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		07/12/2018

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
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 7/10/18 through 7/12/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/10/18 through 7/12/18. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 111 certified bed facility was 104 at the time of the survey. The survey sample consisted of 21 current Resident reviews and three closed record reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care regarding medication administration for one of 24 residents in the survey sample. Three doses of the opioid pain medication Lortab	F 658	1. Resident #22 EMAR checked. No other dose of Lortab documented as given when supply not available. 2. Residents receiving controlled medication are at risk for this issue. An orders audit was performed to identify those residents.	8/1/18

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

Electronically Signed — 07/26/2018

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.

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		07/12/2018

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 658	Continued From page 1 were recorded as given to Resident #22 when the medication was not available and not actually administered to the resident. The findings include: Resident #22 was admitted to the facility on 5/16/07 with diagnoses that included anemia, blindness due to macular degeneration, depression, anxiety, chronic pain, high blood pressure, osteoarthritis and dementia. The minimum data set (MDS) dated 4/19/18 assessed Resident #22 with severely impaired cognitive skills. Resident #22's clinical record documented a physician's order dated 5/21/18 for the medication Lortab 5-325 milligrams (mg) to be administered three times per day for pain management. The resident's medication administration record (MAR) listed the Lortab was scheduled each day at 8:00 a.m., 1:00 p.m. and 8:00 p.m. Resident #22's MAR for July 2018 documented the Lortab was given as ordered until 7/9/18. The MAR documented Lortab was not given on 7/9/18 at 8:00 a.m. and 1:00 p.m. because the medication was "not available." A dose was marked as given on 7/9/18 at 8:00 p.m. The MAR documented on 7/10/18, the 8:00 a.m. and 1:00 p.m. doses of Lortab were not available for administration. The narcotic count sheets for Resident #22's Lortab supply documented the last dose was removed from the locked storage on 7/8/18 at 8:00 a.m. There was no other Lortab available or signed out of the narcotic box for Resident #22 until 7/10/18 at 9:00 p.m. Resident #22's MAR	F 658	3. Licensed nursing staff have been reeducated concerning the appropriate process for documentation requirements for medication administration. Each nurse has been observed during med pass to validate competency with the process. 4. The Director of Nursing/designee will observe med pass ongoing to validate effectiveness of reeducation. These observation will be documented for 1 nurse a day for 7 days, then one per week for 11 weeks. The nurses observed will be on varying shifts. The Director of Nursing or designee will report results of monitoring at monthly QAPI meeting for review and recommendation for the duration of the monitoring period.	

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		07/12/2018

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 658	Continued From page 2 documented the resident was given a dose of Lortab on 7/8/18 at 1:00 p.m. and 8:00 p.m. and on 7/9/18 at 8:00 p.m. when the count sheets indicated no Lortab was available. On 7/12/18 at 8:07 a.m., the licensed practical nurse (LPN #4) caring for Resident #22 was interviewed about how the Lortab was given if not available. LPN #4 stated the pharmacy did not process the refill order for the Lortab because the physician did not complete the script properly. On 7/12/18 at 8:10 a.m., accompanied by LPN #4 and LPN #3, the emergency medication supply was inspected. LPN #4 stated no Lortab had been removed from the emergency box on 7/8//18 or 7/9/18 for Resident #22. LPN #4 reviewed the narcotic count sheets and stated the last supply of Lortab was signed out on 7/8/18 at 8:30 a.m. LPN #4 stated the next dose of Lortab for Resident #22 was not signed out until 7/10/18 at 9:00 p.m. after a new supply arrived. LPN #4 stated she did not know why the doses were marked as given when the medication was not available. On 7/12/18 at 9:50 a.m., LPN #5 that marked the Lortab dose on 7/8/18 at 1:00 p.m. as given was interviewed. LPN #5 stated she did not actually give the 1:00 p.m. dose of Lortab on 7/8/18 because it was not available. LPN #5 stated she meant to go back and "cross out" the dose on the MAR but she forgot. These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 7/12/18 at 12:45 p.m. The DON stated at this time the three doses of Lortab were signed off on the MAR but not actually given to the resident.	F 658		

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		07/12/2018

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 658	Continued From page 3 The facility's policy titled General Dose Preparation and Medication Administration (revised 1/1/13) stated on page 3, "Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused...) on appropriate forms..." The Lippincott Manual of Nursing Practice 10th edition on page 16 states regarding professional standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to...follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered..." (1) The Nursing 2017 Drug Handbook on page 1603 states concerning patient safety during drug therapy, "...Applying the nurse process (assessment, nursing diagnosis, planning, intervention, and evaluation) during drug therapy enables the nurse to systematically identify the drug therapy needs of each patient, thereby reducing the number of adverse events and providing safe patient care..." Nursing steps listed for safe drug therapy included, "... Document medication administration..." (2) The Nursing 2017 Drug Handbook on page 726 describes Lortab (hydrocodone/acetaminophen) as a schedule II opioid analgesic used for the management of moderate to moderately severe pain. (2)	F 658		

