

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345269</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>01/14/2026</b>
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NAME OF PROVIDER OR SUPPLIER <b>Autumn Care of Salisbury</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1505 Bringle Ferry Road , Salisbury, North Carolina, 28146</b>
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F0000	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was conducted from 1/13/2026 through 1/14/2026. Event ID# 1E0FE0-H1. The following intake was investigated: 2710559.</p> <p>1 of the 2 complaint allegations resulted in deficiency.</p>	F0000		
F0607 SS = D	<p>Develop/Implement Abuse/Neglect Policies</p> <p>CFR(s): 483.12(b)(1)-(5)(ii)(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95,</p> <p>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.</p> <p>§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>§483.12(b)(5)(iii) Prohibiting and preventing</p>	F0607		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0607 SS = D	<p>Continued from page 1 retaliation, as defined at section 1150B(d)(1) and (2) of the Act.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, Resident Representative, Nurse Practitioner, and staff interviews, the facility failed to implement their abuse policy and procedures in the areas of reporting, investigation and protection after an allegation of abuse for 1 of 4 residents reviewed for abuse (Resident #1).</p> <p>The findings included:</p> <p>Review of the facility Resident Abuse Policy with the last revision date of 7/11/2024 revealed the following:</p> <p>"It is the facility's policy to investigate all allegations, suspicions, and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property, and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately report begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy...If a staff member is accused or suspected of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property, the facility immediately remove staff member from resident care area and request a written statement from accused staff member. The accused staff member will remain under direct supervision until statement is complete and/or law enforcement arrives if applicable. The accused staff member will then be removed from the facility and the schedule pending the outcome of the investigation...If appropriate the social services department should be notified of the incident so that they may take appropriate interventions to care for the psychosocial needs of any involved resident. The resident's responsible party and the resident's attending physician will be notified of the incident. Documentation in the nurses' notes should include the results of the resident's range of motion, body assessment, vital signs, the notification of the physician and the responsible party and treatment provided. Appropriate quality assurance documentation should be completed as well. All allegation of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable state agency."</p>	F0607		

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F0607 SS = D	<p>Continued from page 2 Resident #1 was readmitted to the facility 1/7/25 with diagnoses including hemiplegia (paralysis on one side of the body), diabetes and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 10/17/25 documented Resident #1 to be moderately cognitively impaired. The MDS documented Resident #1 had clear speech with distinct intelligible words, and she was usually understood, with difficulty communicating some words or finishing thoughts. The MDS documented Resident #1 had adequate vision and hearing and did not use corrective lens or hearing aids. The MDS documented Resident #1 required substantial assistance with toileting and bed mobility. The MDS documented Resident #1 had limited range of motion for one side on her upper and both sides of her lower body.</p> <p>Review of the medical record for Resident #1 revealed no notes regarding an allegation of abuse by Resident #1.</p> <p>Nursing notes dated 12/25/25 indicated Resident #1 was at her baseline and denied pain.</p> <p>Handwritten statements documented by the Activities Director, the Activities Assistant, and 2 NAs were reviewed. The statements documented on 12/26/25 indicated Resident #1 reported to them that a male NA had hit her face. The statements documented notification of the Administrator of the allegation.</p> <p>The Activities Assistant was interviewed on 1/14/26 at 9:39 AM. The Activities Assistant reported she was passing out the daily newsletter before breakfast on 12/26/25 to residents and when she entered Resident #1's room, she noted that Resident #1 was very upset and crying, and Resident #1 was patting her left cheek with her left hand and saying "hit-hit." The Activities Assistant reported the Activities Director was at Resident #1's beside and NA #1 had gone to get the Administrator. The Activities Assistant reported that she saw Resident #1 later in the day on 12/26/25 and she was upset, crying and repeated the same actions of patting her cheek and saying "hit-hit." The Activities Assistant reported Resident #1's face was pink on the left side but not bruised.</p> <p>An interview was conducted with NA #1 on 1/13/26 at 6:52 PM. The NA reported she was passing breakfast trays on 12/26/25 and when she entered Resident #1's room, she saw Resident #1 crying with the Activities Director holding her hand. NA #1 reported she approached Resident #1 and Resident #1 said to her "pow-pow" while patting her left check with her left</p>	F0607		

