STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 survey was conducted 12/13/17 through 12/14/17. Complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 169 certified bed facility was 149 at the time of the survey. The survey sample consisted of nine current resident reviews (Residents #1 through #7 and Residents #14 through #15) and six closed record reviews (Residents #8 through #13).	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the abuse and neglect policy for one of 15 residents in the survey sample, Resident #10. The facility staff failed to implement the facility	F 607	F607 1. Resident #10 no longer resides in this facility. 2. Residents who sustain an injury of unknown origin have the potential to be affected by this deficient practice. 3. Facility staff were in-serviced by the	1/12/18

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

Electronically Signed | 01/12/2018

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F 607	Continued From page 1 abuse and neglect policy after discovering bruising underneath and on top of Resident #10's top and bottom lips on 6/29/17. The findings include: Resident #10 was admitted to the facility on 2/12/17 with the following diagnoses; swelling in the legs, depression, difficulty with swallowing, pain and stroke. Resident #10 was discharged from the facility on 8/4/17. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/17 coded Resident #10 as scoring a four on the BIMS (brief interview for mental status) indicating that Resident #10 was severely impaired with decisions of daily living. Resident #10 was also coded as requiring maximum assistance of one person with activities of daily living and set up assistance with eating. A review of Resident #10's progress notes revealed, in part, the following notes; -"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note Text: Wound type is bruising. Wound Location upper lip. Length (cm) (centimeters) 2 (two). Width (cm) 2 (two). Depth (cm) 0 (zero). Area is in house acquired. n/a (non applicable) Skin impairment was not present on admission. 6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager. -"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note	F 607	DON or designee on the abuse policy, to include injuries of unknown origin. 4. Audits of resident injuries will be conducted five times weekly for twelve weeks by the DON or designee, to determine that the source of the injury has been identified and to assure that the abuse policy has been implemented and followed. Results of audits will be submitted to the QAPI committee for three months for review and revision as needed. 5. Date of compliance: January 16, 2018	

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F 607	Continued From page 2 Text: Wound type is bruising. Wound Location bottom lip. Length (cm) (centimeters) 0.5. Width (cm) 1 (one). Depth (cm) 0 (zero). Area is in house acquired. n/a (non applicable) Skin impairment was not present on admission. 6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager. -"6/30/17 11:40 Type: Head to Toe Eval. (evaluation) Overview: Occurrence Details: Resident noted with reddish bruising measuring 2 cm x 2 cm oval in shape to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with reddish purple bruising measuring 1 cm x 1 cm linear in shape with round edges to medial lower lip that is a mirror image to top lip. Resident without c/o (complaint of) pain before after during and after assessment (sic). RP (responsible party) present and is aware of area. MD (medical doctor) made aware. Immediate Intervention: Mouth assessed for any further injury. Resident is known for aggressive behavior at times. Resident has full range of motion to all extremities. Residents family/responsible party was notified of occurrence. (Name of RP) Resident continues with poor safety awareness and is impulsive and combative at times." Signed by LPN #10, a unit manager. A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date Initiated: 3/14/16. Revision on 7/1/17.	F 607		

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A review of Resident #10's incident reports revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found."

A review of the investigation conducted by ASM (administrative staff member) #2, the director of nursing, revealed, in part the following documentation; "July 18, 2017. On 6/29/17, writer was called by (name of LPN #12) on the Spring Unit and asked to speak with (name of Resident #10's) daughter. Writer met daughter in hallway and walked with her to resident's (Resident #10's) room. Daughter pointed out bruising on resident's upper lip and then flipped it up to show bruising underneath. Resident was asked by writer if she remembers how her lip became bruised, and resident stated she did not. Daughter told writer she wonders why she was not notified of the bruising. She feels her mother could not have done this to herself. Daughter does not think her mother fell, as she would have been notified. Daughter wonders if her mother was hit by another resident since this has occurred in the past. Daughter said she understands accidents happen but that she feels

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someone would have noticed and should have called her. Writer told resident's daughter that this would be reported to nursing. Writer left resident's room and met (name of LPN #10) as she was walking onto the Spring Unit and both parties walked to resident's room. Resident's daughter showed (name of LPN #10) the bruising and told her what she had told the writer. (Name of LPN #10) said that she would begin an investigation. (Name of LPN #10) and writer told daughter she would be followed-up with. Writer reported to Supervisor." Signed by OSM (other staff member) #3, the social worker.

