STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

(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 An unannounced Complaint investigation survey was conducted on 4/6/21 through 4/8/21. 1 of 10 complaints resulted in a deficiency. Event ID# OQJ211.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to protect a cognitively impaired resident from verbal and physical abuse from a staff member for 1 of 4 resident's reviewed for employee to resident abuse. Resident #1. The findings include: Resident #1 was originally admitted to the facility on 1/12/21 with diagnoses including Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, Chronic Atrial Fibrillation, and Type 2 Diabetes Mellitus and Dementia. According to the most	F 600	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSIONS STATED ON THIS STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW.	4/21/21

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

Electronically Signed | 04/22/2021

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F 600	Continued From page 1 recent Medicare 5 day Minimum Data Set dated 1/18/21, Resident #1 was cognitively impaired, independent with transfers, required extensive assistance with bed mobility, and was independent with mobility in his room and on the unit. Review of Resident #1's care plan dated 1/13/21 revealed a goal for the resident to have no behaviors and to maintain behavioral manifestation to a minimum. Interventions included encouraging the resident to express feelings (anger, sadness, guilt) and help to come up with alternative ways to handle feelings of anger and frustration. Maintain a calm, non-threatening manner while working with the resident. Provide reassurance and comfort measures and to use short simple sentences. During an interview on 4/6/21 at 2:08 PM, NA #1 revealed the incident happened on second shift. She stated Resident #1 was standing at the nurse's station. She stated Resident #1 was told to go to his room by Nurse #1, and Resident #1 said no. She revealed Nurse #1 said I'll beat your (derogatory word) and grabbed Resident #1 by the arm and dragged him down the 600 hall. She stated she kept yelling at Nurse #1 to walk away. She stated Nurse #1 held his hands behind his back and said to Resident #1, hit me, hit me. NA #1 said she told Nurse #1 to let Resident #1 go. NA#1 stated NA#5 intervened and got Resident #1 away from Nurse #1 and escorted him to his room. She stated she told Nurse #2 and Nurse #2 sent Nurse #1 home. During an interview on 4/6/21 at 2:21 PM, NA#2 stated she was sitting at the computer charting when Nurse #1 stood up and told Resident #1 to	F 600	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: On 1/25/21 the employee was suspended immediately pending the facility investigation. The resident was checked for harm and his skin check was normal. The resident discharged home on 2/26/2021. The employee was discharged from employment on 2/1/2021. OTHER RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED AND CORRECTIVE ACTION TAKEN: All interviewable residents were interviewed using a resident abuse questionnaire. Skin assessments were done on those residents not interviewable. No further issues were determined. SYSTEMATIC CHANGE IMPLEMENTED: All staff were inserviced on facility and regulatory abuse and neglect policies and procedures. A Resident Council meeting was held by the Administrator reviewing facility resident abuse and neglect policies and procedures including education regarding types of abuse, scenarios and reporting. MONITORING: Resident abuse questionnaires will be completed on 5 random residents daily 5	

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F 600	Continued From page 2 go to bed. NA#2 said Nurse #2 grabbed Resident #1's arm and walked him down the hallway and she heard Resident #1 yelling, "let go, you're hurting me." She revealed NA #1 told Nurse #1 three times to let go of Resident #1. She said Nurse #1 told Resident #1 to go to his room and Resident #1 said "I'm not going." She revealed Nurse #1said, "Oh you're going to your room." NA#2 stated by that time, NA#5 came around the corner and got Resident #1 and took him to his room. During an interview on 4/6/21 at 3:08 PM, NA#3 revealed she was sitting at the nurse's station and she heard a commotion on the 600 hall. She stated she saw Nurse #1 with his hands behind his back, standing in front of Resident #1. She revealed she could not see much because she was so far away. She said she was almost a whole hall away. She said she did not have to say or do anything because Nurse #2 handled the situation. During an interview on 4/6/21at 4:15 PM, NA#4 revealed she was sitting at the nurse's station charting and she observed Nurse #1 with his hands behind his back standing in front of Resident #1 and asking the resident if he was going to hit him. During an interview on 4/6/21 at 4:30 PM Nurse #2 revealed she was charting at the nurse's station and NA#1 informed her that she witnessed abuse and she needed to report it. She revealed NA#1 explained that the incident happened between Nurse #1 and Resident #1. She stated Resident #1 came down to the nurse's station, holding up his catheter bag in his hand and Nurse #1 approached him and asked him to	F 600	days per week for one week; then 3 days per week for 4 weeks then once per week for 7 weeks. Results of these questionnaires will be reviewed daily by the Administrator and/or DON and reviewed in the facility QAPI meetings. The Resident Abuse Questionnaire will be completed with 5 random employees daily for 5 days for one week, then 3 times per week for 4 weeks then once per week for 7 weeks. Results will be reviewed by the Administrator and/or DON. Results were also reviewed in facility QAPI meetings held on 1/23/2021 and 4/21/2021 and will be reviewed in future QAPI meetings.	

