| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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<br><br>The survey team entered the facility on 4/3/24 to conduct a complaint investigation and exited on 4/8/24. Additional information was obtained on 4/16/24. Therefore, the exit date was changed to 4/16/24. Event ID# MXED11.<br>The following intakes were investigated: NC00214216, NC00215026, and NC00215213. Intake NC00215213 resulted in immediate jeopardy.<br><br>2 of the 3 complaint allegations resulted in deficiency.<br><br>Past Non-Compliance was identified at:<br><br>CFR 483.12 at tag F600 at a scope and severity (J)<br><br>The tag F600 constituted Substandard Quality of Care.<br><br>Non-compliance began on 3/28/24. The facility came back in complaince on 4/2/24.<br>A partial extended survey was conducted. | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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. | F 600 | | |

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

Electronically Signed | 04/18/2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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<br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, the facility's surveillance video, and interviews with staff and law enforcement, the facility failed to protect a cognitively impaired female resident's (Resident #1) right to be free from sexual abuse by a male visitor. On 03/28/24, the Visitor was at the facility visiting his family member (Resident #2) in a common area of the facility when he left that area and went to her (Resident #2's) semi-private room on the secured dementia unit where she resided with Resident #1. Resident #1 was in her bed when the Visitor was observed by Nursing Assistant (NA) #1 as he leaned over Resident #1 with his back to the door. NA #1 asked what he was doing and the Visitor turned around and adjusted the waist of his pants. The Visitor admitted to law enforcement that he took his hand and placed it on Resident #1's vagina. Resident #1 was incapable of giving consent for the Visitor to touch her. Resident #1 indicated the Visitor "hurt me" and that she was scared he was going to come back. This deficient practice was for 1 of 3 residents reviewed for abuse.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 09/27/22 with diagnoses which included, in part, dementia with other behavioral disturbance, anxiety and depression.<br><br>A review of Resident #1's care plan revealed a | F 600 | Past noncompliance: no plan of correction required. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | F 600 | | |

focus, revised on 08/28/23, that she had inappropriate behaviors such as agitation, altercations with roommate, refusing showers, and taking her roommate's belongings. There was no care plan in place related to sexual behaviors.

A review of Resident #1's Minimum Data Set (MDS), dated 02/29/24, revealed that Resident #1 was moderately cognitively impaired and had no physical, verbal, or other behavioral symptoms and no rejection of care or wandering behaviors at the time of the assessment. The MDS indicated Resident #1 had no impairment in her upper and lower extremities. The assessment indicated the resident had been dependent on staff for assistance with dressing her lower body and toileting and that she had required substantial/maximal assistance with dressing her upper body, personal hygiene and bathing.

An observation of Resident #1's room was conducted on 04/03/24 at 11:55 a.m. She resided on the secured unit with a roommate, Resident #2. Resident #1's bed was the A bed, closest to the door.

Review of the facility's Initial Allegation Report, completed by Nurse #1 on 03/28/24, revealed an allegation of resident abuse on 03/28/24. The facility became aware of this allegation on 03/28/24 at 9:50 a.m. The allegation stated that NA #1 observed the Visitor (Resident #1's roommate's male family member) standing over her bed and as he turned around, he was observed tucking his penis back into his pants. The report indicated that the facility reported this incident to law enforcement on 03/28/24 at 10:00 a.m. and to the State agency on 03/28/24.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AUTUMN CARE OF RAEFORD** | **1206 N FULTON STREET RAEFORD, NC 28376** |

| (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 | F 600 | | |

A review of Resident #1's 03/28/24 Progress Notes revealed a note written by Nurse #1 at 9:50 a.m. which indicated she was called to the resident's room by NA #1 who reported she observed the Visitor standing over Resident #1 with his hand in his pants and when he turned around his penis outside of his pants. Nurse #1 wrote she moved the Visitor away from the resident and made the Administrator of the facility aware of the incident.

A review of NA #1's written statement, dated 03/28/24, read as follows: "I noticed [the Visitor] walk by and enter the resident's room (in which his [family member] shares a room with). So I followed him when he went back to the room where the incident occurred. He was standing over the resident and I asked what are you doing sir, he replied I'm fixing her back in the bed. He was putting his penis back in his pants and I immediately called for the nurse and ask him to leave the room and I checked on the resident to see if she was ok and she stated she wasn't."

