STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495196		C 07/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF ALTAVISTA	1317 LOLA AVE ALTAVISTA, VA 24517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 07/25/2017. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 111 certified bed facility was 101 at the time of the survey. The survey sample consisted of five (05) current Resident reviews (Residents #1 through #5).	F 000		
F 221 SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221		7/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/02/2017

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.

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F 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to ensure one of five residents in the survey sample was free from physical restraints, Resident #1. Facility staff failed to ensure Resident #1 was free from the use of physical restraints. Resident #1 was found with her right arm tied to the arm of her wheelchair (w/c) with a geri-sleeve on 07/18/17. Findings included: Resident #1 was admitted to the facility on 09/29/14 with diagnoses including, but not limited to: Depression, Anxiety, Alzheimer's Disease, Dementia without Behaviors, Diabetes, Hypertension and Coronary Artery Disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/09/2017. Resident #1 was assessed as severely impaired in her short and long term memory and daily decision making skills.	F 221	F221 Facility will conduct %100 audit of all residents to ensure NO resident has restraints on inappropriately. DOC 7/18/17 Unit manager or designee will round every two hours to ensure no resident is restrained. Administrator/DON will continue to make rounds on all shifts. On-going Facility will re-educate all staff on abuse, restraints, and mandatory reporting guidelines. Staff members will be re-educated prior to being allowed to return to work. DOC 7/26/18 The facility will continue to monitor all residents in facility through rounding. On-going All corrective action will be completed by 7/26/17.	

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F 221	Continued From page 2 Resident #1's electronic medical record (EMR) was reviewed on 07/25/17 at 12:45 p.m. During this review a "Head to Toe Evaluation" with an attached "Progress Note" dated 07/18/17 was noted with the following documentation: "[Resident #1] found sitting in wheelchair with her right arm tied to armrest of her wheelchair with a geri-sleeve. Her right arm was tied under the armrest." Subsequent review of the facility investigation included the following documentation. A facility reported incident (FRI) from the ADON (assistant director of nursing) included: "Approximately 3:45pm, CNA [certified nursing assistant] [Name] went into resident's room. Found sitting in w/c with right arm tied to w/c armrest with a geri-sleeve that was tied in a tight knot. Resident also had a geri-sleeve on right arm as ordered. Arm was up under armrest. A witness statement dated 7-18, written by CNA #1 included the following: "Tuesday evening when I arrived at work at 2, I started passing my pads & [and] towels out to residents. Then around 2:30 I went in [Resident #1's] room to take care of her roommate... [Resident #1] was asleep at the time but I didn't notice her arm was tied to her wheelchair with a geri sleeve. When I finished with [Name of roommate] I went to answer a call light, afterwards I went back to [Resident #1] room at 3:00 with the sit to stand [lift] to change her. First I took off her brace on her left arm, then I noticed her right arm was tied to her wheelchair on the outside with a geri sleeve. Next I went to the nurses station to tell a nurse, how I had found [Resident #1] arm tied to her chair & she & another nurse went to her room to look at it..." (sic)	F 221		

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F 221	Continued From page 3 A witness statement dated 7-18-17, written by LPN #1 (licensed practical nurse) included the following: "I was called to room [room number] by charge nurse & ADON. Resident was up to w/c, right arm was tied to armrest of w/c with a geri-sleeve that was double-knotted. Resident's hand was holding side panel of w/c and arm was under armrest. I checked tension on the geri-sleeve used to tie arm down, and there was not enough "give" to allow resident to move her arm..." Three other witness statements were obtained from CNA's working on the hallway where Resident #1 was located. All three statements included documentation that Resident #1 was never witnessed tied to her wheelchair with a geri-sleeve. The final investigative report dated 7/21/17, signed by the Administrator included the following: "On 7/18/17 [Resident #1] was found in her room in her wheelchair with her right arm tied to wheelchair arm rest with a Geri-sleeve. CNA who discovered [Resident #1] reported findings to the LPN on duty. Additional LPN, ADON and social worker were all called to the room to assess the situation. Geri-sleeve was removed, skin assessed, no injuries were noted, no adverse reactions were noted as resident is not cognitively intact. Responsible party, physician, APS [adult protective services], DHP [department of health professions], and law enforcement were all notified on 7/18/17. Investigation was begun on 7/18/17 by ADON, Social Worker, and staff development LPN. Continued investigation on 7/19/17 was	F 221		

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F 221	Continued From page 4 conducted by Administrator and DON [director of nursing]. Staff working with Resident involved on 7/18/17 were interviewed and statements were given. Upon completing all interviews and investigations, at present, we cannot pinpoint a certain individual to be at fault in this incident..." During a meeting with the Administrator, DON, and Regional Nurse on 7/25/17 at 3:00 p.m., this surveyor was shown documentation where immediate facility staff inservicing regarding abuse/neglect and mandatory reporting was started on 7/18/17. The DON stated, "This inservicing will be completed on 7/26/17 for all facility staff." The Regional Nurse stated, "No employee has worked any shift without first receiving this mandatory inservice." No further information was received prior to the exit conference on 7/25/17 at 3:45 p.m.	F 221		