

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 Bringle Ferry Road Salisbury, NC 28146	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>Based on record reviews, and residents and staff interviews, the facility failed to honor residents' preferences for a shower for 3 of 3 residents reviewed for choices (Resident #32, Resident #77, and Resident# 24.)</p> <p>The findings included:</p> <p>1a. Resident #32 was admitted to the facility on [DATE] with diagnoses including dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #32 to be moderately cognitively impaired. The MDS assessed Resident #32 to require substantial assistance with showering/bathing.</p> <p>The MDS documented Resident #32 said it was very important to choose between a shower and a sponge bath.</p> <p>Review of the facility shower schedule revealed Resident #32 (who resided on the 200 hall) was scheduled for a shower on Tuesday and Friday.</p> <p>The Activities of Daily Living log for Resident #32 was reviewed and it was noted on Friday 2/28/25 she did not receive a shower.</p> <p>Resident #32 was interviewed on 3/3/25 at 2:23 PM and she reported she did not get a shower on 2/28/25 and this was upsetting to her.</p> <p>A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on [DATE]. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #32. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #32 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #32 did not request a shower from her on 2/28/25.</p> <p>b. Resident #77 was admitted to the facility on [DATE] with diagnoses including asthma.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The annual MDS dated [DATE] documented Resident #77 said it was very important to choose between a shower and a sponge bath.</p> <p>The quarterly MDS dated [DATE] assessed Resident #77 to be moderately cognitively impaired and she required substantial assistance with showering/bathing.</p> <p>Review of the facility shower schedule revealed Resident #77 (who resided on the 200 hall) was scheduled for a shower on Tuesday and Friday.</p> <p>The Activities of Daily Living log for Resident #77 was reviewed and she did not receive a shower on 2/28/25.</p> <p>Resident #77 was interviewed on 3/5/25 at 10:25 AM and she reported she did not receive a shower on 2/28/25 and she wanted a shower. Resident #77 reported not receiving her shower was upsetting to her.</p> <p>A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on [DATE]. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #77. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #77 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #77 did not request a shower from her on 2/28/25.</p> <p>c. Resident #24 was admitted to the facility 5/12/23 with diagnoses including heart disease.</p> <p>The annual MDS assessment dated [DATE] documented the staff assessment of daily and activity preferences that Resident #24 preferred to receive a shower or a bed bath.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 was cognitively intact and she required moderate assistance with showering/bathing.</p> <p>Review of the shower schedule for Resident #24 (who resided on the 200 hall) revealed she was scheduled for a shower on Tuesday and Friday.</p> <p>The Activities of Daily Living log for Resident #24 was reviewed and she did not receive a shower on 2/28/25.</p> <p>Resident #24 was interviewed on 3/5/25 at 10:28 AM. Resident 24 reported she did not receive a shower on 2/28/25 and she wanted a shower. Resident #24 reported she thought she would be offered a shower later on that date, but no one offered her a shower, and this was upsetting to her.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was conducted with Nursing Assistant (NA) #3 on 3/6/25 at 8:49 AM. NA #3 reported she was an agency NA, and she was first assigned to the facility on [DATE]. NA #3 reported she was assigned to another hall at the start of the shift at 7:00 AM but soon after, she was moved to the 200 hall and was assigned to provide care to Resident #24. NA #3 reported she had been told by other staff (uncertain of which staff member) that there were no showers for the hall, and she did not offer Resident #24 a shower on 2/28/25. NA #3 reported if she had been told the facility had a shower schedule, she would have checked it to see if any of her assigned residents had a shower scheduled on that date. NA #3 reported Resident #24 did not request a shower from her on 2/28/25.</p> <p>The Director of Nursing (DON) was interviewed on 3/6/25 at 9:37 AM. The DON reported NA #3 did not get accurate information from other staff members and Resident #32, Resident #77, and Resident #24 should have been offered a shower on 2/28/25. The DON reported she expected the bathing preferences of residents to be honored.</p> <p>The Administrator was interviewed on 3/6/25 at 2:01 PM and she reported she expected residents to receive showers on their scheduled days if they wanted a shower.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>Based on record review, and Responsible Party and staff interviews, the facility failed to make prompt efforts to resolve a grievance 1 of 3 residents reviewed for grievances (Resident #72).</p> <p>The findings included:</p> <p>The facility grievance policy dated 11/2016 and revised 8/2018 read, in part: Upon receipt of an oral, written or anonymous grievance . the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated; .the Grievance Committee/Grievance Official shall complete an investigation of the resident's grievance. This may include a review of the facility processes, programs, and policies, as well as interview with staff, residents and visitors, as indicated; Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: the date the grievance was received, the summary of the statement of the resident' grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action that was or will be taken, and if corrective action was taken a summary of the corrective action .the Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the grievance was resolved or will be resolved. A copy of the written grievance decision will be provided to the resident upon request.</p> <p>Resident #72 was admitted to the facility 6/29/22 with diagnoses including Parkinson's Disease.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #72 to be severely cognitively impaired.