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F0607 SS = D	<p>Continued from page 3 hand. NA #1 explained that Resident #1 had severe aphasia (difficulty with speech related to a stroke) and needed time to communicate. NA #1 reported that Resident #1 continued to pat her cheek and ask, "why he pow-pow? Why he pow-pow?" and Resident #1 was crying and upset. NA #1 noted that Resident #1's left cheek was pink and swollen. NA #1 reported she left immediately to get Unit Manager #1 and the Administrator.</p> <p>The Activities Director was interviewed on 1/14/26 at 9:20 AM. The Activities Director reported she was on the 400 hall the morning of 12/26/25 to assist the NAs with breakfast trays and when she entered Resident #1's room, Resident #1 was frantically motioning for the Activities Director to come to her. The Activities Director explained that Resident #1 was crying and her left cheek was red. Resident #1 was very upset and was patting the left side of her face with her left hand and saying "hit-hit." The Activities Director reported she asked Resident #1 "when" and Resident #1 said "last night." The Activities Director reported NA #1 entered the room and when NA #1 was told what happened, she left to get Unit Manager #1 and the Administrator. The Activities Director reported that Resident #1 was upset and crying each time the Activities Director saw her on 12/26/25, which was later in the afternoon after lunch and again before the evening meal. The Activities Director described Resident #1's cheek as being pink and swollen but not bruised.</p> <p>The Environmental Supervisor was interviewed on 1/14/26 at 9:53 AM. The Environmental Supervisor explained she was very familiar with Resident #1 and often stopped by to see her. The Environmental Supervisor reported that the morning of 12/26/25 she went in to say good morning to Resident #1, and Resident #1 called the Environmental Supervisor by name and said "hit-hit" and was very upset and crying. The Environmental Supervisor reported she left the room to notify the Unit Manager #1 and was told by Unit Manager #1 that they were aware of the allegation. The Environmental Supervisor described Resident #1 as having a pink and swollen left cheek but did not observe bruising.</p> <p>NA #2 was interviewed on 1/14/26 at 10:34 AM. NA #2 reported she took a meal into Resident #1 on 12/26/25, (but could not recall which meal it was) and she reported Resident #1 grabbed her hand and said, "hit-hit." NA #2 reported Resident #1's left cheek was puffy, red and she noticed a bruise under the left eye, which she reported. NA #2 reported she went to NA #1 and asked if NA #1 knew what was going on with Resident #1 and NA #1 told NA #2 it had been reported to the</p>	F0607		

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F0607 SS = D	<p>Continued from page 4 Unit Manager and Administrator.</p> <p>An interview was conducted with Nurse #3 on 1/14/26 at 11:27 AM. Nurse #3 explained she was assigned to Resident #1 on 12/26/25 and the Unit Manager had informed her of the allegation of abuse by Resident #1. When Nurse #3 went into Resident #1's room, Resident #1 grabbed her hand and said "pow." Nurse #3 reported Resident #1 was very upset on 12/26/25. Nurse #3 reported NA #2 reported bruising under Resident #1's eye and she completed a skin assessment and reported she did not observe bruising or injuries. When asked why this assessment was not documented in the medical record, Nurse #3 reported she was told by the DON not to "worry about the charting" and "she would take over the investigation."</p> <p>Unit Manager #1 was interviewed on 1/14/26 at 10:43 AM. Unit Manager #1 reported on 12/26/25 during breakfast, NA #1 reported to her that "something was wrong" with Resident #1. Unit Manager #1 explained she asked what happened and NA #1 reported Resident #1 said someone hit her. Unit Manager #1 explained she told NA #1 to get the Administrator, and she went to Resident #1's room. Unit Manager #1 described Resident #1's aphasia as having limited speech and confusing yes/no answers at times. Unit Manager #1 explained Resident #1 was patting the left side of her face with her left hand and saying "pow-pow my face." Unit Manager #1 explained the Activities Director and Activities Assistant were in the room, and she asked them to leave. Unit Manager #1 described that Resident #1 started to cry and said "pow-pow my face, pow-pow my face. He. He. I don't know." Unit Manager #1 reported the Administrator arrived at Resident #1's room and started asking Resident #1 questions. Unit Manager #1 explained that an allegation of abuse usually meant the accused staff member was suspended during an investigation, but NA #3 was not suspended and remained on the schedule to work. Unit Manager #1 reported she did not want NA #3 to work with Resident #1, and she changed his assignment to another hall. Unit Manager #1 reported on 1/10/26 NA #3 reported for work, and she noticed he was assigned to Resident #1 and she told him she was going to change the assignment. When he got upset about the change in assignment, Unit Manager #1 explained he could accept the change or clock out. Unit Manager #1 reported NA #3 clocked out and left the building on 1/10/26. Unit Manager #1 explained that she completed a skin assessment on Resident #1 on 12/26/25 and had a paper copy of the assessment but was waiting for direction from the Administrator regarding documentation in Resident #1's medical record. Unit Manager #1 reported NA #3 was the only white male working on 12/25 to</p>	F0607		