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		07/12/2018

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 658	Continued From page 4 (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. (2) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to implement interventions for the prevention of pressure ulcers for two of 24 residents in the survey sample. Residents #203 and #80 did not have protective booties in use or heels floated as required in their plan of care. The findings include: 1. Resident #203 was admitted to the facility on	F 686	1. Resident #203. Boots were placed on residents' bilateral feet. Resident #80 boot to right foot placed on. Heel elevator in place when in bed. Residents with interventions for protective equipment in their care plan are at risk. 2. An audit will be performed to identify which residents have interventions for prevention of pressure ulcers in their care plan and resident care guide and verify that they are in place.	8/1/18

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		07/12/2018

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 686	Continued From page 5 6/28/18 with diagnoses that included aneurysm, aphasia, dysphagia, diabetes, high blood pressure, bipolar disorder and urinary tract infection. The minimum data set (MDS) dated 7/5/18 assessed Resident #203 with short and long-term memory problems and severely impaired cognitive skills. On 7/11/18 at 11:00 a.m., Resident #203 was observed in bed. The resident had no booties in place on her feet. The resident was moving her feet back and forth on the bed with her heels rubbing against the sheets. The resident's feet were bare with no socks or any type of protection. Resident #203 was observed again on 7/11/18 at 11:21 a.m. moving her feet around in bed without booties on her feet. Resident #203's clinical record documented a physician's order dated 6/29/18 for, "Blue boots to bilateral feet" every shift and to "Elevate heels when in bed..." The resident's plan of care (revised 7/4/18) listed the resident was at risk of skin breakdown. Interventions to maintain skin integrity included blue boots to both feet and heel elevation when in bed. On 7/11/18 at 11:24 a.m., accompanied by certified nurse's aide (CNA) #1, Resident #203 was observed in bed with her heels directly on the bed covers and without protective booties. CNA #1 was interviewed at this time about protection for the resident's feet. CNA #1 stated the resident was supposed to have booties on when in bed. CNA #1 stated the resident moved her feet/legs about frequently and sometimes kicked	F 686	3. There is a care guide for each resident available to nursing staff listing the individual interventions for each resident. The interdisciplinary team will ensure when the care plan is updated with interventions that the care guide is also updated. This will occur during the daily clinical meeting. 4. The Director of Nursing/designee will make rounds to ensure that the interventions are in place for each resident as care planned. Monitoring will occur daily for 7 days and then 1 time per week for 11 weeks. 5. The Director of Nursing/designee will report results of monitoring at quarterly QAPI meeting for review and recommendations for the duration of the monitoring period.	

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		07/12/2018

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 686	Continued From page 6 the booties off. CNA #1 searched for the booties and located them in the resident's closet. CNA #1 stated the booties were on the resident earlier in the morning. CNA #1 stated she did not know how the booties got in the closet or why they were not in place. These findings were reviewed with the administrator and director of nursing during a meeting on 7/11/18 at 4:15 p.m. 2. Resident # 80 was admitted to the facility 1/23/18 with diagnoses to include, but not limited to high blood pressure, dementia, and GERD. The most recent MDS (minimum data set) was a quarterly review dated 7/3/18 and had Resident # 80 coded with severe impairment in cognition with a total summary score of 06 out of 15. On 7/10/18 beginning at 11:15 during initial tour of the facility Resident # 80 was observed in bed with bare feet, and was sliding his feet up and down on the bed surface. There were fall mats observed to each side of the bed. The clinical record was reviewed 7/11/18 at 10:00 a.m. The current POS (physician order summary) for July 2018 included orders carried forward from 5/28/18 for "Blue boot to right foot when in bed every shift for skin integrity...Heels elevated when in bed." On 7/11/18 at 3:00 p.m., Resident # 80 was observed in bed. The blue booties were in a chair across the room. Resident # 80's feet were bare, and he was continually sliding his feet up and down on the bed surface. The resident's heels were not floated. The resident was asked if the boots were supposed to be on. He stated "I think	F 686		

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		07/12/2018

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 686	Continued From page 7 so; they took them off when they put me back in bed but didn't put them on..." At 3:15 p.m. LPN # 1, was asked about the boots. She stated "He should have a boot on the right foot; he has a place there we're trying to protect from getting worse..." (It should be noted here Resident # 80 had a scabbed area to outer right ankle). LPN # 1 stated "I'm not sure who put him back to bed, probably second shift; he should have it on his right foot." LPN # 1 was also made aware the resident did not have heels elevated per physician order on 7/10/18 and 7/11/18. On 7/12/18 at 8:45 a.m., Resident # 80 was observed in bed eating breakfast. His heels were not floated, and the boot was not on right foot. LPN # 2 was then interviewed and stated the aide who had Resident # 80 was currently feeding another resident, but she would come to the room and see what was going on. LPN # 2 put the boot back on Resident # 80's right foot telling him "you need to have this boot on to protect your ankle!" The cushion used to elevate the resident's heels was laying on top of the floor mats which were folded up and placed under the window. On 7/12/18 beginning at 12:45 p.m. during a meeting with the administrator and DON (director of nursing) they were informed of the above observations. No further information was provided prior to the exit conference.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		8/1/18