On 12/13/17 at approximately 3:00 p.m. ASM #2, the director of nursing, provided a copy of a FRI (facility reported incident) to this writer. The FRI was submitted to the Office of Licensure and Certification for an injury of unknown origin on 7/18/17, 19 days after the bruises were observed on Resident #10's lips. The following conclusion was documented on the FRI; "When interviewing the aide, she stated that another resident had attempted to take (name of Resident #10's" flatware at the dining table. When (name of Resident #10) moved the flatware, the other resident struck her in the lower face with a butter knife. She stated she reported this incident to a nurse. There were two nurses on duty. The first nurse interviewed said the aide did report the incident to him and he reported to the nurse assigned to the resident. The nurse assigned said that she had not investigated because she had not witnessed the incident. Staff were counseled on reporting incidents and conducting thorough investigations per facility policy." ASM #2 was asked to provide the full investigation for the bruises found on Resident #10's lips.

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A full investigation was provided to this writer by the director of nursing on 12/4/17 at 8:00 a.m.

A review of the facility policy titled "Virginia Resident Abuse Policy" revealed, in part, the following documentation; "POLICY: This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Injury of Unknown Source; An injury is classified as an "Injury of Unknown Source" when both the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; AND b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. 6) Initial Reports. A. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source... must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. 7) Investigate. Once the Administrator and DOH (department of health) are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The investigation must be completed within five (5) working days from the alleged occurrence."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process for reporting a resident to resident altercation with a

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F 607	Continued From page 6 resulting injury. ASM #2 stated, "The supervisor on the hallway will initiate the investigation, but it falls on me or the ADON (assistant director of nursing) to complete the investigation." ASM #2 was asked if there was an injury of unknown origin would a FRI be sent to the state agency. ASM #2 stated, "Yes we need to send the FRI immediately and then follow up with an investigation." ASM #2 was asked about Resident #10's injuries to her top and bottom lips. ASM #2 stated that it should have been investigated when the original resident to resident altercation occurred on 6/28/17 but that she was not notified about the incident until the daughter complained on 7/10/17 that an investigation had not been completed in regards to the bruising. When asked what happened ASM #2 stated, "Neither nurse on 6/28/17 documented about the resident to resident altercation. They should have documented and made me aware of the incident but they did not report to me and did nothing." ASM #2 what happened after the social worker spoke with the daughter on 6/29/17 in regards to the bruising. ASM #2 was unable to say what happened or why there was such a delay in reporting to the office. On 12/14/17 at 4:00 p.m. the administrator (Administrative staff member [ASM] #1), corporate nurse (ASM #3) and director of nursing (ASM #2) were made aware of the above concerns. No further information was provided prior to the end of the survey.	F 607		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii)	F 608		1/12/18

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F 608	Continued From page 7 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to report a suspected crime in a timely manner. The findings include: A facility reported incident (FRI) dated, 9/11/17	F 608	F608 1. No residents were affected by this deficient practice. 2. Residents who are victims of a suspected crime have the potential to be affected by this deficient practice. 3. Facility staff were in-serviced by the DON or designee on the abuse policy, to	