An interview was conducted with the Director of Nursing (DON) on 04/04/24 at 3:37 p.m. The DON explained she had not been at work on the day of the incident (3/28/24) however she had been informed of it via a telephone call from the facility on 3/28/24. The DON further explained she had returned to work on 03/29/24 and during her review of the incident and of the different written statements by staff, she questioned a discrepancy she noticed regarding whether or not NA #1 had witnessed the Visitor's penis. She reported a discussion was held with NA #1 and explained the nursing assistant had made an assumption when she saw the Visitor adjusting

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

the waist of his pants as he turned to face her. The DON acknowledged she and the Administrator asked NA #1 to write an addendum to her original written statement which clarified what she had actually witnessed.

A review of an undated addendum NA #1 had written to her original statement read as follows: "I was going to assist a resident with a.m. care. Before I went in the room to assist a resident, I went in to [Resident #1] room to check on her to see if she was awake and upon me entering the room I witnessed [the Visitor] standing over her with his hands on her body. His hands was on her arm and thigh. I asked him what was he doing and as he turned towards me he was adjusting his pants (I did not see his penis out of his pants) and he stated he was helping her back on the bed. I asked him to leave the room and I yelled for the nurse to come. When the nurse escorted him out of the room, I checked on [Resident #1] and asked her if she was ok and she stated no I'm not ok. I observed her and noticed her brief the crotch part was moved to the side and I asked her if she was ok and she said no. I remained in with her until the nurse came back to the room to check on [Resident #1]."

An interview was conducted with NA #1 on 04/03/24 at 12:43 p.m. NA #1 confirmed she had been assigned to care for Resident #1 on 03/28/24 from 7:00 a.m. until 3:00 p.m. NA #1 stated around 9:15 a.m. on 03/28/24 she had been doing her morning rounds on the dementia unit and had been ready to provide care to a resident who resided in the room across from Resident #1. She indicated because Resident #1 had been assessed as a fall risk, she had decided to pop her head into her room to quickly

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

check on her before beginning care with the other resident. NA #1 explained she peeked into Resident #1's room and noticed the Visitor (family member of her roommate, Resident #2) standing over Resident #1's bed. NA #1 explained the Visitor had been standing beside the bed on the resident's right side, towards the middle of the bed. She further explained Resident #1 was lying on her back and he was leaning towards her with his left hand on her right upper arm and his right hand was on her right thigh. She stated the bed covers were pulled up to the resident's waist and that she had been wearing a hospital gown and an adult pull-up brief at the time of the incident. She clarified that the resident's brief was not exposed at the time of that observation. NA #1 described how she had asked the Visitor what he was doing and stated he stood up straight and turned towards her. As he was turning towards her, she said she noticed him adjusting his pants. When asked to explain, she stated he had been wearing a pair of jeans however could not recall if the buttons or zipper to his jeans were undone, or if he had been wearing a belt. She stated the Visitor then told her he was helping Resident #1 back on her bed. NA #1 denied seeing the man's penis. NA #1 said the Visitor started walking towards the doorway as if to leave the room and she immediately yelled for Nurse #1 to come to the room while the Visitor stood in the hallway outside the room. NA #1 stated as Nurse #1 approached the two of them (NA #1 and the Visitor) in the hallway, she told the nurse what she had witnessed, and then Nurse #1 asked the Visitor to go back to the dayroom where he had been visiting his family member (Resident #2) and escorted him to that area of the unit. NA #1 explained that she sat with Resident #1 until the Administrator and Nurse #2 got to her room. NA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

#1 indicated she had asked Resident #1 if she was okay and the resident said no. She stated she then pulled back the bed linens and saw that the leg opening part of her adult pull-up brief appeared to have been pulled away from her groin area which exposed her pubic hair and nothing else.

A second interview, via telephone, was conducted with NA #1 on 04/04/24 at 8:25 a.m. to discuss the reason she had written an addendum to her original written statement. In that addendum, NA #1 clarified she had not seen the Visitor's penis. NA #1 explained after she had discussed the incident at length with the Administrator and DON, she had been asked to write an addendum which clarified that she did not see the Visitor tucking his penis back in his pants. NA #1 further explained that because she had seen the Visitor adjusting the waist of his pants as he turned to respond to her question, she had assumed that he was tucking his penis back into his pants. NA #1 indicated both the Administrator and DON had expressed to her they wanted the reports to the State to be accurate.