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		07/12/2018

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 689	Continued From page 8 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of a Facility Reported Incident, observations, clinical record review, and staff interviews, the facility staff failed for two of 24 residents in the survey sample, Residents # 80 and 97, to provide adequate supervision and assistance devices to prevent accidents. 1. Resident # 97 sustained a fracture of the left femur during a transfer, which constituted harm. 2. Resident # 80, who was identified as at high risk for falls, was observed without fall mats to each side of the bed per physician orders and care plan interventions. The findings include: 1. Resident # 97 was admitted to the facility on 10/22/12, and most recently readmitted on 2/16/18 with diagnoses that included atrial fibrillation, Alzheimer's Disease, Non-Alzheimer's Dementia, depression, Vitamin-D deficiency, chronic pain, Hereditary Corneal Dystrophies, status post left above the knee amputation, and dysphagia. According to the most recent Minimum Data Set (MDS), a Quarterly with an Assessment Reference Date of 6/30/18, the resident was assessed under Section C (Cognitive Patterns)	F 689	1. Resident #97 has had no further issues related to transfers. Resident #80's fall mats were placed as soon as identified as missing 2. Residents using total lifts or having fall mats as an intervention are at risk. 3. Nursing staff have been reeducated concerning the proper use of the total lift. Nursing staff have also been reeducated to review the resident care guide to ensure that all planned interventions are in place. 4. The Director of Nursing/designee will make rounds to ensure that the interventions are in place for each resident as care planned. Monitoring will occur daily for 7 days and then 1 time per week for 11 weeks. The Director of Nursing or designee will observe the total lift usage for appropriate procedure. This will be documented for one transfer on varying shifts daily for 7 days and then weekly for 11 weeks. 5. The Director of Nursing/designee will report results of monitoring at quarterly QAPI meeting for review and recommendations for the duration of the monitoring period	

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		07/12/2018

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 689	Continued From page 9 as having short and long term memory problems, with severely impaired daily decision making skills. Further review of the 6/30/18 Quarterly MDS revealed that under Section G (Functional Status), the resident was assessed as not walking in her room or the unit corridor; as being totally dependent with one person physical assist for eating, for person hygiene, and for locomotion on and off the nursing unit; and as totally dependent with two persons physical assist for bathing, for dressing, for transfer, and for bed mobility. Resident # 97's care plan, dated 3/11/16, and updated on 1/29/18, included the following problem, "At risk for self care deficit dementia." The goal for the problem was, "Will have ADL's (Activities of Daily Living) met daily through next review." Interventions to the stated problem included, "Transfer with assist of 2 using total lift and green sling." A more recent care plan, dated 2/17/18 and updated on 2/28/18, included the following problem, "The resident has an ADL self care performance deficit." The goal for the problem was, "The resident will improve current level of function through the review date." Interventions to the stated problem included, "The resident requires 2 staff participation with transfers. Uses total lift and green sling." The Intake Detail of a Facility Reported Incident (FRI), filed with the State Agency on 2/13/18, noted "Report received indicating resident had left femur fracture. Investigation pending."	F 689		

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		07/12/2018

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 689	Continued From page 10 The facility's follow-up report to the FRI noted that "On 2/12/18, it was reported...that resident (name of resident) leg looked 'broken' when 2 CNA's (Certified Nursing Assistant) were providing assistance to bed with a total lift." The follow-up report went on to note that "...the CNA assigned to the resident did not properly utilize the equipment needed for the care of (name of Resident # 97)." Following assessment by nursing staff, and after notification to the physician, and the resident's family, the resident was transported to the hospital for evaluation and treatment. Resident # 97 was admitted to the hospital for treatment of a fractured left femur. During their investigation the following written statements were provided by the second CNA in the room who witnessed the incident. The first statement, dated 2/12/18, the CNA wrote, "I spotted (name of CNA providing care) tonight and as I seen her in total lift, her leg looked as if it were dangling and when we got her layed in bed her leg looked detached from joint. (sic)" In a second statement, dated 2/13/18, the same CNA wrote, "Yesterday, Feb 12, 2018, (name of CNA providing care) asked if I could spot her to check (name of resident) in her chair. I didn't notice anything out of the normal with her leg. That was before 4:00 p.m. Around 8 pm as I was going to another residents she stopped me and said she had (name of resident) all ready could I spot her. I said yes. She seemed panicky. She had the sling under her. As we got her in the air I noticed her leg was dangling which wasn't normal beings her legs are contracted. I couldn't really tell if something was wrong until we laid her down	F 689		