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F 600	Continued From page 3	F 600		

go to his room to drain the catheter. Nurse #2 said NA#1 told her Nurse #1 grabbed Resident #1's arm and led him down the hallway. Nurse #2 said she went down to the 600 hall medication cart to take Nurse #1's keys and escorted him to the time clock and out of the facility. Nurse #2 stated NA#1 notified the DON after she walked Nurse #1 out of the building. She said she completed Resident #1's skin assessment and there were no bumps or bruises. Nurse #2 stated Resident #1 did not appear to be upset and he did not remember anything that happened. She stated he was perfectly pleasant.

During an interview on 4/6/21 at 7:00 PM, NA# 5 stated Resident #1 was standing at the nurse's station and he was talking about going home. She revealed she and other staff were encouraging him to go to his room. NA#5 said Nurse #1 was sitting at the desk charting and he stood up, slammed his chair and said, "I'm going to beat your, (derogatory words)" grabbed Resident # 1 by his arm and dragged him half way down the 600 hall and cornered him in the hallway. She stated Resident #1 kept saying, "let me go." "Let go or I'll punch you." NA #5 revealed Nurse #1 said, "hit me, hit me, hit me," "I dare you to hit me". She said NA#1 told Nurse #1 at least three times to walk away. NA#5 stated she and three other staff escorted Resident #1 to his room. She stated she called Nurse #2 and Nurse #2 escorted Nurse #1 out of the building.

Nurse #1 was not available for interview. Nurse #1's written statement read in part, "At approximately 9:15 PM on January 25th, Resident #1 was walking the 600 wing hallway unassisted as he does every night. He wandered around the 600 hall nurse's station and was

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F 600	Continued From page 4	F 600		

holding up his foley catheter bag folded and crumpled up in his hand as he always does. Approximately 9:30 PM, Resident #1 stopped at the nurse's station and asked me questions about exiting the building. I stated it was 9:30 PM at night and that he needed to go back to his room and sit or lie down so that the foley catheter bag could drain because it shouldn't be crumpled up in his fist. I told him that his family member wanted him to be in bed because it was after 9:30. I approached him and explained that because the foley catheter bag was wadded up that it's not doing its job and it could cause him health issues. He argued with me that it was just fine. I placed my hand on his back and said "Come on, we need to get you up to your room so that you can sit or lie down." I was speaking firmly and matter- of -factly. He stated something contradictory and wasn't budging. This technique has worked fine several nights in the past to successfully motivate him towards his room and once we get him sat down and the foley draining properly, he's in a pleasant mood and generally ready for bed. The evening of the 25th was different. He seemed to be in a more bullish mood and refused to budge. I took his free right hand in mine and continued holding my left hand on his back. I firmly stated, "come on, it's time to go up to your room." We both got about 2 steps pulling against each other for a few seconds and he jerked away and told me to get my hands off of him or he was going to (assault) me. I completely released him with my hands open, in the air by my head, and my hands away from him. I told him to go ahead and hit me if that's what he wanted to do. At that point, NA#1 said, "Just walk away, just walk away." That is exactly what I did. I turned around and walked away. Approximately 15 minutes after the incident, while I was giving

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F 600	Continued From page 5	F 600		

report to Nurse #2, Resident #1 walked by the nurse's station again, smiled and asked, "How are y'all doing!" His normal friendly manner."

During an interview with the Director of Nursing (DON) and the Administrator on 4/6/21 at 3:24 PM, the Director of Nursing revealed the incident was immediately reported by NA #1. The DON revealed Nurse #2 was also notified. She stated she told Nurse #2 to clock Nurse #1 out to go home. The DON revealed Resident # 1 was assessed, but the resident did not recall what happened. She stated Nurse #1 was suspended, the report was called in, skin checks were done, statements were gathered from witnesses and the cardex care plan was updated. The DON revealed they monitored Resident #1's psychological well being. She revealed every morning they reviewed residents to determine if they had any concerns and skin checks and weights were reviewed. The DON revealed the residents were aware of their rights. The Administrator revealed Nurse #1 was terminated, 24 hour and 5 day reports were completed with a confirmation fax. He stated 100% of all staff were inserviced on the abuse policy of reporting abuse, and a Qapi (Quality Assurance Performance Improvement) meeting was held on January, 27th. The Administrator stated the medical doctor and family was notified. He revealed resident's rights were reviewed in Resident Council meetings. He stated thirteen residents were interviewed and asked if they felt respected by staff. The Administrator revealed there was ongoing education on resident's rights and abuse. He revealed they had not done any monitoring or audits regarding staff to resident abuse.