A review of Nurse #1's written statement, dated 03/28/24, read as follows: "[The Visitor] was visiting his [family member (Resident #2)] in the private dining room. This writer observed [the Visitor] going back and forth to [Resident #2's room number] with tissue in his hand on two occasions. The second time the CNA [certified nursing assistant] went to the room and called this writer to the room. I met [the Visitor] in the hallway. He stated he was 'getting tissue.' There was a box of tissue at the table with his [family member (Resident #2)]."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

An interview was conducted with Nurse #1 on 04/03/24 at 11:54 a.m. Nurse #1 confirmed she had been assigned to care for Resident #1 on 03/28/24 from 7:00 a.m. until 7:00 p.m. Nurse #1 explained she had been made aware of an incident involving Resident #1 at approximately 9:50 a.m. when NA #1 had called her name and motioned for her to come towards Resident #1's room. She noted that NA #1 was outside of Resident #1's room and the Visitor stood in an area between the 600 and 700 Hall. Nurse #1 explained she asked NA #1 what happened and said NA #1 told her that the Visitor had been in the room with Resident #1 alone. Nurse #1 stated she then asked the Visitor what he had been doing in there and stated he told her that he had gone into the room to get some tissue. Nurse #1 stated NA #1 then told her that the Visitor had been standing over Resident #1 while she was in her bed with his hand in Resident #1's adult brief and when he turned towards her, he put his penis back into his pants. Nurse #1 indicated she escorted the Visitor to the dayroom where he had been visiting with his family member (Resident #2) and stated she instructed him to stay there, which he agreed to do. Nurse #1 stated she had instructed the activities aide to go sit with Resident #1 and she left the secured dementia unit to get Nurse #2 and the Administrator who were in a meeting in the conference room. She expressed to them (the Administrator and Nurse #2) that she needed help and told them what had been reported to her by NA #1. Nurse #1 indicated both Nurse #2 and the Administrator then went to the dementia unit and she had been given instructions to begin the paperwork for an investigation as well as to call the police. Nurse #1 stated Resident #1 was sent to the hospital for evaluation. Nurse #1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

acknowledged the police and Emergency Medical Services (EMS) got to the facility around the same time and both agencies looked over the resident before EMS took the resident to the hospital. She also stated the police officer took pictures of Resident #1's room and collected her bed linens. Nurse #1 said she then contacted Resident #1's medical doctor (MD) to inform them of the incident and reported no new orders were given at that time. Nurse #1 explained that the resident was normally anxious and took scheduled antianxiety medication but she (Nurse #1) worried the resident would experience increased anxiety later so she contacted the MD to see if she could get something else for Resident #1's anxiety if needed. Nurse #1 stated Resident #1 appeared a little anxious prior to going to the hospital. When asked about the Visitor, Nurse #1 stated he had visited his family member (Resident #2) on many occasions and had never displayed any inappropriate behavior during those visits.

A second interview was conducted with Nurse #1 on 04/04/24 at 2:40 p.m. Nurse #1 stated Resident #1 was alert but confused and would often think staff or other residents on the dementia unit were arguing with her or would think the people on the television were arguing with her. Nurse #1 confirmed that Resident #1 would tell staff that this man or that man was her brother or her husband and quite frequently thought she was pregnant, however, never made sexualized remarks to people. Nurse #1 explained on the day of the incident, the Visitor had done nothing to cause suspicion during his visit with his family member.

A third interview was conducted, via telephone,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

with Nurse #1 on 04/16/24 at 10:51 a.m. Nurse #1 stated when she escorted the Visitor down the hall and back to the dayroom, she instructed him to wait there and explained she had given instructions to the Life Enrichment Assistant to supervise the Visitor there until she returned. Nurse #1 stated the only other resident who was in the dayroom with Visitor was his family member (Resident #2). Nurse #1 explained approximately 5 minutes had elapsed from the time she left the unit until the time she returned to the unit along with Nurse #2 and the Administrator.

A review of Nurse #2's written statement, dated 03/28/24, read as follows: "After alleged allegations writer interviewed resident. Writer asked resident was she ok. Resident stated 'I'm scared. He's going to come back.' Writer asked who will come back and what did he do? Resident states 'he hurt me.' Writer states how and where did he hurt you. Resident places hands on genitalia and states 'right here.' Writer asked what did he do right there. Resident states 'he was doing something with his fingers and it hurts on the inside.' Writer then left resident's bedroom and informed administrator."

Nurse #2 had written an addendum to her statement, dated 03/29/24. It read as follows: "Prior to interviewing resident writer observed resident in bed gripping shirt and shaking. Brief was exposed and blanket was observed positioned below hip line. Writer later identified CNA [NA #1] pulled covers back."