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		07/12/2018

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 689	Continued From page 11 in the bed. She didn't seem to be in pain though. (sic)" At approximately 12:45 p.m. on 7/12/18, during a meeting that included the Administrator, the Director of Nursing (DON), and the survey team, the incident that resulted in Resident # 97 sustaining a femur fracture was discussed. Asked about the green sling, the DON said the slings vary as to the size and weight of the particular resident. The DON confirmed that Resident # 97 was to use the green sling. Asked specifically what happened, the DON said, "She (the resident) was not positioned correctly in the sling. The sling in there (used for the transfer) was not the proper size." The DON went on to say that the CNA who performed the transfer is no longer employed at the facility. At the time of the Exit Conference, no further information was provided by the administrative staff. 2. Resident # 80 was admitted to the facility 1/23/18 with diagnoses to include, but not limited to high blood pressure, dementia, and GERD. The most recent MDS (minimum data set) was a quarterly review dated 7/3/18 and had Resident # 80 with severe impairment in cognition with a total summary score of 06 out of 15. On 7/10/18 beginning at 11:15 during initial tour of the facility Resident # 80 was observed in bed with bare feet, and was sliding his feet up and down on the bed surface. There were fall mats observed to each side of the bed. The clinical record was reviewed 7/11/18 at 10:00 a.m. The current POS (physician order	F 689		

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		07/12/2018

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 689	Continued From page 12 summary) for July 2018 included orders carried forward from 7/7/18 for "Mats in floor beside bed every shift." The care plan was reviewed and under "Focus" was noted a recent fall without injury 6/25/18 and fall mats per order was added 7/7/18. On 7/12/18 at 8:45 a.m. Resident # 80 was observed in bed eating breakfast; fall mats were folded up and against the wall and not on each side of the bed. Spoke with LPN (licensed practical nurse) # 2, who stated aide who had the resident was currently feeding another resident, but she would come to room and see what was going on. LPN # 2 stated "I think we took up the mats to get his over bed table to him..." LPN was advised the resident had been observed prior to this morning with breakfast and lunch trays and mats down. LPN # 2 did not respond. On 7/12/18 beginning at 12:45 p.m. during a meeting with the administrator and DON (director of nursing) they were informed of the above observations. No further information was provided prior to the exit conference.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		8/1/18

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		07/12/2018

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 700	Continued From page 13 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to accurately assess and attempt alternatives prior to use of bed rails for four of 24 residents in the survey sample. Resident #22, #26, #47 and #97 had bed rails in use without an accurate assessment for bed rail safety. There were no appropriate alternatives offered or attempted prior to use of the bed rails. The findings include: 1. Resident #47, with a history of seizures and severe cognitive impairment, had a bed rail in use without an accurate assessment for safety and without prior attempted or offered alternatives. Resident #47 was admitted to the facility on 11/16/15 with a re-admission on 8/28/17. Diagnoses for Resident #47 included anemia, dementia with behaviors, Parkinson's disease, seizures and anxiety. The minimum data set (MDS) dated 5/14/18 assessed Resident #47 with	F 700	1. Resident #47 #26 #22 #97 were re-assessed accurately for bed rails. 2. All residents with bed side rails are at risk for this issue. 3. Residents with side rails were re-assessed. 4. Re-education of nursing staff on completion of bedrail assessment accurately has been completed. 5. The Director of Nursing or designee will audit 2 bed side rail assessments for accuracy weekly for 12 weeks. 6. The Director of Nursing/designee will report results of monitoring at quarterly QAPI meeting for review and recommendation.	

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		07/12/2018

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 700	Continued From page 14 short and long-term memory problems and severely impaired cognitive skills. This MDS listed Resident #47 as totally dependent upon two people for bed mobility. On 7/11/18 at 7:48 a.m., Resident #47 was observed in bed. The bed was against the wall on one side with a 1/4 length bed rail in the up position on the opposite side of the bed. The raised bed rail was positioned near the head of the bed and was padded with gray foam covered with black tape. Resident #47's clinical record documented no physician's order for a padded bed rail. The resident's plan of care (revised 2/18/18) documented the resident was at risk of seizure activity. The record documented the most recent seizure activity occurred on 2/8/18. A bed rail assessment dated 5/29/18 documented the resident needed the side rail for "turning and repositioning in bed." This assessment form listed the resident was at risk of entrapment and indicated, "The resident or part of his/her body could be caught between rails, the opening of the rails, or between the bed rails and mattress." The assessment had a space for but listed no alternatives attempted or offered prior to the use of the bed rails. On 7/11/18 at 9:33 a.m., the certified nurses' aide (CNA #2) caring for Resident #47 was interviewed about the bed rail. CNA #2 stated Resident #47 was totally dependent upon the staff for turning and moving about in bed. CNA #2 stated the resident did not hold or turn himself in bed with use of the bed rail. CNA #2 stated she was not sure why the padded bed rail was in	F 700		