</p> <p>The Responsible Party provided an email dated 11/11/24 at 2:49 PM from the Responsible Party to Social Worker (SW) #1, read, I received a very concerning call last night that (Resident #72) has no Parkinson's medications to take because (the medications) could not be found. This is obviously a very, very big deal, and I need to know exactly how this happened and what is the solution. From my understanding, she may have already been out of medications for a couple of days before I was notified. Can you please let me know the full details surrounding this situation? Thank you.</p> <p>A grievance dated 11/11/24 filed on behalf of Resident #72 by the Responsible Party documented the Responsible Party reported his concern to SW #1 and indicated he had concerns about medication administration for Resident #72. The concern was assigned to the Director of Nursing (DON) on 11/11/24 and the DON documented on the grievance attempted to call (Responsible Party) time 3 to discuss medications and answer questions. At the bottom of the grievance form it was documented by the DON she had attempted to call the Responsible Party on 11/12/24 at 5:00 PM, 11/12/24 at 5:30 PM, and 11/13/24 at 11:30 AM. The resolution of the concern section of the grievance form had documentation that no the concern was not resolved because the Responsible Party was unable to be reached.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Responsible Party was interviewed by phone on 3/3/25 at 3:07 PM. The Responsible Party reported he had filed a grievance with the facility in November 2024 regarding his mother's medications and the facility had not contacted him regarding the grievance or a resolution. The Responsible Party explained that in addition to emailing SW #1, he had verbally expressed concerns to other staff members, including the floor nurse, and the care planner, and he had not received any resolution to those issues. The Responsible Party explained that he was very busy, and he wanted communication by email so that he was better able to respond to the facility. The Responsible Party explained he had emailed several administrative staff members with his concerns, but no one had reached out to him.</p> <p>SW #2 was interviewed on 3/6/25 at 1:25 PM. SW #2 reported she had been at the facility for 3 weeks and had not been handling the grievance process. SW #2 reported SW #1 had been at the facility when the Resident #72's Responsible Party filed the grievance.</p> <p>SW #1 was not available for interview.</p> <p>The DON was interviewed on 3/6/25 at 1:47 PM. The DON explained because SW #2 was new, she and the Administrator had taken over the Grievance Official responsibilities until SW #2 was ready to take on that responsibility. The DON reported she was told by SW #1 that Resident #72's Responsible Party had told SW #1 he would only accept email and not phone calls from the DON. The DON reported she attempted to contact the Responsible Party three times, and he did not return her calls, and she did not know what concerns he had regarding medication administration. The DON explained she was not aware the Responsible Party wanted email exchanges until after she attempted to call him, and she did not email the Responsible Party about his concerns. The DON reported she thought the Administrator was handling the grievance with Resident #72's Responsible Party and she did not reach out to him to get the details about his grievance filed on 11/11/24.</p> <p>The Administrator was interviewed on 3/6/25 at 2:01 PM and she reported Resident #72's Responsible Party was reporting his concerns to a former Nursing Assistant (NA) who no longer worked at the facility. The Administrator reported that when the NA left the facility, the Responsible Party had complaints that he was reporting to different staff, but when he put the grievance in writing, the DON was unable to contact him by phone to discuss the issues. The Administrator reported she did not feel that email was appropriate to discuss grievances, and the DON had not pursued the investigation because she had been unable to talk to the Responsible Party. The Administrator reported she had not attempted to call or email Resident #72's Responsible Party regarding the grievance he filed on 11/11/24.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on record review and staff interviews the facility failed to protect a resident's right to be free from staff to resident abuse. While Nurse Aide (NA) #6 and NA #7 were providing care for a cognitively impaired resident, the resident became agitated. NA #7 slapped the resident on the left upper thigh and NA #6 held the residents' hands during care while the resident was agitated and being combative. This deficient practice was found for 1 of 3 residents reviewed for abuse (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, major depressive disorder, dementia, contracture right knee, and contracture to left knee.</p> <p>Review of Resident #3's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #3 was severely cognitively impaired and required extensive assistance with two people assist for bed mobility and transfers. The MDS further revealed Resident #3 was not coded for any behaviors.</p> <p>Review of Resident #3's care plan revised on 02/13/25 revealed the resident was at risk of adjustment issues due to showing sign and symptoms of depression, anxiety, and psychosocial wellbeing issues. Resident #3 exhibited the following inappropriate behaviors, negative statements, and resistance of care. Resident #3 had the potential to be verbally aggressive, inappropriate, demonstrate physical behavior, wanders the facility, and depression. The goal was for Resident #3 to maintain comfort and dignity daily with calm relaxed manners, clean appearance, positive decision making, maintain psychosocial wellbeing, positive expressions, positive body language. Resident #3 would be monitored and met with appropriate interventions. Interventions included for Resident #3 was to always approach in a calm and relaxed manner, encourage activity distraction, encourage resident to express needs, explain all procedures and care before beginning to assist, monitor and report and mood changes to nurse, and observe and report to the nurse any behavior issues.</p> <p>Review of the initial facility reported incident dated 03/25/25 at 8:00 AM revealed it was reported that an employee stated that they helped another employee with providing incontinence care and during the process the employee slapped the resident with her hand. The accused employee was told to leave the facility and removed from the schedule until the investigation was completed. It further revealed skin assessment did not show any findings.