An interview was conducted with Nurse #2 on 04/04/24 at 11:05 a.m. Nurse #2 confirmed she worked on 03/28/24 as the wound care nurse

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

during day shift hours. Nurse #2 stated she had been made aware of the incident involving Resident #1 when Nurse #1 came to the conference room and told her that she needed to speak with her. She stated she and Nurse #1 went to the Staff Development Coordinator's office where Nurse #1 shared the details of the incident and then she returned to the conference room and shared those details with the Administrator. Nurse #2 explained she and the Administrator immediately went to the dementia unit and stated she had been given instructions by the Administrator to interview Resident #1 while he went to talk with the Visitor. Upon entering Resident #1's room, Nurse #2 stated the resident appeared nervous and afraid and was noted to be trembling. The resident was gripping onto her gown and she was shaking. She noted the bed linens were pulled over Resident #1's legs to her waist and she was gripping her gown. Nurse #2 said she walked over to the resident's bed and asked her what was wrong and stated Resident #1 said, "I'm scared" to which she asked her what she was scared of. Nurse #2 stated the resident said, "that man hurt me" and then she asked the resident where he had hurt her and said the resident took her hands and patted the area at the top of her adult pull-up brief and said, "right here." Nurse #2 asked the resident to elaborate and stated the resident said he had done something with his fingers, and it hurt on the inside. Nurse #2 acknowledged she assessed Resident #1 and pulled her bed linens back exposing her brief; however, Nurse #2 could not recall if the brief had been shifted to expose any of her private parts. Nurse #2 then described she pulled Resident #1's brief down and checked it but did not see any blood in it and did not see any signs of trauma to her external private parts.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | | |

A review of the Administrator's written statement, dated 03/28/24, read as follows: "Writer approached [the Visitor] at approximately 11AM while he was sitting in activities room with [his family member]. Writer informed [the Visitor] that he needed to leave the facility due to a report of inappropriate behavior. [The Visitor] collected his belongings and left the memory care unit with writer. As writer was escorting [the Visitor] to the front entrance, he told writer that he [the Visitor] messed up, because when he went into his [family member's] room to get something, the lady in the room with her [Resident #1] called him over to her bed and stated that she wanted him to 'f**k' her. He said he [the Visitor] only touched her leg and then the lady [NA #1] came to the room. Writer informed [the Visitor] that the police were being called and that he needed to wait in the social worker's office. [The Visitor] complied and was supervised by [Nurse #2] until police arrived."

A review of the law enforcement report, completed on 03/28/24, revealed the incident had occurred on 03/28/24 and had been reported to them by the facility on 03/28/24 at 10:01 a.m. The report indicated the Visitor committed a forcible sexual offense by touching a disabled individual's private part (Resident #1).

An interview was conducted with the local police department's lead detective on this case on 04/03/24 at 12:58 p.m. The Detective explained once she arrived at the facility, she had been briefed by the officers who had initially reported to the facility. She stated she did not speak with Resident #1 but had watched the responding officer's body camera footage and stated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 | F 600 | | |

Resident #1 admitted to the officer that a man had touched her private parts. The Detective stated she had spoken with the accused individual (the Visitor), read him his rights, and then asked him to go to the police department so that she could conduct an interview with him privately. The Detective indicated the accused individual drove himself voluntarily to the police department as one of the police officers followed behind him. Before leaving the facility, the Detective spoke with Nurse #2 and the facility's Administrator and stated the Administrator informed her of his conversation with Nurse #1. The Detective acknowledged it had been suggested NA #1 had witnessed the accused individual tucking his penis back into his pants, however, she had been informed on 04/02/24 by the Administrator that the accused individual's penis had never been exposed. After speaking with the Administrator, the Detective then spoke with Nurse #2 who reported that the accused individual had told her that he had not had sex in a long time and that Resident #1 said to him, "I want you to f**k me." The Detective stated Nurse #2 continued detailing her conversation with him and stated the accused individual had told her that he approached Resident #1 who had been in her bed and he had touched her in her private parts. The Detective stated Nurse #2 then told her that she had asked the accused individual if anything else had happened or did he touch himself and said Nurse #2 said he told her that he may or may not have touched himself on the outside of his pants, that he could not remember. The Detective stated the Administrator informed her that as he was walking the accused individual from the dementia unit to another office, the Visitor had apologized to him (the Administrator) and told him that he was embarrassed. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 13 | F 600 | | |

