2. She (NA # 1) tried to take Resident # 1 out of the room but Resident # 1 did not want to leave. Resident # 2 was taken and put at a different table. After a few minutes, Resident # 1 wheeled in her wheelchair out of the activity room and left. At the time, Resident # 1 did not have any marks on her face or outward signs of injury. Before Resident # 1 went to bed that night, NA # 1 heard Resident # 1 say, “he hit me.” She was not assigned to care for Resident # 1 or Resident # 2 on the evening of the incident. NA # 2 had been the assigned Nurse Aide on the residents’ hall and therefore NA # 2 had spoken to the Nurse. She did not know what NA # 2 told the nurse regarding what had happened. She (NA # 1) had not spoken to a nurse. She had been asked to write a statement that night and put it under the Administrator’s door. She had done so. A couple days later she noticed that Resident # 1 had a black eye. No one had asked her about the incident after the incident occurred until the current day when she was talking to the surveyor. The surveyor was the first person to talk with her about the incident. Resident # 3, who she heard tell Resident # 2 to hit Resident # 1 again during the incident, had always “started things.” Resident # 3 would tell other residents that Resident # 1 was “crazy” and other negative remarks about the resident. She had reported Resident # 3’s remarks to nurses but had not reported them to the Administrator. The Administrator had not talked to her about the 2/14/26 incident. Review of NA # 2’s statement in the facility’s investigative file revealed NA # 2 wrote the following	F0607		

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F0607 SS = D	Continued from page 6 information. She (NA # 2) was sitting at the nursing station charting when she heard a loud commotion in the Activity Room. When she got in there to find out what was going on, NA # 1 had separated Resident # 1 and Resident # 2 who were in the middle of a physical altercation. NA # 1 pulled Resident # 1 away and she (NA # 2) asked Resident # 2 to go to another table and he did. She (NA # 2) did not "see who passed the first lick but they were both hitting each other." NA # 2 was interviewed on 3/4/26 at 4:45 PM and reported the following information which included differing details of the incident regarding what she heard to prompt her to go into the activity room on 2/14/26 and what she saw. NA # 2 reported the following specific details. She and NA # 1 were at the nursing desk together on the evening of 2/14/26. Resident # 1, # 2, and # 3 were all in the activity room watching television. She did not recall that there were any other residents with them. She heard Resident # 3 yell, "They are fighting. They are fighting." She entered with NA # 1 and saw that both Resident # 1 and Resident # 2 were hitting each other but she did not recall where the blows were on each of the resident's bodies. She did not know who had struck the first blow. Neither resident reported how it had started. NA # 1 took Resident # 1 back to her room. Resident # 2 stayed in the activity room. She had not known either resident to fight before and it was a surprise to her that it had occurred. NA # 1 told whoever the nurse on duty was what had occurred. She did not recall which nurse that was. She (NA # 2) was assigned to Resident # 2 but not to Resident # 1. That night Resident # 1's eye was okay but in a couple of days it turned black. Nurse # 1 was interviewed on 3/5/26 at 9:50 AM and reported the following information. On the 3:00 to 11:00 PM shift on 2/14/26, she was the assigned nurse for Resident # 1 and Resident # 2. A Nurse Aide told her that Resident # 1 and Resident # 2 were in an altercation and that Resident # 1 had started hitting Resident # 2. Resident # 2 did not hit back at first and then he did. She did not recall which Nurse Aide had told her about the incident. The incident occurred in the Activity Room. She checked the residents and they had no marks. It was a very busy night, and she did not call the Administrator but knew she should have done so. The Scheduler was interviewed on 3/4/26 at 4:25 PM and reported the following information. She was the Administrator on Duty for the weekend of 2/14/26. She had been in the facility on the evening of 2/14/26 when she heard NA # 1 at the nursing station talking to	F0607		