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F 608	Continued From page 8 was received at the Virginia Department of Health, Office of Licensure and Certification. The "Report Date" documented, 9/11/17. The "Incident Date" documented a question mark. Under "Incident Type;" was hand written, "Unusual occurrence." The form documented, "Possible diversion of medications to be returned to pharmacy for facility credit. See attached letter to Board of Nursing. Investigation ongoing with local law enforcement. Facility internal investigation: completed on 9/11/17." The letter addressed to the Board of Nursing, dated 9/11/17, documented, "We are reporting an unusual set of circumstances involving # 15 (nursing license number). Apparently related to an acrimonious separation from her husband, (LPN # 15) reported to our DON (director of nursing) that he would be creating problems for her on her job. On Saturday, September 2, 2017 an individual brought in a bag with some 23 punch card of various medications. He indicated the bag of medication were left by (LPN # 15) in a house they shared prior to their recent separation. Although the identifying information on the top of the cards had been, for the most part, removed, it was determined that at least 3 of the cards had enough information to show they came from our facility. We contacted the (Name of local sheriff's office) on October 5, 2017 (a typographical error - (September 5, 2017) for assistance. We requested a written statement from (LPN # 15) regarding the medications. She declined to write a statement. She was interviewed by (Name of Deputy) on this same date in the Administrator's office at (Name of facility). The drugs brought to the facility consisted of 23	F 608	include reporting of suspected crimes. 4. Audits of reports of unusual occurrences will be conducted five times weekly for twelve weeks to determine whether a possible crime has been committed. Results of audits will be submitted to the QAPI committee monthly for three months for review and revision as needed. 5. Date of compliance: January 16, 2018.	

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"punch cards" and one zip-lock bag. (An inventory is included). It is our belief, these medicine (sic) which we identified as coming from here, were the property of the facility and were to have been returned to our pharmacy for a facility credit since the two residents were no longer in the facility. One resident had discharged home on 2/22/17 and the other had expired in the facility on 6/23/17. We will be sending you, under separate cover, a copy of the personnel record for (LPN #15). She has been suspended and we are continuing our sharing of information and cooperation with the local authorities. We will keep you informed of the investigation."

List of mediations on the medication cards:
1. Cephalexin 500 mg (milligrams) (an antibiotic used to treat infections) 28 total pills. (1)
2. Metronidazole 500 mg (an antibiotic used to treat infections) 24 total pills (2)
3. Ciprofloxacin (an antibiotic used to treat infections) 22 total pills. (3)
4. Amozclav (Augmentin) (an antibiotic used to treat infections) 14 total pills. (4)
5. Levofloxacin 500 mg (an antibiotic used to treat infections) 7 total pills. (5)
6. Metronidazole 500 mg, 22 total pills.
7. Metronidazole 500 mg, 12 total pills.
8. Cephalexin 500 mg, 16 total pills.
9. Metronidazole 500 mg, 30 total pills.
10. Ciprofloxacin 250 mg, 29 total pills.
11. Omeprazole 20 mg (used to treat acid reflux - indigestion) 27 total pills. (6)
12. Promethazine 12.5 mg (An antihistamine used mostly to treat nausea and vomiting) 25 total pills. (7)
13. Dicycolmine 10 mg (used to treat irritable bowel syndrome) 29 total pills. (8)
14. Folic Acid 1 mg (water soluble vitamin) 25

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total pills. (9)
15. Trazadone 50 mg (an antidepressant and used for insomnia) (10)
16. Acetaminophen (Tylenol) (used to treat mild pain and fever) 325 mg, 30 total pills. (11)
17. Acetaminophen 650 mg, 28 total pills.
18. Prednisone (a corticosteroid used to treat inflammation) 2.5 mg, 13 total pills. (12)
19. Prednisone 5 mg, 9 total pills.
20. Musinex (sic) (Guaifenesin) (Used to move phlegm and mucus from the lungs) 600 mg, 20 total pills. (13)
21. Musinex (sic) 600 mg, 20 total pills.
22. Musinex (sic) 600 mg, 20 total pills.
23. Musinex (sic) 600 mg, 20 total pills.
24. Excedrin Tension Headache (no strength documented) (contains Acetaminophen and caffeine) (used to treat headaches) 15 total pills. (14)

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 12/14/17 at 9:50 a.m. When asked to tell of her involvement with the incident of the possible drug diversion, ASM #2 stated, "She was a fairly good nurse, she had lung cancer. She had told me of the situation she was going through with her husband and said he would try to make trouble for her at her job and would be telling lies about her. I was told the drugs were brought into the facility, I was not here. (Name of administrator - ASM #1) and I went through the bag of medications. Most of the names had been ripped off. We could figure out two or three of them. Those were drugs that would have been sent back to the pharmacy for credit. ASM #1 called the local police. My recollection if that the police came in and we called her in to talk." When

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asked if she handled any of this, ASM #2 stated, "No, (ASM #1) handled all of this." ASM #2 further stated, "The police had us call the pharmacy to get the cost of the medications that were taken to determine if it rose to the level of a crime."