Detective stated she then left the facility to go interview the accused individual at the police department while another detective remained at the facility to gather evidence. When asked if the Detective considered the Visitor to be alert and oriented, she confirmed she had asked him questions such as the day, date and year and remarked he was correct on all accounts with the exception of getting the date wrong by one day. She also reported that he (the Visitor) was still able to drive a vehicle and had been able to describe his usual activities when he visited his family member at the facility. She stated he reported having a medical condition related to his blood pressure which required him to take medication. During the interview at the police department, the Detective explained the Visitor confessed to her and explained that he told her he had been thinking it had been so long since he had sex and that he had been attracted by the offer made by Resident #1. The Detective continued, stating the Visitor told her that he had approached Resident #1's bed and Resident #1 had been the one who pulled her bed linens down and pulled her underwear to the side exposing her vagina to him. The Detective stated the Visitor then said he took his hand and placed it on her (Resident #1's) vagina. The Detective then said she asked him if he had inserted a finger into her vagina and stated he told her (the Detective) that everything had happened so fast that he could not remember. The Detective stated she asked the Visitor to provide a DNA (a molecule that contains the genetic code that is unique to every individual) sample and he had done so voluntarily after which he was placed under arrest and charged with felony second-degree forceful sexual offense. When asked to explain the charges, the Detective explained that because

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 14 | F 600 | | |

Resident #1 was considered disabled and mentally incapable of giving consent, this offense could be anything but penetration. The Detective further explained the Visitor was processed in the county jail and there he remained on a high bond. She also stated that the Visitor was told that he can no longer go to the facility or have any contact with Resident #1.

An interview was conducted with the Life Enrichment Assistant from the Activities Department on 04/04/24 at 1:16 p.m. The Life Enrichment Assistant confirmed she had been working on 03/28/24 during the day shift and at the time of the incident with the Visitor and Resident #1, she had been doing activities with the residents on the secured dementia unit in the activities/dining room area. The Life Enrichment Assistant stated she often interacted with Resident #1 during activities and explained she was familiar with Resident #1's usual moods and behaviors. The Life Enrichment Assistant further explained that she had been asked by the Administrator to sit with Resident #1 as they waited for EMS to arrive. The Life Enrichment Assistant stated while she sat with Resident #1, the resident appeared to be acting a little stressed or scared at that time. Because she had worked with her before, the Life Enrichment Assistant stated she knew that Resident #1 had those types of behaviors occasionally but was unsure of what had caused the resident to act that way on that date. During her interaction with Resident #1, the Life Enrichment Assistant said she asked her how she was doing and said the resident replied, "I could be better" to which she responded "why, what's wrong?" The Life Enrichment Assistant detailed how the resident then moved her hand to her perineal area (the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 15 | F 600 | | |

area between a person's anus and vulva) and told her that the man (the Visitor) had touched her vagina.

A second interview was conducted, via telephone, with the Life Enrichment Assistant on 04/16/24 at 10:10 a.m. The Life Enrichment Assistant stated upon entering the secured dementia unit to begin an activity with the residents, she observed NA #1 in the hall motioning for Nurse #1 to come to Resident #1's room. She stated she then observed Nurse #1 escorting the Visitor to the dayroom and heard her tell him to stay there. The Life Enrichment Assistant explained Nurse #1 did not give her any details of what had just occurred in Resident #1's room but asked her to supervise the Visitor in the dayroom while she went off the unit to talk with Nurse #2 and the Administrator. The Life Enrichment Assistant stated only the Visitor and the Visitor's family member (Resident #2) were in the dayroom during that time. She stated prior to the Administrator escorting the Visitor off the secured dementia unit, he instructed her to go to Resident #1's room and sit with her until EMS arrived.

A review of Resident #1's Emergency Room visit notes on 03/28/24 at a local hospital revealed the following:
-- Medical history and physical exam were completed by a Registered Nurse. Findings included vital signs within normal limits. An emotional assessment was documented as quiet and cooperative. A systems examination revealed no abnormalities. There were no signs of physical trauma noted on the anatomical drawing of the female body. A pelvic exam revealed no abnormalities.
-- She was assessed by a medical doctor and his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 16 | F 600 | | |

assessment read as follows: "Chief Complaint: Sexual Assault. History of Presenting Illness: ...female with a [past medical history] significant for dementia who presents to the ED [Emergency Department] via EMS for evaluation of an alleged sexual assault. Per EMS, patient comes from [name of skilled nursing home] and staff there reported her roommate's [Resident #2] [family member] confirmed that he [the Visitor] 'touched her inappropriately' this morning. Staff notes that he was in the room for quite a while and when he came out he was 'adjusting his pants.' Patient states that 'he started at my head and worked his way down' noting that he touched her head, her breasts and her vaginal area. He denied [the Visitor] any penetration on scene ... Patient claims that he [the Visitor] did penetrate her. Patient reports that she did not give consent. Denies any injuries or pain, but history is severely limited secondary to her dementia ... Physical Exam ... general - she is not in acute distress ... psychiatric ...mood normal ...behavior normal ... Clinical Impressions - sexual assault of adult, initial encounter, prophylactic antibiotic, severe dementia without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety ..."
-- The record indicated Resident #1 was discharged back to the facility on 3/28/24.