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F0607 SS = D	Continued from page 7 someone else saying that Resident # 2 had hit Resident # 1. She did not clarify where Resident # 1 had been hit. She went to talk to the nurse on the hall and found out that the nurse was aware of the incident. She went to look at Resident # 1 and did not see any marks on the resident. Resident # 1 told her (the Scheduler) that a man had hit her and described a physical feature of the male resident. She talked to Resident # 2 who said he did not know what she was talking about. She (the Scheduler) called the Administrator and referred to Resident # 1 and Resident # 2 and told the Administrator that Resident # 2 may have hit Resident # 1. Resident # 1 had been assessed and there were no marks. The Administrator told her (the Scheduler) to have NA # 1 write a statement and put it under her door. She made sure the residents were separated. During an interview with the local police department on 3/5/26 at 12:17 PM, it was confirmed that they did not receive a report of alleged assault until 2/17/26 at 12:17 PM. The DON (Director of Nursing) was interviewed on 3/5/26 at 12:15 PM and reported she had been off on 2/14/26 through 2/16/26 and no one had reported any alleged abuse to her. The Scheduler had reported to her on 2/16/26 that Resident # 1's eye was dark underneath the eye. At the time she became aware, the Administrator had already noticed the darkened area also. During interviews with the Administrator on 3/4/26 at 2:00 PM, 3/5/26 at 8:00 AM and 3/5/26 at 11:20 AM, the Administrator reported the following information. The Scheduler had called her at home on the evening of 2/14/26 and told her there was a resident-to-resident altercation between Resident # 1 and Resident # 2. She was told that it was a verbal altercation which was non-physical and no one had been hurt. She was aware that Resident # 1, who was cognitively impaired, had a history of telling other residents things like where they could sit in the common area. She had assumed Resident # 2 was the aggressor in the verbal altercation and told the Scheduler to make sure he was monitored. On 2/15/26 (Sunday) she called and talked to a nursing staff member, who validated Resident # 1 and Resident # 2 were being kept apart, monitored, and there were no problems. On Monday (2/16/26) Resident # 1 was gone for most of the day for dialysis and therefore she did not get an opportunity to talk to her. She did not look at NA # 1's statement until Tuesday (2/17/26). She did not talk to NA # 1 on 2/17/26 and first talked to NA # 1 on 3/4/26 and had her update her statement. On Tuesday (2/17/26) she talked to Resident # 1 and noticed that her eye was	F0607		

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F0607 SS = D	Continued from page 8 darker underneath. She asked her what had happened and Resident # 1 initially told her that a branch had hit her on the way to dialysis. (She had gone to dialysis the previous day). She asked Resident # 1 to think and see if there was anything else that she recalled that might have caused the dark area under her eye. Resident # 1 then said that there was a guy who was going to beat her up. The guy would not do what she asked him to do and then he pushed her. Resident # 1 had pointed to her right anterior shoulder when she said the guy had pushed her. She (the Administrator) then talked to Resident # 2 on 2/17/26 and he said he “did not have a problem with anyone.” Resident # 2 reported he had not hit anyone, and he wanted to be left alone. Then she had talked to Resident # 3 who had been the only resident who had witnessed the incident. Resident # 3 was cognitively intact, but she (the Administrator) could not voice an opinion on whether the resident was credible or not. Resident # 3 had told her (the Administrator) that Resident # 1 started hitting Resident # 2 when he would not do what she wanted him to do. Resident # 2 had backed up and pushed her away in a defensive manner but had not hit Resident # 1 at all. She (the Administrator) called the police to report the alleged assault on 2/17/26 and found that the family had become aware of the resident’s bruising below her eye by someone other than a staff member and had already called the police themselves that day a very short time period before she had done so. She knew there had been different stories told by different individuals and she had not been able to substantiate that abuse had occurred. The Administrator did validate that the incident was not reported to her (as the Administrator) as abuse initially in order that the report to the police and state agency report be initiated per their policy. She also validated that the investigation into the alleged abuse did not begin until 2/17/26 because details had not been communicated clearly to her and she had been busy and not read NA # 1’s statement when she returned to work on Monday (2/16/26).	F0607		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use	F0842	F842 Address the corrective action for those residents found to have been affected by the deficient practice. On 3/4/26 resident #1 medical record was updated to reflect the Physician's Assistant assessment visit of #1 following the altercation by the Physician's Assistant. On 3/25/26 the Administrator confirmed that the Care Plans for Residents 1 and 2 were updated to reflect the risk of resident to resident behavioral interaction by a licensed nurse.	03/30/2026