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F0607 SS = D	<p>Continued from page 5 12/26/25 during the night shift and NA #3 was assigned to Resident #1.</p> <p>A skin assessment dated 12/26/25 completed by Unit Manager #1 documented no skin issues and no bruising noted.</p> <p>Review of the time sheets for NA #3 revealed he worked 12-hour shifts from 7:00 PM to 7:00 AM on 12/26/25, 12/27/25, 12/28/25, 1/2/26, 1/3/26, and 1/4/26.</p> <p>NA #3 was interviewed by phone on 1/14/26 at 11:58 AM. NA #3 reported he was assigned to Resident #1 on 12/25/25 from 7:00 PM until 7:00 AM on 12/26/25 and there was nothing unusual about that shift. NA #3 reported he and NA #5 had switched assignments because NA #5 had asked him to switch. NA #3 reported he was not aware of Resident #1's allegation of abuse. NA #3 reported the night shift from 12/25/25 to 12/26/25 was "normal" and he provided incontinence care to Resident #1 "at least once" and he denied harming or hitting Resident #1. NA #3 reported he was told he could not take care of Resident #1, but he didn't receive a reason why his assignment was moved. NA #3 reported he was not interviewed by the Administrator or anyone else or asked to write a statement about what occurred that night shift. NA #3 reported he worked his full shift on 12/26/25, and worked full 12-hour shifts on 12/26/25, 12/27/25, 12/28/25, 1/2/26, 1/3/26, 1/4/26, and when he worked on 1/10/26, his assignment was changed after he had clocked in for 20 minutes by Unit Manager #1. NA #3 explained when he complained to Unit Manager #1 about having his assignment changed, he was told he could either accept the change in schedule or clock out and leave. NA #3 reported he clocked out and left.</p> <p>An interview was conducted with the Social Worker (SW) on 1/14/26 at 10:05 AM. The SW reported she did not work on 12/26/25 and returned to work on 12/29/25. The SW explained she had not been notified of an allegation of abuse from Resident #1. The SW explained she would have completed a trauma response assessment for Resident #1 and made referrals to appropriate providers, as well as interviewed other residents about abuse.</p> <p>The Human Resources (HR) Director was interviewed on 1/14/26 at 10:19 AM. The HR Director explained that she returned to work on 12/29/25 after the holidays and found a written statement by the Activities Director regarding Resident #1's allegation of abuse. The HR Director reported she immediately went to the Administrator, and the Administrator had reported to her that the incident was "taken care of." The HR</p>	F0607		