During an interview conducted with Nurse #1 on 04/03/24 at 11:54 a.m., she stated after Resident #1 returned from the hospital (on 3/28/24 at approximately 4:00 p.m.), she and Nurse #2 completed a head-to-toe assessment on her which revealed no areas of trauma or bruising. Nurse #1 stated after Resident #1 returned from the hospital, she had been at her usual baseline mood and affect with no recollection of having

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 17 | F 600 | | |

gone to the hospital that day. Nurse #1 indicated Resident #1 returned from the hospital around 4:00 p.m. that afternoon.

A review of Resident #1's Head to Toe Evaluation, completed by Director of Nursing (DON) and dated 03/29/24 at 5:12 p.m., revealed Resident #1 had a normal exam with no complaints of pain and displayed no significant behavioral changes within the last 24 hours.

During an interview with the Director of Nursing (DON) on 04/04/24 at 3:37 p.m. she stated she had assessed Resident #1 on 03/29/24, just after lunch that day, and that there had been no signs or symptoms of trauma or distress. The DON remarked that Resident #1 seemed to be at her baseline regarding her behaviors, mood and affect; she also confirmed that the resident often thought she was pregnant or in labor. The DON confirmed Resident #1 was not seen by the facility's medical doctor after the incident of 03/28/24 but stated after the incident, the resident had been scheduled to see the facility's psych provider on 04/04/23.

During an interview with Nurse #2 on 04/04/24 at 11:05 a.m. she described Resident #1's emotional state after her return from the local hospital. Nurse #2 stated Resident #1 appeared to be at her baseline in regard to mood and affect. She said she had asked the resident how she was doing and said that the resident told her she had been at the hospital having a baby which was a common theme when talking with the resident. Nurse #2 stated Resident #1 was taken to her room and a full assessment had been completed which revealed no signs of trauma including vaginal discharge or blood nor any

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 18 | F 600 | | |

bruising, redness, or trauma to that area. Nurse #2 stated she and the DON repeated this exam again on 03/29/24 with no signs or symptoms of any trauma.

A review of the facility's surveillance video was conducted with the Administrator in attendance on 04/03/24 at 3:00 p.m. As the Administrator pulled up the surveillance video footage from their secured dementia unit on 03/28/24, he explained the times noted on the surveillance cameras were not 100% accurate but further explained the footage would show the length of time the Visitor was in Resident #1's room. According to the time stamps of the footage, the Visitor was observed approaching Resident #1's room at 9:16 a.m. and then entered her room at 9:16:16 a.m. The door to the room was never closed. NA #1 was observed walking down the hall towards Resident #1's room and then standing at the opening of the door and looking inside at 9:17:37 a.m. NA #1 then motioned to someone to come to the room. The Visitor was observed leaving the room at 9:17:56 a.m. which indicated he was in the room alone with Resident #1 for one minute and forty seconds.

Attempts made to contact Resident #1's Responsible Party by phone on 04/04/24 were unsuccessful.

An interview was conducted with the Administrator on 04/05/24 at 12:00 p.m. The Administrator detailed the 03/28/24 incident involving Resident #1 and the Visitor. He explained Nurse #1 had come to the conference room on 03/28/24 around 10:00 a.m. where he had been involved in their usual morning meeting and had asked to speak with Nurse #2 outside of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 19 | F 600 | | |

the conference room. The Administrator explained both nurses (Nurse #1 and Nurse #2) returned to the conference room and informed him of what had just occurred on their secured dementia unit with Resident #1 and the Visitor and that he immediately went to that area. After locating the Visitor in the dayroom sitting with his family member and giving instructions to the staff about what needed to occur, he stated he escorted the Visitor off the dementia unit to the Social Worker's office where Nurse #2 supervised him while he waited for law enforcement to arrive to the facility. The Administrator stated he immediately began an investigation. The Administrator stated as he had been walking the Visitor to the Social Worker's office, the Visitor told him, "I'm so sorry I got wrapped up in that, I went to get something for [Resident #2] but that lady [Resident #1] said come here, I want you to f**k me but all I did was touch her leg and then that lady [NA #1] came in." The Administrator, when asked, stated the Visitor had never displayed any inappropriate behaviors and did not know why the Visitor had done what had been reported to him. The Administrator said there had been no way he could have predicted what the Visitor did and felt he and the staff had followed their protocols after the incident by immediately securing the Resident #1's safety by removing the Visitor away from Resident #1 and beginning their investigation of the incident. The Administrator explained all staff from the different departments at the facility had been educated on their abuse policy and that they implemented a new policy which identified individuals that may be placed on a restricted visitation. The Administrator further explained the new policy included a notebook that contained a picture of the individual who had been placed on a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 20 | F 600 | | |

restricted visitation and a log of the times the individual visited their facility and explained these individuals would only be allowed to visit the facility Monday through Friday, in the lobby, and the visitation would be supervised by a staff member at all times. The Administrator further explained that notebooks had been placed at different locations of the facility and included areas such as the front reception desk and the nurses' stations. The Administrator also explained the Responsible Party of Resident #2 had made it clear to him that she did not want the Visitor visiting Resident #2 ever again and therefore, the Visitor involved in the incident with Resident #1, would not be allowed to return to the facility