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

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

(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
F0842 SS = D	Continued from page 9 or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there	F0842	Continued from page 9 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/30/26 a review of resident to resident altercations for the past 30 days was completed by the Director of Nursing/designee to confirm that appropriate nursing documentation is found in the medical record of assessments/evaluation, provider assessment and notifications following an occurrence. No concerns were noted during this review. On 3/30/26 the Medical Records clerk completed review of physician's visit logs for the last 30 days against the appropriate resident's medical record to ensure there is documentation in the medical record for each of those visits. Address what measures will be put in place or system changes made to ensure that the deficient practice will not recur. Monday-Friday Director of Nursing will review incident Risk Management entries during clinical meeting to ensure that medical record reflects resident to resident altercation and provider resident visits related to any such incident. On 3/23 the Administrator provided each medical provider with a reminder notice regarding the necessity and importance of completing timely documentation of each resident visit in the medical record. On 3/30/26, the DON/designee completed education with the Licensed Nurses on documentation standards for resident-to-resident altercation, including documentation of occurrences, resident evaluations/assessment and monitoring, and notifications to appropriate parties. Licensed nurses identified not receiving the education will be scheduled to receive prior to working next shift. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The medical records clerk will audit 4 sampled of physician visit dates against provider documentation in the medical record weekly X 12. Monday-Friday Director of Nursing will review incident Risk Management review during clinical meeting to ensure identified Resident to Resident altercation are documented in the medical record and resident medical provider visits related to incident if applicable for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly X 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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

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

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F0842 SS = D	Continued from page 10 is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and Physician Assistant, the facility failed to ensure the medical record was complete regarding altercations that had occurred and a Physician Assistant's assessment following an altercation. This was for 2 of 2 sampled residents whose records were reviewed related to an altercation (Residents # 1 and # 2). The findings included: 1a. Resident # 1's was admitted to the facility on 8/24/22 and Resident # 2 was admitted on 5/24/21. Review of a facility investigative file into alleged abuse which occurred during an altercation on 2/14/26 between Resident # 1 and Resident # 2 revealed written statements from witnesses regarding details of what transpired in the altercation. A review of Nurse Aide (NA #1's) statement revealed she witnessed Resident # 2 hit Resident # 1. A review of NA # 2's statement revealed Resident # 1 and Resident # 2 were both hitting each other. Nurse # 1 had been assigned to care for Resident # 1 and Resident # 2 on 2/14/26. During an interview with Nurse # 1 on 3/5/26 at 9:50, Nurse # 1 reported she did not recall which Nurse Aide had informed her about an	F0842		

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

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

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F0842 SS = D	Continued from page 11 altercation, but she had been told that Resident # 1 hit Resident # 2 and then Resident # 2 hit Resident # 1 back. Nurse # 1 further reported she had been very busy, checked the residents, saw no injuries or marks, but did not document in the medical record the altercation or her assessment of the residents. During an interview with the Administrator on 3/5/26 at 3:45 PM, the Administrator reported Nurse # 1 should have made a notation in each resident's record that the residents had been involved in an altercation. 1b. On 2/17/26 Resident # 1 was documented on a skin audit report as having bruising to the cheek area below her left eye. Physician Assistant # 1 was interviewed on 3/5/26 at 1:10 PM and reported the following information. She recalled assessing Resident # 1 after Resident # 1 had been involved in an altercation on 2/14/26 and after Resident # 1 was identified to have a bruise below her eye. She did not recall for sure which day this had been but knew it had been after the bruise and altercation had been reported to her from staff. Resident # 1's eye was not painful or shut. Resident # 1 did not have vision problems. Resident # 1 had reported she had been hit in another room and did not give details. She (PA # 1) reported she did not make a notation about her assessment of Resident # 1 in Resident # 1's medical record. During an interview with the Administrator on 3/5/26 at 3:45 PM, the Administrator reported PA # 1 should have made a notation in Resident # 1's record about her assessment of Resident # 1 when she evaluated her for the bruised eye following the altercation.	F0842		