An interview was conducted with ASM #1, the administrator, on 12/14/17 at 10:05 a.m. When asked when he was first made aware of the drugs being brought into the facility, ASM #1 stated, "On the Friday (9/1/17) before the medications arrived at the facility, I got an anonymous phone call from a man. He informed me that a nurse was diverting drugs. I instructed him to either call the police or identify himself to me so that I could report it. He hung up. A man came into the facility on Saturday (9/2/17) and gave the medications to a nurse on duty. On 9/5/17, I contacted the local police. A deputy came. We called her (LPN #15) into the building. The deputy was in my office with (LPN #15), (name of ASM #2) and (LPN #15). (ASM #2) asked (LPN #15) to write a statement but she refused. The deputy made some calls outside, one to a judge, and apparently there were things she was telling us that were not truthful in relations to her situation at home." When asked if this was an unusual circumstance and a suspected crime, ASM #1 stated, "Yes, it was. Over the years I've been an administrator, anytime there is an unusual case, I let the local law enforcement agency handle it." When asked why he didn't report the suspected crime prior to 9/11/17, ASM #1 stated, "I was letting the police department handle it." When asked if he is required to report suspected crimes in the facility, ASM #1 stated, "I guess we should have notified your office sooner. Lesson learned."

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(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 608	Continued From page 12 The facility policy, "Crime Reporting" documented in part, "It is (Name of corporation)'s policy to notify owners, operators, employees, managers, agents and contractors of (Name of Corporation)'s nursing facilities (collectively referred to as 'Covered Individuals' and individually as 'Covered Individual' of their duty to report reasonable suspicion of crimes to the Secretary and law enforcement....Notification to Covered Individuals will require that all reasonable suspicions are immediately communicated to the Administrator of the nursing facility....d. Examples of situations that would be considered crimes in all subdivisions would include but are not limited to: murder, manslaughter, rape, assault and battery, sexual abuse, theft/robbery, drug diversion for personal us or gain, identify theft and fraud and forgery." ASM #1 was made aware of the above findings on 12/14/17 at approximately 12:25 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009528/?report=details. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011192/?report=details (3) This information was obtained from the following website:https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm? archiveid=14776 (4). This information was obtained from the following website:	F 608		

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https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=44390.
(5) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a1f01e8e-97e9-11de-b91d-553856d89593.
(6) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c63b2dd4-ac8a-47a1-889b-94d68137bd01.
(7) This information was obtained from the following website:
https://pubchem.ncbi.nlm.nih.gov/compound/promethazine#section=Top.
(8) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ac145b81-5f26-4914-b47f-6c4958e94146.
(9) This information was obtained from the following website:
https://medlineplus.gov/folicacid.html.
(10) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=19770.
(11) This information was obtained from the following website:
https://pubchem.ncbi.nlm.nih.gov/compound/acetaminophen#section=Top.
(12) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011828/?report=details.
(13) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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F 608	Continued From page 14 T0010512/. (14) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=12c074d1-81ac-47d2-8747-b018cda0058a	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		1/12/18

