STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY REHABILITATION AND NURSING CENTER	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 01/16/24 through 01/19/24. Event ID# WG6X11. The following intakes were investigated NC00212167, NC00212042, NC00211691, NC00209041, NC00207830, and NC00208968. 2 of the 19 complaint allegations resulted in a deficiency.	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 review, observations and resident, staff, Police Officer, Nurse Practitioner and Medical Doctor interviews, the facility failed to protect a resident's right to be free from employee to resident physical abuse for 1 of 3 residents investigated for abuse (Resident #7). Resident #7 reported to the facility that Nurse Aide (NA)#1 had punched her in her right eye. Resident #7	F 600	On 1/13/24, Resident #7 reported that NA#1 hit her in her right eye during morning care which resulted in bruising to the right eye. Pain monitoring by the licensed nurse on 1/13/24 revealed no reported pain. The Administrator and Director of Nursing (DON) were notified at the time of the incident. Staff statements	2/15/24

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

Electronically Signed | 02/09/2024

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F 600	Continued From page 1 revealed that Nurse Aide #2 was present during this incident and witnessed the allegation. After this incident Resident #7 had a circular reddish, purple bruise below her right eye and reported she felt angry and upset at the time of the incident. The findings included: Resident #7 was admitted to the facility on 11/3/17 with diagnoses that included hypertension, schizophrenia, dementia, cerebellar stroke syndrome, glaucoma, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated 1/3/24, indicated Resident #7's cognition was moderately impaired and she required extensive to total assistance with activities of daily living. The assessment indicated the resident did not receive anticoagulants during the 7-day look back period. Behavioral symptoms and rejection of care were not observed. A review of Resident #7's care plan revised on 12/28/23 indicated that Resident was resistive to care due to dementia: refused showers, medication, and activities of daily living (ADL). The goal was the Resident would cooperate with care. The intervention included staff would allow the resident to make decisions about treatment regime, provide sense of control, and educate regarding consequences regarding refusals. A review of the 24-hour initial report dated 1/13/24 revealed on 1/13/24 at 11:13 am, the facility was made aware of the employee to resident abuse. Law enforcement was notified on 1/13/24 at 12:00 pm. The Original Allegation Details read in	F 600	were obtained, police and Adult Protective Services notified and an investigation was initiated which was substantiated. NA#1 was suspended on 1/13/24 and was reported to the North Carolina Department of Health Nurse Aide Registry by the DON on 1/16/24. Skin assessments were completed on 1/13/24 by the licensed nurse on the identified hall (100 hall) of the not interviewable residents with no concerns noted. The interviewable residents were interviewed on 1/13/24 on the identified hall (100) by the licensed nurse with no additional reports of abuse/neglect note. Resident #7 was seen by the Nurse Practitioner on 1/16/24 with no new orders. Pain assessment completed on 1/14/24 by the licensed nurses with no pain reported. Resident #7 was seen by psychiatric services on 1/26/24 with mood and anxiety reported as good and no new orders. Resident #7 denies any signs of trauma related to the incident and continues to feel safe supported in the facility. The current residents have the potential to be affected by this deficient practice.	

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F 600	Continued From page 2 part, "Resident Reported that Nursing Aide (NA) #1 hit her in the eye during ADL care. Resident was assessed for injury with no injury reported. Responsible Party (RP) and Medical Doctor (MD) notified. NA #1 was sent home, and the staffing agency was notified that NA will not be allowed to work pending outcome of the investigation. Resident's Brief Mental Status (BIMS) 12." A review of a statement dated 1/13/24 from NA #1 read in part, "I went into room 109 to assist bed 109A with patient care me and another NA (NA #2) as we approached the bed to tell her what we was about to do I grabbed the remote to her bed and the remote was beside her head I grabbed the remote she started yelling saying that the remote hit her in the head and it never touched her. I explained to her that it never touched her but, in her mind, she just kept saying that she was hit by the remote. I proceeded with care trying to redirect her and she just kept yelling, scratching, grabbing, and kicking me repeatedly I was still trying to redirect her that I only was trying to clean her up and she was swinging so wild that she hit herself in the face I walked out the room while NA #2 still in room and went to notify nurse what was going on and when the nurse came in the she said I'm going to get her fired and the nurse started asking her what was going on and me and NA #2 walked out the room we was asked after to write statements I never touched the resident she was repeatedly fighting me for no reason at all." Attempts to contact NA #1 on the 1/18/24 and 1/19/24 were not successful. An interview was conducted with Nursing Aide (NA) #2 on 1/18/24 at 2:16 pm and he stated on	F 600	A skin audit will be completed by 2/14/24 on all current residents by the Director of Nursing/Unit Manager. The interviewable residents will also be interviewed by 2/14/24 by social services to ensure that any other concerns with abuse/neglect have been addressed. Starting 1/15/24, facility staff to include the licensed nurses, certified nursing assistants, certified medication aides, housekeeping/laundry, dietary, social services, maintenance staff, agency staff and therapy staff were educated by the Staff Development Coordinator (SDC), Unit Managers, and/or Nursing Supervisors related to ensuring that residents remain free from Abuse/Neglect. Staff will not be allowed to work until the education is completed. The facility staff to include the licensed nurses, certified nursing assistants, certified medication aides, housekeeping/laundry, dietary, social services, maintenance staff, agency staff and therapy staff will be educated by the Staff Development Coordinator (SDC), Unit Managers, and/or Nursing Supervisors by 2/14/24 related to management of residents with behaviors that are resistant to care. Staff will not be allowed to work until the education is completed.	