</p> <p>Review of the investigation completed by the Administrator related to Resident #3's incident revealed the following:</p> <p>-Nurse Aide (NA) #6 written statement dated 03/02/25 read in part, around 1:00 AM she and NA #7 went to put Resident #3 in bed. Resident #3 was lying on her left side and NA #6 was on her right side. Resident #3 started to be aggressive and started to hit and cuss and called NA #7 the N Word. NA #7 stated she was proud of her skin. NA #6 and NA #7 continued care and Resident #3 hit NA #6 a few times and as NA #6 was getting the other side of the brief out Resident #3 hit NA #7 and NA #7 let the resident down on the bed and hit her thigh. NA #6 was trying to hold Resident #3's hands trying to prevent but she had let go of hands. NA #6 and NA #7 finished care and left the room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Nurse Aide (NA) #7 statement dated 03/02/25 read in part, on 03/02/25 NA #6 asked to assist to put Resident #3 in bed around 1:00 AM. NA #7 revealed taking off Resident #3's pants the resident began to hit, and NA #6 stated she is going to try to hit you. Resident #3 tried to hit NA #6 and NA #6 told the resident not to hit her. Resident #3 began to call NA #7 a ni**ger and monkey. NA #7 stated I swear to god I never touched that lady. NA #7 indicated NA #6 never voiced any concerns during care. NA #7 revealed she had tried to leave during care, but NA #6 had begged her to stay and help finish the resident. After care was provided NA #6 and NA #7 went immediately to the nurses' station discussing how Resident #3 had been combative and had called NA #7 names. NA #7 revealed she finished her charting at the nurses' station and passed out ice and did not go back to Resident #3's room. Around 5:00 AM Nurse #7 told NA #7 she had to leave the facility, and she left.</p> <p>- Nurse #7 written statement dated 03/02/25 read in part, Nurse #7 was not in the room of question. NA #6 reported NA #7 hit resident on her left upper thigh. Resident #3 was also combative.</p> <p>Review of NA #7's time sheet revealed she worked on 03/1/25 from 7:00 PM until 5:45 AM on 03/02/25.</p> <p>A phone interview conducted with NA #7 on 03/05/25 at 12:30 PM revealed NA #6 had asked her to assist with Resident #3 to complete incontinence care. NA #7 indicated she had cared for Resident #3 before, and the resident could be combative and resistive to care at time. NA#7 further revealed NA #6 and NA #7 began care and Resident #3 became combative and hit NA #6. NA #7 revealed NA #6 stated, You don't need to hit us were just trying to help you. NA #7 indicated she wanted to stop and walk away from assisting the resident, but NA#6 wanted to complete care due to Resident #3 having a bowel movement. NA #7 stated Resident #3 continued to call her a ni**ger and a monkey, and she replied that she was proud to be a nig**er. NA #7 revealed Resident #3 was combative while she cleaned her. NA #6 held Resident #3's hands for an estimated time of 5 minutes so that she could not hit the NAs during care. NA #7 revealed Resident #3 attempted to hit her but never made contact. NA #7 denied being aggressive or slapping Resident #3.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview conducted with NA #6 on 03/04/25 at 6:40 PM revealed on 03/02/25 she and NA #7 went into Resident #3's room to give incontinence care. NA #6 revealed she had cared for Resident #3 before and was sometimes combative and resistive to care. NA #6 indicated Resident #3 was not cognitively intact and was hard to understand. NA #6 revealed she and NA #7 had used a mechanical lift and got Resident #3 undressed with no issues. It was further revealed when Resident #3 was rolled on her right side she became combative and hit NA #6 in the arm. NA #6 stated she told Resident #3, we don't hit, and everything was okay. NA #6 revealed she and NA #7 continued care and rolled Resident #3 back to her back that Resident #3 was attempting to punch and grab at both NA's. NA #6 stated Resident #3 hit her in the arm again. NA #6 indicated Resident #3 started to grab at herself and she took Resident #3's hands and held them for 2-3 minutes while Resident #3 continued to be combative. NA #6 and NA #7 rolled Resident #3 onto her left hip as NA #6 continued to hold Resident #3's hands. NA #6 indicated Resident #3 fell loose from NA #6's grip and struck at NA #7 hitting her in the arm. NA #6 stated at this time NA #7 laid the residents' leg back down from cleaning her and slapped her on her right upper thigh with an open hand. NA #6 revealed she was in shock and did not say anything to NA #7. NA #6 indicated Resident #3's behavior remained combative throughout care and seemed agitated. NA #6 stated she had been educated to walk away if residents were combative but did not with Resident #3 due to wanting to ensure, she was clean from her bowel movement. NA #6 revealed she and NA #7 completed care on Resident #3 and she did not report until around 5:00 AM to Nurse #7 due to being busy on the floor with residents. NA #6 indicated NA #7 worked the rest of the shift with residents answering call lights.</p> <p>A phone interview conducted with Nurse #7 on 03/05/25 at 11:15 AM revealed on 03/02/25 around 5:00 AM NA #6 reported to her that Resident #3 was combative during care and had called NA #7 a ni**er, and hit the resident on her thigh. Nurse #7 further revealed NA #6 had stated the incident occurred between 1 and 1:30 AM. Nurse #7 stated she conducted a skin assessment on Resident #3 and found no new skin marks or issues. Nurse #7 indicated both NAs had been educated on walking away from residents if they are combative during care. Nurse #7 Indicated Resident #3 could sometimes be combative and resistive during care.</p> <p>An interview conducted with the Director of Nursing (DON) and the Administrator 03/05/25 at 12:00 PM revealed on 03/02/25 at 5:30 PM they were notified NA #6 had observed NA #7 hitting Resident #7 on the upper left thigh. The Administrator and DON were not aware NA #6 had restrained resident #3 during care by holding hands to prevent her from hitting the NA's. The DON further revealed she advised Nurse #7 to take NA #7 off the floor immediately sent her home. The DON revealed that NAs had cared for Resident #3 and the resident could be combative and resistive with care.