A second interview was conducted with the Administrator, via telephone, on 04/16/24 at 9:50 a.m. The Administrator explained after the Visitor was escorted to the dayroom by Nurse #1, she instructed the Life Enrichment Assistant to supervise him until she returned to the secured dementia unit. The Administrator stated when he arrived on the secured dementia unit, he immediately went to the dayroom where the Visitor and his family member (Resident #2) were sitting. He clarified that no other residents were in that room during the approximately 5 minutes it took for Nurse #1 to leave the secured dementia unit and then return with Nurse #2 and himself. He verified the Visitor had been supervised by the Life Enrichment Assistant while in the dayroom. The Administrator stated he then escorted the Visitor to Social Worker's office where he remained, supervised by Nurse #2, until the police arrived at the facility. During a follow up telephone call to the Administrator on this date (4/16/24) at 1:36 p.m., the Administrator

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 21 | F 600 | | |

explained the facility's doors are locked 24 hours a day, 7 days a week, and can only be opened by a staff member using a code for both entry to and exit from the facility. He further explained after the incident involving Resident #1 and the Visitor, staff from all departments were made aware of fact that the Visitor was not allowed to enter the building. The Administrator stated the Visitor's picture has been placed in the Restricted Visitation notebook as well as his picture being posted at each nurses' station, the employee time clock, and beside each department's posted staffing schedule so that all staff would know what he looked like. The Administrator clarified the one and only notebook's designated location is at their front receptionist's desk and stated that while the Visitor is currently the only person noted in there, the purpose of the notebook is to contain pictures and visitation logs of any individual found to have violated the residents' rights and placed on restricted visitation.

An observation of Resident #1 was conducted on 04/03/24 at 11:50 a.m. Resident #1 was sitting in her wheelchair eating her lunch in the dining room on the secured dementia unit. She was awake and alert to her surroundings as she sat with a couple of other residents at a dining room table. She was in no apparent distress. She did not answer questions appropriately and appeared focused on the meal in front of her.

The Administrator was notified of Immediate Jeopardy on 04/04/24 at 12:29 p.m.

The facility provided the following corrective action plan with a completion date of 04/02/24: Address how corrective action will be accomplished for those residents found to have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 22 | F 600 | | |

been affected by the deficient practice:

On 3/28/2024, Certified Nursing Assistant #1 observed visitor at bedside of Resident #1 standing over the bed and his left hand on her right shoulder and his right hand on her right upper thigh. The CNA also reported that upon her entering the room that his hand moved toward the zipper of his pants. CNA #1 immediately summoned the nurse and remained with resident #1 to ensure she was supervised. Nurse #1 reported incident to Wound Nurse. Police, Resident #1's attending physician, Responsible Party and Emergency Medical Technicians were also notified. Wound Nurse notified Administrator, and Administrator escorted visitor to the social services office where he remained supervised by Wound Nurse until the police arrived. Resident #1 was taken to the hospital for evaluation of alleged sexual assault. Resident returned to the facility at 5:30PM with no new orders and no findings of sexual assault were indicated. A head-to-toe assessment was completed by Wound Nurse upon resident's arrival to the facility, and no issues were noted related to the alleged sexual assault or any other areas. The resident's provider was contacted upon resident's return to the facility and an order for Atarax for anxiety was provided and a follow-up appointment was scheduled for 4/4/2024 with the In-House Psychiatric Provider. Resident was placed on every 15-minute checks to ensure resident's needs were addressed and provided. An initial report was submitted to North Carolina HealthCare Personnel Registry on 3/28/2024.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 23 | F 600 | | |