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F 600	Continued From page 3 1/13/24 NA #1 asked him to assist her with Resident #7. NA #2 stated both NA # 1 and himself assisted Resident #7's roommate first, and then NA #1 went to start on Resident #7 while I finished lowering roommate's bed. He stated he walked around the privacy curtain to assist with Resident #7, and Resident was kicking and swinging at NA #1, and the resident was saying you hit my head, you hit my head and something about a remote, NA #1 was saying no she didn't to Resident and Resident #7 took another swing at NA #1, and then NA #1 took one of her hands and held Resident #7's hands to her chest and with her other hand, closed her fist and hit Resident in her right eye. NA #2 stated Resident #7 said to NA #1 "you're done," and asked NA#2 if he had seen that. NA #1 told me to go get the nurse and I told NA #1 to go and get the nurse. He stated Nurse #2 came in the room and asked what happened and Resident #7 pointed to NA #1 and the Resident said she hit me. NA #2 stated both NA #1 and he left the room and was told to write a statement of what happened. An interview was conducted with Nurse #2 at 2:16 pm on 1/18/24. She indicated she was the Nurse on duty on 1/13/24 and she saw NA #1 come out of Resident #7's room, and overheard NA #1 report to NA# 4, that Resident was refusing care. Nurse #2 indicated she went into Resident #7's room and observed Resident with some discoloration under her right eye. Nurse #2 indicated, NA #2 was in the room and NA #1 re-entered the room. She stated she asked Resident #7 what happened, and Resident #7 pointed to NA #1 and stated that woman hit me. Nurse #2 stated she then asked NA #1 to leave Resident's room. Nurse #2 indicated that NA #1	F 600	The newly hired facility staff to include licensed nurses, certified nursing assistants, certified medication aides, housekeeping/laundry, dietary, social services, maintenance staff, agency staff and therapy staff will not be allowed to work until the education is completed. The Director of Nursing/Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure that residents continue to be free from Abuse/Neglect. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review to ensure the facilities continued compliance.	

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F 600	Continued From page 4	F 600		

was asked to go home and provide a statement about what happened. Nurse #2 stated she did a skin assessment and no other bruising to Resident's body except for the bruising to corner of right eye that was possibly light purple in color. She indicated she reported the incident to the Unit Manager that was working in the facility that day.

A second interview with Nurse #2 was conducted at 3:45 pm on 1/18/24 and she described Resident #7's right eye as being discolored with little purplish dots under the eye that weren't connected. No bruising/discoloration was observed anywhere else on Resident's body.

A review of the Nurse Practitioner (NP) note dated 01/15/23 indicated "patient (Resident #7) reported to the NP that Resident #7 was involved in an altercation with a staff member and sustained facial bruising after being hit in the face. Resident #7 indicated that NA #1 came in to change her and she had a very nasty attitude and was being rude and forceful. Resident #7 indicated that she did not want to be changed and NA #1 started to change her anyway and she asked her to stop, Resident #7 indicated that NA #1 balled up her fist and hit me in my face, NP ordered a facial X-ray."

Review of the facial x-ray results dated 1/15/24 revealed negative for fracture.