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F 609	Continued From page 15 by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an injury of unknown origin for one of 15 residents in the survey sample, Resident #10. The facility staff failed to implement the facility abuse and neglect policy after discovering bruising underneath and on top of Resident #10's top and bottom lips on 6/29/17. The findings include: Resident #10 was admitted to the facility on 2/12/17 with the following diagnoses; swelling in the legs, depression, difficulty with swallowing, pain and stroke. Resident #10 was discharged from the facility on 8/4/17. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/17 coded Resident #10 as scoring a four on the BIMS (brief interview for mental status) indicating that Resident #10 was severely impaired with decisions of daily living. Resident #10 was also coded as requiring maximum assistance of one person with activities of daily living and set up assistance with eating. A review of Resident #10's progress notes revealed, in part, the following notes; -"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note Text: Wound type is bruising. Wound Location upper lip. Length (cm) (centimeters) 2 (two). Width (cm) 2 (two). Depth (cm) 0 (zero). Area is in house acquired n/a (not applicable) Skin	F 609	F609 1. Resident #10 no longer resides in the facility. 2. Residents experiencing an injury of unknown origin have the potential to be affected by this deficient practice. 3. The DON or designee in-serviced CNAs and nurses on the facility abuse policy, including requirements for timely reporting of injuries of unknown origin. 4. Reports of injuries of unknown origin will be audited five times weekly for twelve weeks by the DON or designee to assure compliance. Results of audits will be taken to the QAPI Committee monthly for three months for review and revision. 5. Compliance date: January 16, 2018.	

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impairment was not present on admission. 6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager.
-"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note Text: Wound type is bruising. Wound Location bottom lip. Length (cm) (centimeters) 0.5. Width (cm) 1 (one). Depth (cm) 0 (zero). Area is in house acquired. n/a Skin impairment was not present on admission. 6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager.
-"6/30/17 11:40 Type: Head to Toe Eval. (evaluation) Overview: Occurrence Details: Resident noted with reddish bruising measuring 2 cm x 2 cm oval in shape to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with reddish purple bruising measuring 1 cm x 1 cm linear in shape with round edges to medial lower lip that is a mirror image to top lip. Resident without c/o (complaint of) pain before after during and after assessment (sic). RP (responsible party) present and is aware of area. MD (medical doctor) made aware. Immediate Intervention: Mouth assessed for any further injury. Resident is known for aggressive behavior at times. Resident has full range of motion to all extremities. Residents family/responsible party was notified of occurrence. (Name of RP) Resident continues with poor safety awareness and is impulsive and combative at times." Signed by LPN #10, a unit manager.

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A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date Initiated: 3/14/16. Revision on 7/1/17.

A review of Resident #10's incident reports revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found."

A review of the investigation conducted by ASM (administrative staff member) #2, the director of nursing, revealed, in part the following documentation; "July 18, 2017. On 6/29/17, writer was called by (name of LPN #12) on the Spring Unit and asked to speak with (name of Resident #10's) daughter. Writer met daughter in hallway and walked with her to resident's (Resident #10's) room. Daughter pointed out bruising on resident's upper lip and then flipped it up to show bruising underneath. Resident was asked by writer if she remembers how her lip became bruised, and resident stated she did not. Daughter told writer she wonders why she was

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not notified of the bruising. She feels her mother could not have done this to herself. Daughter does not think her mother fell, as she would have been notified. Daughter wonders if her mother was hit by another resident since this has occurred in the past. Daughter said she understands accidents happen but that she feels someone would have noticed and should have called her. Writer told resident's daughter that this would be reported to nursing. Writer left resident's room and met (name of LPN #10) as she was walking onto the Spring Unit and both parties walked to resident's room. Resident's daughter showed (name of LPN #10) the bruising and told her what she had told the writer. (Name of LPN #10) said that she would begin an investigation. (Name of LPN #10) and writer told daughter she would be followed-up with. Writer reported to Supervisor." Signed by OSM (other staff member) #3, the social worker.

On 12/13/17 at approximately 3:00 p.m. ASM #2, the director of nursing, provided a copy of a FRI (facility reported incident) to this writer. The FRI was submitted to the Office of Licensure and Certification for an injury of unknown origin on 7/18/17, 19 days after the bruises were observed on Resident #10's lips. The following conclusion was documented on the FRI; "When interviewing the aide, she stated that another resident had attempted to take (name of Resident #10's" flatware at the dining table. When (name of Resident #10) moved the flatware, the other resident struck her in the lower face with a butter knife. She stated she reported this incident to a nurse. There were two nurses on duty. The first nurse interviewed said the aide did report the incident to him and he reported to the nurse assigned to the resident. The nurse assigned

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said that she had not investigated because she had not witnessed the incident. Staff were counseled on reporting incidents and conducting thorough investigations per facility policy." ASM #2 was asked to provide the full investigation for the bruises found on Resident #10's lips.