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>43643</p> <p>Based on record review and staff interviews, the facility failed to follow and implement abuse policies in the area of identification, protection and reporting for 1 of 3 residents reviewed for abuse (Resident #3). While Resident # 3 was being abused, Nurse Aide (NA) #6 did not intervene, stop, or report NA #7 when she slapped Resident #3 on the thigh. Also, NA #7 did not intervene or report immediately NA #6 for restraining Resident #3's hands during care when NA #6 held onto Resident #3's hands with her hands. As a result, NA #6 and NA #7 worked the rest of their shift, putting other residents at risk for abuse.</p> <p>The findings included:</p> <p>Review of the facility policy and procedure titled North Carolina Resident Abuse Policy, with a revised date of 07/11/24, read in part 1.) Under Protect the Resident, If the resident is injured. If the resident is injured as a result of the alleged or suspected incident, the facility should take immediate action to treat the resident. Under part a.) Staff should report all incidents immediately to their direct supervisors. Addressed under part 2.) If a staff member is accused or suspected, 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. Under definitions it reads in part, restraints (physical or chemical) may only be used per MD order in compliance with regulations and guidelines.</p> <p>Review of the investigation completed by the Administrator related to Resident #3's incident revealed the following:</p> <p>-Nurse Aide (NA) #6 written statement dated 03/02/25 read in part, around 1:00 AM she and NA #7 went to put Resident #3 in bed. Resident #3 was lying on her left side and NA #6 was on her right side. Resident #3 started to be aggressive and started to hit and cuss and called NA #7 the N Word. NA #7 stated, She was proud of her skin. NA #6 and NA #7 continued care and Resident #3 hit NA #6 a few times and as NA #6 was getting the other side of the brief out during care Resident #3 hit NA #7 and NA #7 let the resident down on the bed and hit her thigh. NA #6 was trying to hold Resident #3's hands trying to prevent but she had let go of the residents' hands. NA #6 and NA #7 finished care and left the room.</p> <p>- Nurse Aide (NA) #7 statement dated 03/02/25 read in part, on 03/02/25 NA #6 asked to assist to put Resident #3 in bed around 1:00 AM. NA #7 revealed taking off Resident #3's pants the resident began to hit, and NA #6 stated She is going to try to hit you. Resident #3 tried to hit NA #6 and NA #6 told the resident not to hit her. Resident #3 began to call NA #7 a ni**ger and monkey. NA #7 stated I swear to god I never touched that lady. NA #7 indicated NA #6 never voiced any concerns during care. NA #7 revealed she had tried to leave during care, but NA #6 had begged her to stay and help finish the resident. After care was provided NA #6 and NA #7 went immediately to the nurses' station discussing how Resident #3 had been combative and had called NA #7 names. NA #7 revealed she finished her charting at the nurses' station and passed out ice and did not go back to Resident #3's room. Around 5:00 AM Nurse #7 told NA #7 she had to leave the facility, and she left.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Nurse #7 written statement dated 03/02/25 read in part, Nurse #7 was not in the room of question. NA #6 reported, NA #7 hit a resident on her left upper thigh. Resident #3 was also combative.</p> <p>Review of NA #7's timecard revealed she worked on 03/1/24 from 7:00 PM until 5:45 AM on 03/02/25.</p> <p>A phone interview conducted with NA #7 on 03/05/25 at 12:30 PM revealed NA #6 had asked her to assist with Resident #3 to complete incontinence care. NA #7 indicated she had cared for Resident #3 before, and the resident could be combative and resistive to care at times. NA#7 further revealed NA #6 and NA #7 began care and Resident #3 became combative and hit NA #6. NA #7 revealed NA #6 stated, You don't need to hit us were just trying to help you. NA #7 indicated she wanted to stop and walk away from assisting the resident, but NA#6 wanted to complete care due to Resident #3 having a bowel movement. NA #7 stated Resident #3 continued to call her a ni**ger and a monkey, and she replied to the resident She was proud to be a nig**er. NA #7 revealed Resident #3 was combative while she cleaned her. NA #7 explained NA #6 held Resident #3's hands for an estimated time of 5 minutes so that she could not hit the NAs during care. NA #7 revealed Resident #3 attempted to hit her but never made contact. NA #7 denied being aggressive or slapping Resident #3.</p> <p>Review of NA #6's timecard revealed she worked on 03/1/24 from 7:00 PM until 7:45 AM on 03/02/25.</p> <p>A phone interview conducted with NA #6 on 03/04/25 at 6:40 PM revealed on 03/02/25 she and NA #7 went into Resident #3's room to give incontinence care around 1:00 AM. NA #6 revealed she had cared for Resident #3 before, and the resident was sometimes combative and resistive to care. NA #6 indicated Resident #3 was not cognitively intact and was hard to understand. NA #6 revealed she and NA #7 had used a mechanical lift to put the resident into bed and then got Resident #3 undressed with no issues. It was further revealed when Resident #3 was rolled on her right side she became combative and hit NA #6 in the arm. NA #6 stated she told Resident #3, We don't hit, and everything was okay. NA #6 revealed she and NA #7 continued care and rolled Resident #3 back to her back that Resident #3 was attempting to punch and grab at both NA's. #6 stated resident #3 hit her in the arm again. NA #6 indicated Resident #3 started to grab at her own thighs and she took Resident #3's hands and held them for 2-3 minutes while Resident #3 continued to be combative. NA #6 and NA #7 rolled Resident #3 onto her left hip as NA #6 continued to hold Resident #3's hands. NA #6 indicated Resident #3 freed herself loose from NA #6's grip and struck at NA #7 hitting her in the arm. NA #6 stated at this time NA #7 laid the resident's leg back down from cleaning her and slapped her on her right upper thigh with an open hand. NA #6 revealed she was in shock and did not intervene. NA #6 indicated Resident #3's behavior remained combative throughout care and the resident seemed agitated. NA #6 stated she had been educated to walk away if residents were combative but did not with Resident #3 due to wanting to ensure, she was clean from her bowel movement. NA #6 revealed she and NA #7 completed care on Resident #3, and she did not report NA #7 had slapped Resident #3 on the thigh until around 5:00 AM to Nurse #7 due to being busy on the floor with residents. NA #6 indicated NA #7 worked the rest of the shift with residents and answering call lights.