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F0607 SS = D	<p>Continued from page 6 Director explained that as the day passed on 12/29/25 more staff were approaching her and giving her written statements regarding the incident. The HR Director reported that staff were upset that an investigation had not been completed in a manner that they expected and they wanted someone to investigate the incident. The HR Director explained that staff felt that she might be able to have the incident investigated.</p> <p>The Resident Representative was interviewed by phone on 1/15/26 at 3:31 PM. The Representative explained he arrived at the facility on 12/26/25 about lunchtime to see Resident #1 and he could tell something had upset her. The Representative explained that when he arrived, Resident #1 said "bam-bam" to him and when the Representative questioned Resident #1 if she had hit herself, Resident #1 said "no." The Representative reported he spoke to the Administrator and told the Administrator that Resident #1 was able to recall the visitors she had on 12/25/25 and if Resident #1 reported that someone hit her in the face, he believed that someone hit her in the face. The Representative explained that he did not see a bruise on 12/26/25 on Resident #1's face but Resident #1 was very upset and her left cheek was pink. The Representative reported he returned to the facility on 12/29/25 and there was no bruising on Resident #1's face, but she remained upset. The Representative said he spoke with Unit Manager #1 on 12/29/25 and she had told him NA #3 would not be assigned to Resident #1. The Representative described telling Resident #1 that the NA would not be assigned to her again and she said "Thank you! Thank you!" and became very emotional and teared up. The Representative reported he was told by the Administrator an investigation was being conducted.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 1/14/26 at 11:18 AM. The ADON explained that she was not informed of the allegation of abuse from Resident #1, but when she returned to work on 12/29/25, there was talking on the halls by staff about the allegation and the ADON spoke to the Administrator who reported that she had determined that during incontinence care, something had happened to Resident #1's face. The ADON indicated she had not participated in an investigation into the allegation of abuse because she had been told the investigation was complete.</p> <p>The DON was interviewed on 1/14/26 at 12:08 PM. The DON explained she was not working on 12/26/25 and returned to work on 12/29/25. When the DON returned to work, she was told by the Administrator that Resident #1 had indicated that she was hit but the Administrator had</p>	F0607		

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F0607 SS = D	<p>Continued from page 7</p> <p>determined that during incontinence care, NA #3's arm rested against Resident #1's face. The DON reported she attempted to call NA #3 to interview him, but he did not return her call. The DON reported she had interviewed NA #1 but had not documented the interview. The DON reported that NA #1 told her that Resident #1 had reported that a white male had hit her on the face on 12/26/25 and that NA #1 had reported the allegation to the Administrator. The DON reported to the Administrator lead the investigation for the allegation of abuse and she did not know why NA #3 was not suspended and why the allegation was not reported. The DON explained the Administrator had determined that Resident #1's face was touched during incontinence care and that the investigation was complete. The DON concluded that she had contacted the staff working the night shift on 12/25 to 12/26/25 and all staff reported not seeing or hearing anything unusual during the shift. The DON reported she did not know if she documented the interviews with staff. The DON was unable to provide written documentation of the interviews she conducted.</p> <p>An interview was conducted with the Administrator on 1/14/26 at 1:04 PM. The Administrator reported that she was working 12/26/25 and she was notified by NA #1 that Resident #1 was alleging she had been hit on the face. The Administrator reported she went to Resident #1's room immediately to observe her and ask questions. The Administrator reported that because of Resident #1's impaired cognition, she kept questions to Resident #1 very basic and asked when it happened and if the person was angry. The Administrator reported Resident #1 said "pow-pow" and when asked to show the part touched, Resident #1 touched her face. The Administrator reported she assisted Resident #1 to roll on her right side towards the Administrator and during the turn, the Administrator's forearm aligned with Resident #1's jawline. The Administrator reported she asked Resident #1 if that is what happened and Resident #1 responded "yes." The Administrator explained she talked to the Representative of Resident #1, and he had said he didn't think what happened was abuse. The Administrator reported she did not think that Resident #1's allegation was valid due to her cognitive status. The Administrator explained that she did not feel that it was an allegation of abuse by Resident #1 and did not suspend NA #3 or complete a 24-hour report (initial allegation report).</p> <p>The Nurse Practitioner (NP) was interviewed on 1/15/26 at 4:13 PM. The NP reported he was not notified Resident #1 had made an allegation of abuse on 12/26/25. The NP reported due to Resident #1's severe</p>	F0607		

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