A full investigation was provided to this writer by the director of nursing on 12/4/17 at 8:00 a.m.

A review of the facility policy titled "Virginia Resident Abuse Policy" revealed, in part, the following documentation; "POLICY: This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Injury of Unknown Source; An injury is classified as an "Injury of Unknown Source" when both the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; AND b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. 6) Initial Reports. A. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source... must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. 7) Investigate. Once the Administrator and DOH (department of health) are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The

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investigation must be completed within five (5) working days from the alleged occurrence."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process for reporting a resident to resident altercation with a resulting injury. ASM #2 stated, "The supervisor on the hallway will initiate the investigation, but it falls on me or the ADON (assistant director of nursing) to complete the investigation." ASM #2 was asked if there was an injury of unknown origin would a FRI be sent to the state agency. ASM #2 stated, "Yes we need to send the FRI immediately and then follow up with an investigation." ASM #2 was asked about Resident #10's injuries to her top and bottom lips. ASM #2 stated that it should have been investigated when the original resident to resident altercation occurred on 6/28/17 but that she was not notified about the incident until the daughter complained on 7/10/17 that an investigation had not been completed in regards to the bruising. When asked what happened ASM #2 stated, "Neither nurse on 6/28/17 documented about the resident to resident altercation. They should have documented and made me aware of the incident but they did not report to me and did nothing." ASM #2 what happened after the social worker spoke with the daughter on 6/29/17 in regards to the bruising. ASM #2 was unable to say what happened or why there was such a delay in reporting to the office.

On 12/14/17 at 4:00 p.m. the administrator (Administrative staff member [ASM] #1), corporate nurse (ASM #3) and director of nursing (ASM #2) were made aware of the above concerns.

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F 609	Continued From page 21 No further information was provided prior to the end of the survey.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate an injury of unknown origin for one of 15 residents in the survey sample, Resident #10. The facility staff failed to implement the facility abuse and neglect policy after discovering bruising underneath and on top of Resident #10's top and bottom lips on 6/29/17. The findings include:	F 610	F610 1. Resident #10 no longer resides in the facility. 2. Residents sustaining an injury of unknown origin have the potential to be affected by this deficient practice. 3. The DON or designee in-serviced CNAs and nurses on the abuse policy, including the investigation of injuries of unknown origin. 4. Audits of injuries of unknown origin will be conducted five times a week for	1/12/18

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F 610	Continued From page 22 Resident #10 was admitted to the facility on 2/12/17 with the following diagnoses; swelling in the legs, depression, difficulty with swallowing, pain and stroke. Resident #10 was discharged from the facility on 8/4/17. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/17 coded Resident #10 as scoring a four on the BIMS (brief interview for mental status) indicating that Resident #10 was severely impaired with decisions of daily living. Resident #10 was also coded as requiring maximum assistance of one person with activities of daily living and set up assistance with eating. A review of Resident #10's progress notes revealed, in part, the following notes; -"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note Text: Wound type is bruising. Wound Location upper lip. Length (cm) (centimeters) 2 (two). Width (cm) 2 (two). Depth (cm) 0 (zero). Area is in house acquired. n/a (non applicable) Skin impairment was not present on admission. 6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager. -"6/30/2017 11:40 (11:40 a.m.) Type: Pressure/Non-Pressure Skin Assessment. Note Text: Wound type is bruising. Wound Location bottom lip. Length (cm) (centimeters) 0.5. Width (cm) 1 (one). Depth (cm) 0 (zero). Area is in house acquired. n/a (non applicable) Skin impairment was not present on admission.	F 610	twelve weeks to assure compliance. Results of audits will be taken to the QAPI committee monthly for three months for review and revision. 5. Date of compliance: January 16, 2018.	