</p> <p>A phone interview conducted with Nurse #7 on 05/05/25 at 11:15 AM revealed on 03/02/25 around 5:00 AM NA #6 reported to her that Resident #3 was combative during care and had called NA #7 a ni**er, and NA #7 hit the resident on the resident's thigh. Nurse #7 further revealed NA #6 had stated the incident occurred between 1:00 AM and 1:30 AM. Nurse #7 indicated she educated NA #6 that she should have reported the incident immediately and not later in the shift. Nurse #7 revealed she immediately removed NA #7 from the floor around 5:00 AM once when NA #6 reported the incident.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with the Director of Nursing (DON) and the Administrator on 03/05/25 at 12:00 PM revealed on 03/02/25 at 5:30 AM they were notified NA #6 had observed NA #7 hitting Resident #7 on the upper left thigh. The DON further revealed she advised Nurse #7 to take NA #7 off the floor immediately and send her home. The DON indicated NA #6 and NA #7 had been educated on reporting abuse and walking away from residents who were combative during care. The DON revealed NA #6 and NA #7 should have walked away from Resident #3 when she was combative, NA #7 should have intervened and reported immediately when NA #6 restrained Resident #3's hands during care and NA #6 should have intervened and reported immediately when NA #7 slapped Resident #3.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>Based on record review, observations, and staff interviews, the facility failed to store an enteral feeding syringe with the plunger separated from the syringe for 2 of 4 residents (Resident #44 and Resident #65) reviewed for enteral feeding management. This practice had the potential for bacterial growth and contamination.</p> <p>Findings included:</p> <p>a. Resident #44 was admitted to the facility on [DATE] with diagnoses of diabetes and difficulty swallowing.</p> <p>A significant change Minimum Data Set assessment dated [DATE] indicated Resident #44 received 51% of more of her total calories from enteral feedings and 501 milliliter of fluids per day by enteral feedings.</p> <p>On 3/3/2025 an observation was made of Resident #44's a plastic enteral feeding flush syringe, stored in a plastic bag and hanging from the feeding tube pump pole, with the plunger in the syringe with thick white liquid in the tip of the syringe.</p> <p>During an observation on 3/4/2025 at 2:00 pm Resident #44's enteral feeding flush syringe was stored in a plastic bag with the plunger in the syringe, hanging from the feeding tube pump pole.</p> <p>An interview was conducted with Nurse #1 on 3/4/2025 at 2:13 pm and she stated Resident #44 was administered medication and flushes through her enteral feeding tube at 7:30 am. Nurse #1 stated she did not know that the plastic syringe should be stored separately from the plunger to allow the syringe to dry to prevent bacterial growth.</p> <p>b. Resident #65 was admitted to the facility on [DATE] with diagnoses of dementia and difficulty swallowing.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #65 received 51 % or more of her total calories from enteral feedings and 501 milliliters of fluids daily by enteral feedings.</p> <p>Resident #65's enteral feeding flush plastic syringe was observed on 3/3/2025 at 12:04 pm, with the syringe stored in a plastic bag on hanging from the tube feeding pump pole, and plunger was stored inside the syringe with a white liquid in the end of the syringe. Nurse #2 had taken the plastic syringe from the plastic bag and was going to administer Resident #65's flush and was stopped and she stated she was not aware the plunger should not be stored in the syringe. Nurse #2 replaced the plastic syringe and administered the flush.</p> <p>An interview was conducted with the Director of Nursing on 3/6/2025 at 2:56 pm and she stated the enteral feeding plastic syringe should be washed and the plunger left out of the syringe to allow it to air dry to prevent any bacterial growth in the syringe.</p> <p>(continued on next page)</p>		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 3/6/2025 at 3:17 pm she stated Nurse #1 and Nurse #2 should have washed the plastic syringe and plunger separately to allow them to dry completely to prevent any bacterial growth.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>Based on record review, observations, and staff interviews, the facility failed to provide clean air intake filters on oxygen concentrators for 2 of 4 residents (Resident #34 and Resident #44) reviewed for respiratory care.</p> <p>Findings included:</p> <p>a. Resident #34 was admitted to the facility on [DATE] with respiratory disease.</p> <p>Review of Resident #34's medical record revealed a Physician's Order written on 11/8/2024 which indicated Resident #34 required oxygen at 2 to 4 liters per minute by nasal canula to keep her oxygen saturation above 90%.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #34 was cognitively intact and received oxygen therapy.</p> <p>During an observation of Resident #34 on 3/5/2025 at 6:39 am she was noted in bed with her nasal canula on and her oxygen concentrator machine was set at 2.5 liters per minute. The oxygen concentrator had a film of black dust approximately 1/8 inch thick covering the air intake filter.</p> <p>On 3/6/2025 at 8:45 am Resident #34 was observed up in her wheelchair in her room. Her oxygen concentrator machine was set at 2.5 liters per minute and 1/8 inch of black dust continued to cover the air intake filter.</p> <p>During an interview and observation of Resident #34's oxygen concentrator with Nurse #1 on 3/6/2025 at 2:46 pm she stated she did not know who was responsible for cleaning the air intake filter on the oxygen concentrators. She stated she thought that either a nurse or nurse aide should be responsible, or housekeeping could also clean the concentrator.</p> <p>b. Resident #44 was admitted to the facility on [DATE] with diagnoses of dementia and respiratory disease.</p> <p>A Physician's Order dated 12/18/2024 indicated Resident #44 required oxygen at 2 liters per minute by nasal canula.</p> <p>A significant change Minimum Data Set assessment dated [DATE] indicated Resident #44's was moderately cognitively impaired and received oxygen therapy.</p> <p>On 3/3/2025 at 10:34 am an observation of Resident #44 revealed she was in bed with her oxygen on at 2 liters per minute by nasal cannula. Her oxygen concentrator machine was at her bedside and had a 1/8-inch film of black dust covering the air intake filter.