Review of the 5-day investigation report dated 1/18/24 revealed the incident occurred on 1/13/24 during the AM care for Resident #7. The report read in part, "Resident #7 alleged she was physically abused when NA #1 hit her in the eye during ADL care. Resident #7 was interviewed by

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the Director of Nursing and law enforcement and the Resident reported NA #1 hit her in the eye during ADL care. The incident was witnessed by another staff member, and he confirmed the allegation. A skin assessment was completed on the resident and no concerns noted. Pain assessment completed with no concerns identified. Resident RP and MD were notified. Resident was assessed by the Nurse Practitioner (NP). Resident declined to press charges against NA #1. Staff continued to observe the Resident for changes in mood and/or behavior and will follow up as needed." Corrective Actions following Incident read in part, "The facility indicated NA #1 will not be allowed to work in the facility and had been reported to the health care personnel registry. Additional assigned resident skin checks revealed no concerns. Staff will be reeducated on Abuse and Neglect. The facility substantiated the allegation, and the accused individual was terminated from the facility on 1/13/2024."

An interview was conducted on 1/18/24 at 1:33 pm with Resident # 7 and she stated she had made an abuse allegation regarding NA #1 who hit her in the eye. Resident #7 indicated that it hurt. Resident #7 further stated she felt fine now, and she was not scared now. Resident #7 also indicated when the incident happened, she felt angry and upset, but was fine now and she felt safe.

An observation was made on 1/18/24 at 1:36 pm of Resident #7's right eye with a circular reddish, purple bruise about the size of two fingers wide below her right eye.

On 1/18/24 at 2:25 pm an interview was

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F 600	Continued From page 6	F 600		

conducted with Nurse #1, and she indicated she had received a report from Nurse #2 on 1/13/24 that Resident #7 alleged NA #1 hit her in the face. She stated she went into Resident #7's room and observed Resident to have a discoloration below right eye and she reported NA #1 had hit her in the eye. Nurse #1 indicated she called the Director of Nursing (DON) and the Administrator and did a 24-hour report to the State.

A phone interview was conducted with the NP on 1/18/24 at 4:05pm. She indicated she assessed Resident #7, on 1/15/24 due to facial bruising. NP indicated Resident #7 told her a staff member had a nasty attitude and was trying to change her and she didn't want to be changed, however she still proceeded to change her. She stated the staff member balled her fist up and hit her in the face. NP indicated she had facial bruising, however her orbital eye cavity was uninjured. She stated the Resident stated it hurt when it happened, but it now only hurts to touch, however Resident refused ice or pain medication. The NP stated Resident #7 had no visual changes, no closed head injury, no head trauma, she bruised significantly, she was intact neurologically. No orbital edema, it was superficial bruising, no head trauma and should fully recover with no negative outcome. She stated during the examination, Resident's demeanor was fine, she was a little tearful.

A telephone interview was conducted with the facility Medical Doctor (MD) on 1/18/24 at 4:13 pm and she indicated she immediately ordered an orbital x-ray, and the facility did neurological checks. The MD stated the building acted appropriately, and there were no negative outcomes other than superficial bruising. They did

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a facial x-ray just to be safe. She stated the x-ray was good, no fractures.

During an interview with the DON on 1/18/24 at 4:30 PM, she indicated Resident #7 had some bruising to her right eye. The DON stated NA #1 was suspended at the time of investigation and she initially denied the incident and a statement was received from her. She indicated attempts were made to contact NA #1 for further interview, however, was unable to contact her.

A telephone interview was conducted on 1/19/24 at 11:09 am with the Salisbury Police Officer and he indicated he responded to a call at Salisbury Rehab and Nursing Center on 1/15/24. He stated he looked back on his call history and verified that the facility called to report the incident before Monday, January 15, 2024. He stated the facility indicated Resident #7 had been assaulted by an agency staff person (NA #1) by hitting Resident in the right eye. He stated he gathered all the details of the investigation and charges would be filed for assault on an elderly person and there will be a warrant for NA #1's arrest by the end of the weekend. He stated he was still working on the police report and indicated it would be ready by the end of the weekend.

During an interview on 01/19/24 at 1:30 PM, the Administrator stated the facility has a zero tolerance of abuse. The Administrator further stated NA #1 was terminated from the facility. He expected all residents to be free from abuse and neglect and free from any retaliation. The Administrator indicated that the abuse allegation was substantiated.