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		07/12/2018

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 700	Continued From page 15 place unless it was to keep him from falling out of bed. On 7/12/18 at 8:18 a.m., the director of nursing (DON) was interviewed about Resident #47's bed rail use. The DON stated the unit managers completed the bed rail assessments. When asked why the resident had a bed rail when assessed with a potential for entrapment, the DON stated she did not think the risk assessment for Resident #47 was accurate. The DON stated the resident had no recent change in condition and she did not think the risk potential was assessed correctly. The DON stated the assessment did not include any attempted alternatives to the bed rail. The unit manager for Resident #47 was on vacation and not available for interview during the survey. These findings were reviewed with the administrator and DON during a meeting on 7/12/18 at 12:45 p.m. 2. Resident #26, with severe cognitive impairment, had bed rails in use without an accurate assessment or prior attempts and/or offers of alternatives to the rails. Resident #26 was admitted to the facility on 10/31/17 with diagnoses that included dementia, high blood pressure, muscle weakness and urinary tract infection. The minimum data set (MDS) dated 4/26/18 assessed Resident #26 with severely impaired cognitive skills and requiring the extensive assistance of one person for bed mobility.	F 700		

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		07/12/2018

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 700	Continued From page 16 On 7/10/18 at 11:28 a.m., Resident #26 was observed in bed. Half-length side rails were in the up position near the head of the bed on both sides. The bed rails were covered with gray foam attached with black tape. Resident #26's clinical record documented a physician's order dated 7/6/18 for "Padded 1/2 bedrails for protection." A bed rail assessment dated 5/29/18 documented the resident needed the bed rails to "assist in turning and repositioning in bed." The form listed no potential risks for Resident #26 but documented no attempted or offered alternatives to the rails. On 7/11/18 at 9:37 a.m., the certified nurses' aide (CNA #2) caring for Resident #26 was interviewed about the bed rails. CNA #2 stated the resident was able to grab and turn in bed with use of the rails. On 7/12/18 at 8:18 a.m., the director of nursing (DON) was interviewed about Resident #26's bed rail assessment. The DON stated the padding was provided to protect the resident from skin tears. When asked about any attempted alternative to the rails, the DON stated, "We will have to look at that." The DON stated the information listed on the bed rail assessment of 5/29/18 was not accurate. These findings were reviewed with the administrator and DON during a meeting on 7/12/18 at 12:45 p.m. 3. Resident #22, with severe cognitive impairment, had bed rails in use without an accurate assessment for safety or any attempted or offered alternatives to the rails.	F 700		

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		07/12/2018

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 700	Continued From page 17 Resident #22 was admitted to the facility on 5/16/07 with diagnoses that included anemia, depression, anxiety, chronic pain, blindness due to macular degeneration, high blood pressure, osteoarthritis and dementia. The minimum data set (MDS) dated 4/19/18 assessed Resident #22 with severely impaired cognitive skills and as requiring the extensive assistance of one person for bed mobility. On 7/10/18 at 3:45 p.m., Resident #22 was observed in bed. Half-length side rails were in the raised position near the head of the bed. Both rails were covered with padded foam attached with black tape. Resident #22's clinical record documented a physician's order dated 3/20/18 for "Padded Bedside Rails." A bed rail assessment dated 5/29/18 listed the need and benefit for the side rails as "used for turning and repositioning in bed." This form documented the resident's potential risk from the use of side rails as, "The resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress." The assessment had a space for but listed no alternatives attempted or offered prior to the use of the bed rails. On 7/12/18 at 9:34 a.m., the director of nursing was interviewed about Resident #22's use of bed rails when she was assessed with a risk of entrapment. The DON stated the bed rail assessment was not accurate. The DON stated the form was confusing and was not filled in correctly.	F 700		

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		07/12/2018

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 700	Continued From page 18 These findings were reviewed with the administrator and DON during a meeting on 7/12/18 at 12:45 p.m. 4. The facility staff failed to accurately assess Resident # 97 for siderail use, failed to offer alternative measures to the use of siderails, and no medical diagnosis was offered for the use of siderails. Resident # 97 was admitted to the facility on 10/22/12, and most recently readmitted on 2/16/18 with diagnoses that included atrial fibrillation, Alzheimer's Disease, Non-Alzheimer's Dementia, depression, Vitamin-D deficiency, chronic pain, Hereditary Corneal Dystrophies, status post left above the knee amputation, and dysphagia. According to the most recent Minimum Data Set (MDS), a Quarterly with an Assessment Reference Date of 6/30/18, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems, with severely impaired daily decision making skills. During the orientation tour at 11:20 a.m. on 7/10/18, and again at 10:50 a.m. on 7/12/18, Resident # 97 was observed in her room, lying in her bed. Padded 1/2 siderails on both sides of her bed were in the raised position. According to a Siderail Assessment, dated 1/28/18, the assessment was conducted at the request of the resident's family. The assessment noted that factors contributing to the resident's need for siderails included "...weakness, unable to support truck (sic) in upright position, leans to left...." Additional considerations included	F 700		