</p> <p>An interview and observation of Resident #44's oxygen concentrator machine was conducted with Nurse #1 on 3/6/2025 at 2:27 pm and Nurse #1 stated the oxygen concentrator's air intake filter was covered with dust and she did not know who should clean them.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Housekeeping Supervisor on 3/6/2025 at 2:49 pm she stated nursing staff was responsible for cleaning the oxygen concentrator air intake filters.</p> <p>An interview was conducted with the Director of Nursing on 3/6/2026 at 2:54 pm and she stated the assigned nurse should clean the oxygen concentrators every Sunday night.</p> <p>On 3/6/2025 at 3:15 pm the Administrator was interviewed and stated the nursing staff should clean the oxygen concentrator machines and the air intake filter at least weekly.</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>Based on record review, and family member, Physician, and staff interviews, the facility failed to ensure a resident was transported to a scheduled neurologist appointment on 2/28/25 for 1 of 1 resident reviewed for medical related social services (Resident #72).</p> <p>The findings included:</p> <p>Resident #72 was admitted to the facility 6/29/22 with diagnoses including Parkinson's disease.</p> <p>Review of Resident #72's medical record revealed a neurologist progress note dated 11/25/24. The note made recommendations for physical therapy, speech therapy, and occupational therapy. The progress note did not mention a follow-up appointment.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #72 to be severely cognitively impaired.</p> <p>A care plan dated 7/8/24 and a revision date of 2/27/25 addressed Resident #72' Parkinson's disease and that family member prefers Resident to be seen by specialist and facility will provide transport as able. Interventions included monitoring for cognitive changes.</p> <p>Review of Resident #72's medical record did not reveal any documentation related to a neurologist appointment on 2/28/25.</p> <p>Resident #72's family member was interviewed by phone on 3/3/25 at 3:07 PM. The family member reported he takes Resident #72 to a neurologist about every 2 months for medication adjustments and recommendations for therapies to treat her disease progression. The family member explained he made an appointment for Resident #72 for 2/28/25 to see the neurologist and he notified the facility of the appointment in November 2024. The family member explained he received a phone call 2 days before the appointment on 2/26/25 when he was told the facility could not provide transportation to the appointment. The family member reported he met Resident #72 at the appointments, but he was unable to transport her to the appointments and relied on the facility to get her to the neurologist. The family member reported he rescheduled the neurologist appointment, but the only available time was in May 2025 and Resident #72 would have to go almost 6 months without seeing the neurologist and this was very upsetting to him.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Transporter was interviewed on 3/5/25 at 2:43 PM. The Transporter reported she was the only driver for the facility van, although the facility did have a contracted transportation company for some transportation. The Transporter explained that about one week before Resident #72's appointment with the neurologist, she realized that she would be unable to take Resident #72 to the appointment because it was approximately 48 miles from the facility to the neurologist and the Transporter had to be close to the facility for another appointment. The Transporter explained she called the contracted transportation company, but they did not have any openings for 2/28/25 to take Resident #72 to her neurologist appointment. The Transporter reported she called Resident #72's family member on 2/26/25 to notify him that the facility would not be able to transport Resident #72 to the neurologist. The Transporter reported the family member was very upset.</p> <p>The Physician was interviewed on 3/6/25 at 11:24 AM. The Physician reported the family member felt that Resident #72 needed to continue the neurologist appointments, but the neurologist had not changed the medications to treat her Parkinson's disease for a long time, and the missed appointment was unlikely to impact her care.</p> <p>The Director of Nursing (DON) was interviewed on 3/6/25 at 1:47 PM. The DON explained that when the Transporter realized she would be unable to take Resident #72 to her neurology appointment, the Transporter attempted to find alternative transportation. The DON reported the contracted transportation company was booked up on 2/28/25 and had been unable to take Resident #72 to the appointment. The DON reported the Transporter communicated this to the family member and the appointment was rescheduled for May 2025. The DON explained that since then, the Transporter has been bringing the transportation schedule for weekly review to identify any conflicts in the schedule, and the DON reported she expected those conflicts to be addressed by arranging transportation with the contracted company.</p> <p>The Administrator was interviewed on 3/6/25 at 2:01 PM. The Administrator reported she discussed the missed appointment with the facility Physician, and he said that the missed appointment had not impacted Resident #72's care. The Administrator reported a transportation conflict prevented the facility from transporting Resident #72 to the appointment and she expected alternative transportation to be arranged if possible for future appointments.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>Based on record review and staff, Physician's Assistant interviews, the facility failed to ensure 1 of 4 residents (Resident #72) reviewed for medication administration was provided medication from the pharmacy as ordered by the physician.</p> <p>Findings included:</p> <p>Resident #72 was admitted to the facility on [DATE] with Parkinson's disease a neurocognitive disorder with dementia.</p> <p>A Physician's Order dated 9/11/2024 indicated Resident #72 was prescribed Carbidopa-Levodopa (medication used to manage the symptoms of Parkinson's disease) 25-100 milligrams 2.5 tablets should be given four times a day.