STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345269	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Salisbury	1505 Bringle Ferry Road Salisbury, NC 28146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). The findings included:Review of the facility Resident Abuse Policy with the last revision date of 7/11/2024 revealed the following: 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.Resident #1 was readmitted to the facility 1/7/25 with diagnoses including hemiplegia (paralysis on one side of the body), diabetes and dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] 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.Review of the medical record for Resident #1 revealed no notes regarding an allegation of abuse by Resident #1.Nursing notes dated 12/25/25 indicated Resident #1 was at her baseline and denied pain.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 (continued on next page)

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 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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to them that a male NA had hit her face. The statements documented notification of the Administrator of the allegation. 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.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 [NAME]-[NAME] while patting her left check with her left 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 [NAME]-[NAME]? Why he [NAME]-[NAME]? 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. 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.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.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 Unit Manager and Administrator.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 [NAME]. 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 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [NAME]-[NAME] 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).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 expressive aphasia, he was not certain if she was reliable due to her cognitive changes and he would have called an expert to examine her to determine what had happened.