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		07/12/2018

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 700	Continued From page 19 "...incontinent of bowel and bladder, dependent for toileting...." The assessment further noted that alternative(s) to siderail use were discussed with the resident's family/responsible party. There was no indication on the assessment form as to what alternative measures were discussed. The question "Physician order has been obtained, including medical symptoms/condition?" was not answered. The conclusion reached by the assessment was for "Siderails at all times when resident is in bed." Further review of the 6/30/18 Quarterly MDS revealed that under Section G (Functional Status), the resident was assessed as not walking in her room or the unit corridor; as being totally dependent with one person physical assist for eating, for person hygiene, and for locomotion on and off the nursing unit; and as totally dependent with two persons physical assist for bathing, for dressing, for transfer, and for bed mobility. Resident # 97's care plan, dated 2/17/18 and updated on 2/28/18, included the following problem, "The resident has an ADL (Activities of Daily Living) self care performance deficit." The goal for the problem was, "The resident will improve current level of function through the review date." Interventions for the stated problem included, "The resident is totally dependent on staff for repositioning and turning in bed." At approximately 12:45 p.m. on 7/12/18, during a meeting that included the Administrator, the Director of Nursing (DON), and the survey team, the use of siderails for Resident # 97, as well as	F 700		

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		07/12/2018

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 700	Continued From page 20 her bed mobility was discussed. According to the DON, the use of siderails can be a nursing judgement. Asked about Resident # 97's ability to voluntarily use the siderails for bed mobility, the DON indicated that staff will place the resident's hand on the siderail to help her turn when providing care. At 1:10 p.m. on 7/12/18, the Maintenance Director was asked about the padding on Resident # 97's siderails. "One of my staff did that," he said. When the surveyor described the padding as thin, black foam rubber wrapped with black electrician's tape, the Maintenance Director said, "That's about right." Asked how siderails come to be padded, the Maintenance Director said, "Nursing tells us to do it. That's generally how we do it." At the time of the Exit Conference, no further information was provided by the administrative staff.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		8/1/18

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		07/12/2018

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 755	Continued From page 21 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure medication was available for administration for one of 24 residents in the survey sample. Resident #22 missed seven doses of the medication Lortab because the medication was not available. The findings include: Resident #22 was admitted to the facility on 5/16/07 with diagnoses that included anemia, depression, blindness due to macular degeneration, anxiety, chronic pain, high blood pressure, osteoarthritis and dementia. The minimum data set (MDS) dated 4/19/18 assessed Resident #22 with severely impaired cognitive	F 755	1. Resident #22 EMAR was checked. No other missed doses of Lortab noted. 2. All residents on controlled substances are at risk. 3. All residents on controlled substances EMAR was compared to narcotic record with all medications present as ordered. 4. Licensed Nursing staff have been reeducated concerning the ordering of drugs requiring hard scrips. This includes that the nurse will request the hard script from MD 3 days prior to medication running out to ensure medication will be available for administration. 5. The Director of Nursing/designee will monitor drugs to ensure hard scripts are obtained and medication available. Monitoring will be documented weekly x4 weeks and then monthly x2 months. The	

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		07/12/2018

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 755	Continued From page 22 skills. Resident #22's clinical record documented a physician's order dated 5/21/18 for the medication Lortab 5-325 milligrams (mg) to be administered three times per day for pain management. The resident's medication administration record (MAR) listed the Lortab was scheduled each day at 8:00 a.m., 1:00 p.m. and 8:00 p.m. Resident #22's MAR for July 2018 documented the Lortab was given as ordered until 7/9/18. The MAR documented Lortab was not given on 7/9/18 at 8:00 a.m. and 1:00 p.m. because the medication was "not available." A dose was marked as given on 7/9/18 at 8:00 p.m. The MAR documented on 7/10/18, the 8:00 a.m. and 1:00 p.m. doses of Lortab were not available for administration. The narcotic count sheets for Resident #22's Lortab supply documented the last dose was removed from the locked storage on 7/8/18 at 8:00 a.m. There was no other Lortab available or signed out of the narcotic box for Resident #22 until 7/10/18 at 9:00 p.m. Resident #22's MAR documented the resident was given a dose of Lortab on 7/8/18 at 1:00 p.m. and 8:00 p.m. and on 7/9/18 at 8:00 p.m. when there was no Lortab available. On 7/12/18 at 8:07 a.m., the licensed practical nurse (LPN #4) caring for Resident #22 was interviewed about the missed doses of Lortab. LPN #4 stated the pharmacy did not process the refill order for the Lortab because the script was missing the DEA (drug enforcement administration) number for the physician. LPN #4 reviewed the narcotic count sheets and stated the	F 755	Director of Nursing/designee will report results of monitoring at quarterly QAPI meeting for review and recommendations for the duration of the monitoring period.	