</p> <p>A Nurse's Progress Note dated 11/10/2024 at 7:28 pm indicated Nurse #7 discovered there was no Carbidopa-Levodopa 25-100 milligrams for Resident #72, and the correct dose was not available from the facility's electronic emergency medication system. The Progress Note further stated Nurse #7 notified the Director of Nursing and the pharmacy the medication needed to be sent to the facility. Nurse #7's Progress Note further stated she was told by the pharmacy that Resident #72's medication would not be sent to the facility until 11/17/2024 and she called the Physician's Assistant and was told the Carbidopa-Levodopa was an essential medication and to call the pharmacy back. Nurse #7 called the pharmacy again and was told they spoke with the Director of Nursing and a Refill Too Soon form was faxed to the facility and once the form was received by the pharmacy the medication would be sent.</p> <p>During the survey attempts were made to reach Nurse #7 who cared for Resident #72 on 11/10/2024 without success.</p> <p>The Medication Administration Record (MAR) for 11/10/2024 indicated Resident #72's Carbidopa-Levodopa was not available to be administered because it was not available. Nurse #7 had documented on the MAR that the 11/10/2024 the 12:00 pm and 4:00 pm doses were not administered, and the Physician's Assistant was notified but no hold order was given for the medication, and the facility was working to resolve the issue.</p> <p>On 11/11/2024 at 10:49 pm a Nurse's Progress Note written by Nurse #6 indicated Resident #72's Carbidopa-Levodopa was held because Nurse #6 was waiting on it to be delivered by the pharmacy and the provider gave an order for the medication to be held. The Progress Note also stated the Physician and Responsible Party were aware.</p> <p>Nurse #6 documented on the MAR on 11/11/2024 the 8:00 am and 12:00 pm doses of Resident #72's Carbidopa-Levodopa were not available and was on hold.</p> <p>No Physician's Order was found for Resident #72's Carbidopa-Levodopa to be held on 11/11/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/20/2024 at 5:39 pm Nurse #6's Progress Note stated Resident #72 did not have a scheduled dose of Carbidopa-Levodopa and the Physician gave an order to hold the medication until it was delivered at midnight from the pharmacy.</p> <p>During a review of the MAR for 11/20/2024 the following doses were documented as not administered by Nurse #6: 11/20/2024 at 12:00 pm, and 11/20/2024 at 4:00 pm. The MAR for 11/20/2024 indicated Resident #72's Carbidopa-Levodopa was on hold.</p> <p>No Physician's Order was found for Resident #72's Carbidopa-Levodopa to be held on 11/20/2024.</p> <p>Nurse #6 was interviewed by phone on 3/6/2025 at 11:52 am and she stated she cared for Resident #72 frequently during November 2024 and remembered there was an issue with getting her Carbidopa-Levodopa from the pharmacy. Nurse #6 stated Resident #72's Carbidopa-Levodopa dose was not available from the electronic emergency medication system, and she reported to the Nurse Practitioner that the medication was not available and got an order to hold the medication. Nurse #6 stated she could not remember the date the medication was not available, but she would have written a nurse note and documented the order to hold Resident #72's medication.</p> <p>During an interview with the Physician's Assistant on 3/6/2025 at 11:18 am she stated Resident #72 had diagnoses of Parkinson's disease with Lewy body dementia and required the physician's ordered Carbidopa-Levodopa. The Physician's Assistant stated she does not remember the staff notifying her Resident #72's Carbidopa-Levodopa was not available or giving an order to hold the medication.</p> <p>During an interview with the Director of Nursing on 3/6/2025 at 2:59 pm she stated she did not recall anyone reporting Resident #72 did not have Carbidopa-Levodopa available for administration. The Director of Nursing stated Nurse #6 and Nurse #7 should have checked the electronic emergency medications and called the pharmacy to ensure Resident #72's medication was sent as soon as possible, and they should have notified the provider.</p> <p>The Administrator was interviewed on 3/6/2025 at 3:15 pm and stated she expected the nursing staff to ensure Resident #72 received her medication from the pharmacy and administered according to the physician's orders.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Autumn Care of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 Bringle Ferry Road Salisbury, NC 28146	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>Based on record review, and staff, Physician's Assistant and Physician interviews, the facility failed to ensure 1 of 4 residents (Resident #72) reviewed for medication administration was free of significant medication errors. Resident #72 was not administered six doses of Carbidopa-Levodopa (a drug that treats Parkinson's disease, a central nervous system disease) 25-100 milligrams 2 1/2 tablets which was ordered four times a day.</p> <p>Findings included:</p> <p>Resident #72 was admitted to the facility on [DATE] with Parkinson's disease a neurocognitive disorder with dementia.</p> <p>A Physician's Order dated 9/11/2024 indicated Resident #72 Carbidopa-Levodopa 25-100 milligrams 2.5 tablets should be given four times a day.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #72 was severely cognitively impaired.</p> <p>A Nurse's Progress Note dated 11/10/2024 at 7:28 pm indicated Nurse #7 discovered there was no Carbidopa-Levodopa 25-100 milligrams for Resident #72, and the correct dose was not available from the facility's electronic emergency medication system. The Progress Note further stated Nurse #7 notified the Director of Nursing and the pharmacy the medication needed to be sent to the facility. Nurse #7's Progress Note indicated she was told by the pharmacy that Resident #72's medication would not be sent to the facility until 11/17/2024 and she called the Physician's Assistant and was told the Carbidopa-Levodopa was an essential medication and to call the pharmacy back. Nurse #7 called the pharmacy again and was told they spoke with the Director of Nursing and a Refill Too Soon form was faxed to the facility and once the form was received by the pharmacy the medication would be sent.</p> <p>Nurse #7 documented on the Medication Administration Record (MAR) on 11/10/2024 at 12:00 pm and 11/10/2024 at 4:00 pm that Resident #72's Carbidopa-Levodopa was not available. The MAR also indicated the dose was not available on 11/10/2024 at 12:00 pm and The Physician's Assistant was notified, and no hold order was given, and the facility was working to resolve the issue. Nurse #7 also documented on the MAR the dose due at 11/10/2024 at 4:00 pm was not administered because it was not available, and the Physician's Assistant and Director of Nursing were notified and the facility continued to work on the issue.