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6/30/2017 Drainage Type. No Drainage. No odor. Area is a new wound. Pain Level is 0 (zero) 0/30/2017 12:00 P.M. Treatment: monitoring." Signed by LPN (licensed practical nurse) #10, a unit manager.
-"6/30/17 11:40 Type: Head to Toe Eval. (evaluation) Overview: Occurrence Details: Resident noted with reddish bruising measuring 2 cm x 2 cm oval in shape to medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with reddish purple bruising measuring 1 cm x 1 cm linear in shape with round edges to medial lower lip that is a mirror image to top lip. Resident without c/o (complaint of) pain before after during and after assessment (sic). RP (responsible party) present and is aware of area. MD (medical doctor) made aware. Immediate Intervention: Mouth assessed for any further injury. Resident is known for aggressive behavior at times. Resident has full range of motion to all extremities. Residents family/responsible party was notified of occurrence. (Name of RP) Resident continues with poor safety awareness and is impulsive and combative at times." Signed by LPN #10, a unit manager.

A review of Resident #10's comprehensive care plan dated 2/12/16 revealed, in part, the following documentation; "Focus: Potential for skin breakdown d/t (due to) incontinence, immobility. 6/30/17 bruise to upper and lower lip. Date Initiated: 3/14/16. Revision on 7/1/17.

A review of Resident #10's incident reports revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to medial upper lip on the inside of mouth with bite marks noted to inside of mouth.

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Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found."

A review of the investigation conducted by ASM (administrative staff member) #2, the director of nursing, revealed, in part the following documentation; "July 18, 2017. On 6/29/17, writer was called by (name of LPN #12) on the Spring Unit and asked to speak with (name of Resident #10's) daughter. Writer met daughter in hallway and walked with her to resident's (Resident #10's) room. Daughter pointed out bruising on resident's upper lip and then flipped it up to show bruising underneath. Resident was asked by writer if she remembers how her lip became bruised, and resident stated she did not. Daughter told writer she wonders why she was not notified of the bruising. She feels her mother could not have done this to herself. Daughter does not think her mother fell, as she would have been notified. Daughter wonders if her mother was hit by another resident since this has occurred in the past. Daughter said she understands accidents happen but that she feels someone would have noticed and should have called her. Writer told resident's daughter that this would be reported to nursing. Writer left resident's room and met (name of LPN #10) as she was walking onto the Spring Unit and both

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parties walked to resident's room. Resident's daughter showed (name of LPN #10) the bruising and told her what she had told the writer. (Name of LPN #10) said that she would begin an investigation. (Name of LPN #10) and writer told daughter she would be followed-up with. Writer reported to Supervisor." Signed by OSM (other staff member) #3, the social worker.

On 12/13/17 at approximately 3:00 p.m. ASM #2, the director of nursing, provided a copy of a FRI (facility reported incident) to this writer. The FRI was submitted to the Office of Licensure and Certification for an injury of unknown origin on 7/18/17, 19 days after the bruises were observed on Resident #10's lips. The following conclusion was documented on the FRI; "When interviewing the aide, she stated that another resident had attempted to take (name of Resident #10's" flatware at the dining table. When (name of Resident #10) moved the flatware, the other resident struck her in the lower face with a butter knife. She stated she reported this incident to a nurse. There were two nurses on duty. The first nurse interviewed said the aide did report the incident to him and he reported to the nurse assigned to the resident. The nurse assigned said that she had not investigated because she had not witnessed the incident. Staff were counseled on reporting incidents and conducting thorough investigations per facility policy." ASM #2 was asked to provide the full investigation for the bruises found on Resident #10's lips.

A full investigation was provided to this writer by the director of nursing on 12/4/17 at 8:00 a.m.

A review of the facility policy titled "Virginia Resident Abuse Policy" revealed, in part, the

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following documentation; "POLICY: This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Injury of Unknown Source; An injury is classified as an "Injury of Unknown Source" when both the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; AND b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. 6) Initial Reports. A. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source... must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. 7) Investigate. Once the Administrator and DOH (department of health) are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The investigation must be completed within five (5) working days from the alleged occurrence."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process for reporting a resident to resident altercation with a resulting injury. ASM #2 stated, "The supervisor on the hallway will initiate the investigation, but it falls on me or the ADON (assistant director of nursing) to complete the investigation." ASM #2 was asked if there was an injury of unknown