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		07/12/2018

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 755	Continued From page 23 last supply of Lortab for Resident #22 was signed out on 7/8/18 at 8:30 a.m. LPN #4 stated the next dose of Lortab for Resident #22 was not signed out until 7/10/18 at 9:00 p.m. after a new supply arrived. LPN #4 stated she did not know why the doses were marked as given when the medication was not available. Based upon the narcotic sign out sheets, Resident #22 missed seven doses of Lortab because the medication was not available. The resident was not administered the scheduled Lortab on 7/8/18 at 1:00 p.m. and 8:00 p.m.; 7/9/18 at 8:00 a.m., 1:00 p.m. and 8:00 p.m.; 7/10/19 at 8:00 a.m. and 1:00 p.m. On 7/12/18 at 9:50 a.m., LPN #5 that marked the Lortab dose on 7/8/18 at 1:00 p.m. as given was interviewed. LPN #5 stated she did not actually give the 1:00 p.m. dose of Lortab on 7/8/18 because it was not available. LPN #5 stated she meant to go back and "cross out" the dose on the MAR but she forgot. These findings were reviewed with the administrator and director of nursing (DON) during a meeting on 7/12/18 at 12:45 p.m. The DON stated at this time the three doses of Lortab signed off on the MAR (7/8/18 at 1:00 p.m. and 8:00 p.m., 7/9/18 at 8:00 p.m.) were not actually given to the resident. The DON stated the nurse should have promptly faxed the corrected script back to the pharmacy in order to get the required Lortab for Resident #22. The facility's policy titled New Orders for Schedule II Controlled Substances (revised 1/1/13) stated, "...For an emergency Schedule II controlled substance order, the authorized	F 755		

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		07/12/2018

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 755	Continued From page 24 Physician/Prescriber should provide the following information to a licensed pharmacist...Controlled substance name...dosage form...strength or concentration per dosage unit...Number of dosage units...Full name and address of the resident to whom the controlled substance is to be dispensed...Name, address and DEA registration number of the prescribing practitioner...Directions for use...If the controlled substance is needed before the pharmacy can make arrangements for a timely delivery, Facility must fax a request to remove a controlled substance from the emergency drug supply to the pharmacy..." The Nursing 2017 Drug Handbook on page 726 describes Lortab (hydrocodone/acetaminophen) as a schedule II opioid analgesic used for the management of moderate to moderately severe pain. (1) (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		8/1/18

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		07/12/2018

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 761	Continued From page 25 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure expired medications were not available for administration in one of 2 medication rooms: west 100 hall. An expired bottle of Ativan (a hypnotic medication) was in the refrigerator and available to be administered. Findings include: An inspection of the medication room on the 100 west hall was conducted 7/11/18 beginning at 8:40 a.m. with LPN (licensed practical nurse) # 2, who was the unit manager. A refrigerator used for narcotic storage only included two bottles of Ativan, both in the original box. One box contained a bottle of open Ativan identified on the top of the box in red writing as opened 7/1/17. The second bottle was unopened, and LPN # 2 stated it was for a resident who had expired approximately six weeks ago. LPN # 2 further stated "Usually (name of director of nursing) will come and get any expired medication out of the fridge; I think the opened bottle of medicine was	F 761	1. Expired medication was immediately removed from locked refrigerator and destroyed by two nurses. All residents who receive refrigerated controlled medication are at risk. 2. All refrigerated controlled medications checked for expiration dates. 3. Licensed Nursing staff have been reeducated concerning the expectation that expired controlled medications will be destroyed by two licensed nurses. 4. The Director of Nursing/designee will monitor medication storage refrigerators. This monitoring will be documented daily for 7 days and weekly for 11 weeks to ensure controlled medications are within compliance for date range. 5. The Director of Nursing/designee will report results of monitoring at quarterly QAPI meeting for review and recommendations for the duration of the monitoring period.	