</p> <p>During the survey attempts were made to reach Nurse #7 who cared for Resident #72 on 11/10/2024 without success.</p> <p>On 11/11/2024 at 10:49 pm a Nurse's Progress Note written by Nurse #6 indicated Resident #72's Carbidopa-Levodopa was held because Nurse #6 was waiting on it to be delivered by the pharmacy and the provider gave an order for the medication to be held. The Progress Note also stated the Physician and Responsible Party were aware.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #72's MAR for 11/11/2024 revealed the following doses of Carbidopa-Levodopa were documented as not administered because the drug was unavailable and was on hold by Nurse #6: 11/11/2024 at 8:00 am, 11/11/2024 at 12:00 pm.</p> <p>An order to hold the Carbidopa-Levodopa on 11/11/2024 at 8:00 am and 12:00 pm was not indicated on Resident #72's Physician's Orders.</p> <p>The Responsible Party provided a copy of an email sent to Social Worker #2 on 11/11/2024 at 2:49 pm which stated he was concerned when he got a call from the facility stating Resident #72 did not have her medication (Carbidopa-Levodopa) and was told she had not had her medication for a couple of days. The Responsible Party's email stated he asked for full details regarding Resident #72 not receiving her medication.</p> <p>During the survey attempts were made to contact Social Worker #2, who no longer worked at the facility, without success.</p> <p>On 11/20/2024 at 5:39 pm Nurse #6's Progress Note stated Resident #72 did not have a scheduled dose of Carbidopa-Levodopa and the Physician gave an order to hold the medication until it was delivered at midnight from the pharmacy. The Progress Note further stated the Responsible Party was made aware the medication would be held.</p> <p>Review of the Medication Administration Record for 11/20/2024 the following doses of Resident #72's Carbidopa-Levodopa were documented as not administered and on hold by Nurse #6: 11/20/2024 at 12:00 pm and 11/20/2024 at 4:00 pm.</p> <p>A Physician's Order was not found to hold Resident #72's Carbidopa-Levodopa.</p> <p>Nurse #6 was interviewed by phone on 3/6/2024 at 11:52 am and stated she cared for Resident #72 frequently during November 2024 and remembered there was an issue with getting her Carbidopa-Levodopa but was not sure about the exact dates of when the medication was not available or when she notified the Physician's Assistant the medication was not available and received a hold order for the medication. Nurse #6 stated she would have documented in a nurse's note on both 11/11/2024 and 11/20/2024 if she documented the medication was not available.</p> <p>During an interview with the Physician's Assistant on 3/6/2025 at 11:18 am she stated Resident #72 had diagnoses of Parkinson's disease with Lewy body dementia and required the physician ordered Carbidopa-Levodopa. The Physician's Assistant stated she did not remember being notified of Resident #72's Carbidopa-Levodopa not being available. The Physician's Assistant stated the missed doses of Carbidopa-Levodopa could have caused problems with Resident #72's mobility, breathing, and swallowing and the dosing and administration of the medication for her Parkinson's disease would have been critical. The Physician's Assistant stated Resident #72 did not have any issues related to the missed doses in November 2024.</p> <p>An interview was conducted with the Physician on 3/6/2025 at 12:30 pm and he stated that although Resident #72's doses of Carbidopa-Levodopa were missed during November 2024 it did not cause her any harm but could have potentially affected her mobility, swallowing and breathing.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing on 3/6/2025 at 2:59 pm she stated she did not recall anyone reporting Resident #72 did not have Carbidopa-Levodopa available for administration. The Director of Nursing stated Nurse #6 and Nurse #7 should have checked the electronic emergency medications and called the pharmacy to ensure Resident #72's medication was sent as soon as possible, and they should have notified the provider.</p> <p>The Administrator was interviewed on 3/6/2025 at 3:15 pm and stated she expected the nursing staff to ensure Resident #72 received her medication as ordered by the physician.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on observation and staff interviews, the facility failed to label and date leftover food items, remove food items with signs of spoilage and not store staff food in 1 of 2 nourishment room refrigerators (the 600 Hall nourishment room); and failed to remove expired food stored for use in 1 of 1 walk-in coolers. These practices had the potential to affect food served to residents.</p> <p>Findings included:</p> <p>1. An observation and interview on the 600 hall nourishment room refrigerator conducted with Nurse Aide (NA) #4 and NA #5 on [DATE] at 10:45 AM revealed a bag of croutons not labeled or dated, a quart size sealed plastic bag with strawberries and blueberries that were observed to have discoloration and with fuzzy white substance, a microwavable dinner tray not labeled or dated of meat and broccoli observed to have discoloration and fuzzy substance on the food, a unlabeled and undated plastic container with white substance that resembled mold, and NA #4's lunch bag. NA #4 revealed she put her lunch in the fridge but was aware that it should not be in there. NA #4 and NA #5 nursing staff and dietary were responsible for checking the nourishment rooms daily and ensuring items are labeled, dated and discarded.</p> <p>2. An observation and interview in the kitchen on [DATE] at 11:35 AM revealed a container of leftover cream of mushroom soup that had a discard date of [DATE] in the walk-in cooler. The Dietary Manager further revealed the soup should have already been discarded and must have been missed when items were checked.</p> <p>A follow up interview conducted with the Dietary Manager on [DATE] at 8:15 AM revealed Dietary Aide #1 oversaw checking nourishment rooms over the weekend. The Dietary Manager further revealed she did not know why the nourishment room on the 600 hall was not checked but expected nourishment rooms and kitchen items to be checked daily for labeling and dating leftover food items.</p> <p>Dietary aide #1 was unable to be interviewed during the survey.</p> <p>An interview conducted with the Administrator on [DATE] at 11:20 AM revealed he expected nourishment rooms to be checked daily and foods be stored and labeled correctly.</p>		