Skin checks were completed by the Wound Care Nurse for all other residents on the memory care unit and no negative findings were revealed on 3/28/2024. Interviews for all interviewable residents were conducted by the Life Enrichment Director on 4/1/2024 in which no negative findings were identified and skin checks for non-interviewable residents were conducted by Wound Care Nurse on 4/1/2024 for all other residents not residing on memory care unit and no negative issues were identified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The facility immediately implemented the systemic change of having restrictions for any visitor that would have the potential to violate the Resident Rights of any resident. This will be determined through the following means: Ongoing abuse reporting and the continuation of the facility's Concierge rounding program in which every resident is assigned an administrative team member to advocate for them. These rounds are conducted at a minimum of 5 times a week. Review of the facility's 24-hour report, which is reviewed five times a week and the facility's Weekend Manager on Duty program, which requires all department managers to complete facility rounds on Saturday and Sunday and to address any concerns related to resident care and satisfaction and to address any issues related to staffing. The Administrator and Director of Nursing will determine the need for visitor restriction based on findings. This restriction will limit the location of visitation to the front lobby in which said visitation will be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 24 | F 600 | | |

supervised by an assigned staff member. Such visitation will also be scheduled by the receptionist/ or designee. Restricted visitation will only be scheduled during the hours that the receptionist is present. No weekend visitation will be allowed, and the facility entrance door remains locked at all times, so a staff member must let any visitor in. All staff will receive education of the systemic change in visitation as well as re-education on the facility's abuse prevention and reporting protocol which defines the different types of abuse by 3/31/2024 by the Administrator and DON. The education did include the requirement of immediate reporting to the facility's Abuse Coordinator who is the Administrator/ or the Director of Nursing in his absence by staff of any behavior that is considered to be suspicious or odd in any way. All newly hired employees will receive education from the Director of Nursing regarding abuse and new visitation restrictions. Staff will receive this education during orientation prior to working on the floor. Family Members and Visitors will be provided with Resident Rights Information through written material by the receptionist upon the visitor's entrance to the facility and the designated staff member will initial on the visitor log for all materials received. Residents Rights will be discussed by the Administrator during any upcoming Family events. All front office staff; Receptionist, Social Worker, Admissions Director, Human Resources, Business Office Manager, Weekend Receptionist #1 and Weekend Receptionist #2 and Scheduler will receive education from the Administrator related to providing Resident Rights materials to visitors by 4/1/2024. 100 % of staff received education and the facility does not have any agency staffing. A log was developed by the Director of Nursing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 25 | F 600 | | |

on 3/29/2024 specifically for supervised/restricted visitation and will be kept at the front reception area. All staff were notified by 4/1/2024 verbally by the Administrator and Director of Nursing of any individual that requires such visitation restrictions.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The log pertaining to supervised visitation and the visitor logs will be audited 5 times a week for 90 days in the facility's morning meeting by the Administrator to ensure ongoing compliance. Abuse monitoring to include identification of any signs of odd or suspicious behavior by any visitor, staff member or resident will be conducted during each morning meeting in which the 24-hour report for Friday, Saturday and Sunday will be reviewed in Monday's meeting. The following staff will attend the morning meeting: Director of Nursing, Administrator, Social Worker, Life Enrichment Director, Admissions Director, Environmental Services Director, ADON, Medical Records Director, MDS Nurse #1, MDS Nurse #2 and Environmental Services Director. Abuse monitoring will be achieved through review of the following: Concierge Rounds, 24-hour report, concerns and grievances and Weekend Manager of Duty report.

The log results and the abuse monitoring will be reviewed monthly in our Quality Assurance and Assessment meeting for 90 days.
The decision to monitor and take to QAA was made on 3/29/2024. The following members will be present: Director of Nursing, Administrator, Social Worker, Life Enrichment Director,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345280 | A. BUILDING _____ B. WING _____ | C 04/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF RAEFORD | 1206 N FULTON STREET RAEFORD, NC 28376 |

| (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 26 | F 600 | | |

Admissions Director, Environmental Services Director, ADON, Medical Records Director, MDS Nurse #1, MDS Nurse #2 and Environmental Services Director, Medical Director, and Pharmacist. The facility's decision to extend the review of logs will be based on the results of the audits.

Immediate Jeopardy Removal Date: 4/2/2024

Compliance Date: 4/2/2024

Onsite validation of the corrective action plan was completed. Interviews confirmed all staff in all of the facility's departments were educated on the facility's abuse policy and procedures as well as the facility's systemic changes which included their new Visitor Restriction policy. The education also included a review of Resident Rights. Review of audits and observation tools were conducted including a review of the new notebook at the receptionist's desk which presently only contained a picture of the Visitor. This log would contain any other individuals placed on restricted visitation moving forward as well as a log of the times these individuals visited their facility. Staff verified individuals on restricted visitation would only be allowed to visit the facility on Monday through Friday during the hours of 8:00 a.m. until 5:00 p.m. The immediate jeopardy removal date and compliance date was verified as 04/02/2024.