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		07/12/2018

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 761	Continued From page 26 discontinued; she hasn't used any for quite some time. I can go check on that and get right back to you." A few minutes later LPN # 2 returned to the med room and stated "That medication was discontinued 2/27/18; she had not gotten any doses of that." LPN # 2 was then asked if she knew when the medication had expired. LPN # 2 did not answer, and the back of the medication box was shown to her which directed in large, bold print "DISCARD 90 DAYS AFTER OPENING (sic)." At 8:45 a.m. on 7/11/18, the DON (director of nursing) was asked for policy on storage/labeling of meds, including discarding discontinued/resident no longer in facility. When the DON was advised of the above findings she stated "We should get the meds out within 48 hours; but the nurse has to let me know they are in there to get." At 9:20 a.m. 7/11/18 the DON told this surveyor "We don't have a policy for how long medications stay in the fridge before they are returned to the pharmacy; however, the expectation is the nurses are supposed to let us know when a med is d/c'd (discontinued), or if a deceased resident had any meds in the fridge so me or the ADON (assistant director of nursing) can get them out within 24-48 hours ...unless it's a weekend. The resident with the Ativan that was opened in 2017 wasn't admitted here until January of this year; that medication came with her, but she never got any of it." The DON was then asked about a medication that came with the resident that was already expired when they received it, and put it in their refrigerator. The DON stated "That one just fell through the cracks."	F 761		

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		07/12/2018

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 761	Continued From page 27 On 7/11/18 at 4:15 p.m. during an end of the day meeting with the administrator and DON the above findings were discussed. The DON was asked if it was standard practice to accept medications already opened from another facility, and if the pharmacy was aware. The DON stated "Well, it isn't a practice anymore." No further information was provided prior to the exit conference.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		8/1/18

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		07/12/2018

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 880	Continued From page 28 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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		07/12/2018

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 880	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to follow protocols for annual review of infection control procedures and failed to indicate accurate revision dates for the procedures. The infection control manual had multiple procedures with no documented effective dates and/or revision dates indicated. There was no evidence the consultant pharmacist was included in the annual procedure review as required in the infection control policy. The findings include: On 7/12/18 at 10:00 a.m., the facility's infection control program manual was reviewed. Multiple policies in the manual had no effective date or revision date. There was no indication on any of the procedures of a recent annual review. Several procedures listed no reference or source of the protocol. One procedure regarding precautions used in the therapy department had hand written changes with no date of who or when the changes were made. Procedures had review dates ranging from 2013 through 2016 and did not indicate a recent annual review. The facility's policy title Infection Prevention and Control Program for Employee, Contact Staff and Volunteers (effective 4/16/18) documented, "Ultimate responsibility for overseeing and implementing the infection prevention/control program is delegated to the Quality Assurance Committee. Committee membership includes but may not be limited to: Medical Director...Administration...Nursing...Infection control designee...Pharmacy Consultant...Responsibilities include but may not	F 880	1. There is no longer a paper manual for the infection control procedures. The infection control procedures are maintained in the DMS web based program. The facility has completed the annual review of infection control procedures with the QAPI committee members which include the Medical Director and the Consultant Pharmacist. This will ensure that individual residents are receiving the benefits of updated infection control procedures. The online policies will be made accessible to the state surveyors. 2. Current residents are at risk in the absence of an annual review of infection control procedures. 3. The Administrator is now aware of the need to ensure that the Medical Director and Consultant Pharmacist have written acknowledgement of their review of the infection control procedures. The infection prevention procedures are updated as needed and reviewed annually by the corporate office and information is sent to the facility to review. This review will include the Medical Director and the Consultant Pharmacist. 4. The Director of Nursing will ensure that the updated infection control procedures are reviewed by the Medical Director and the Consultant Pharmacist as well as reviewed in the monthly QAPI meeting. This will be documented monthly and presented to the QAPI committee meeting to review and make recommendations to ensure that it is maintained ongoing.	

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		07/12/2018

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 880	Continued From page 30 be limited to...Review of infection prevention and control guidelines...Approve all facility infection prevention/control policies...Review and evaluate the infection prevention/control plan no less than annually and revise as necessary." On 7/12/18 at 10:30 a.m., the director of nursing (DON) and administrator were interviewed about the annual review of infection procedures and procedures in the manual without dates or a revision history. The DON stated there was an approval sheet in another book in the infection control nurse's office indicating review of the procedures. After searching, the DON presented a paper titled "Infection Control Policy Review." The paper was dated 4/1/18 and had only the signatures of the administrator, infection control nurse and director of nursing. The form did not include a signature from the medical director or pharmacist and included no reference to any specific procedures or policies. There was no evidence indicating what revisions, if any were made to any of the procedures and policies. The administrator stated the medical director reviewed the procedures at a later date during a quality assurance meeting. The administrator stated some of the procedures were in the computer and were controlled by corporate. The administrator stated they were not able to update the revision dates of the policies and procedures in the computer. The administrator stated the procedures in the infection manual without effective dates and/or revision dates were not in the computer. Concerning the annual review protocol, the administrator stated she did not believe the pharmacist had reviewed the infection procedures. The administrator stated it was not possible to look at the procedures and know when or if the policy was revised.	F 880	Disclaimer: Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	

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		07/12/2018

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 880	Continued From page 31 The facility's infection control nurse was on vacation and not available for interview during the survey. These findings were reviewed with the administrator and DON during a meeting on 7/12/18 at 12:45 p.m.	F 880		