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F 610	Continued From page 27 origin would a FRI be sent to the state agency. ASM #2 stated, "Yes we need to send the FRI immediately and then follow up with an investigation." ASM #2 was asked about Resident #10's injuries to her top and bottom lips. ASM #2 stated that it should have been investigated when the original resident to resident altercation occurred on 6/28/17 but that she was not notified about the incident until the daughter complained on 7/10/17 that an investigation had not been completed in regards to the bruising. When asked what happened ASM #2 stated, "Neither nurse on 6/28/17 documented about the resident to resident altercation. They should have documented and made me aware of the incident but they did not report to me and did nothing." ASM #2 what happened after the social worker spoke with the daughter on 6/29/17 in regards to the bruising. ASM #2 was unable to say what happened or why there was such a delay in reporting to the office. On 12/14/17 at 4:00 p.m. the administrator (Administrative staff member [ASM] #1), corporate nurse (ASM #3) and director of nursing (ASM #2) were made aware of the above concerns. No further information was provided prior to the end of the survey.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		1/12/18

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F 657	Continued From page 28 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to review and revise the comprehensive care plan for three of 15 residents, Resident #s 10, 15 and 1. 1. The facility staff failed to review and revise Resident #10's comprehensive care plan that provided direction on keeping Resident #10 safe following an incident where another resident struck her in the mouth with a butter knife causing an injury to her mouth. 2. The facility staff failed to review and revise	F 657	F657 1. Resident #10 no longer resides in the facility. The Care Plans for residents #1 and #15 were reviewed and revised. 2. Residents involved in a resident-to-resident altercation have the potential to be affected by this deficient practice. 3. The MDS Coordinator or designee educated Interdisciplinary Care Team members and nurses on reviewing, updating and revising care plans for resident to resident altercations. 4. The MDS Coordinator or designee will review care plans for residents involved in	

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F 657	Continued From page 29 Resident #15's comprehensive care plan after she struck Resident #10 in the mouth with a butter knife, causing an injury. 3. Facility staff failed to review and revise the care plan after Resident #1 was struck by Resident #14. The findings include: 1. The facility staff failed to review and revise Resident #10's comprehensive care plan that provided direction on keeping Resident #10 safe following an incident where another resident struck her in the mouth with a butter knife causing an injury to her mouth. Resident #10 was admitted to the facility on 2/12/17 with the following diagnoses; swelling in the legs, depression, difficulty with swallowing, pain and stroke. Resident #10 was discharged from the facility on 8/4/17. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/17 coded Resident #10 as scoring a four on the BIMS (brief interview for mental status) indicating that Resident #10 was severely impaired with decisions of daily living. Resident #10 was also coded as requiring maximum assistance of one person with activities of daily living and set up assistance with eating. A review of Resident #10's incident reports revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to medial upper lip on the inside of mouth with bite marks noted to inside of mouth.	F 657	resident-to-resident altercations five times weekly for eight weeks to assure compliance. Results of audits will be taken to the QAPI committee monthly for three months for review and revision. 5. Date of compliance: January 16, 2018.	

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Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found."

A review of Resident #10's comprehensive care plan did not reveal any information that provided information on how to keep Resident #10 safe following the resident to resident altercation on 6/28/17.

On 12/14/17 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working on Resident #10's unit at the time of the resident to resident altercation. LPN #13 was asked if he recalled the resident to resident altercation on 6/28/17. LPN #13 stated, "Not off the top of my head. I remember I was not in the area when it happened. I didn't see anything happen." LPN #13 was asked whether or not he had completed an incident report. LPN #13 stated that he had not. LPN #13 was asked whether or not he had completed a revision of the comprehensive care plan. LPN #13 stated, "I should have done it, I didn't, we got busy."

On 12/14/17 at 1:15 p.m. an interview was conducted with LPN #14, a floor nurse working on Resident #10's unit at the time of the resident to resident altercation. LPN #14 was asked whether or not she remembered the incident where

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Resident #10 was struck in the face by another resident. LPN #14 stated, "The CNA (certified nurse assistant) came to me and told me about it. We separated the two residents. I didn't know to report, I did tell the unit manager and reported the incident to the oncoming night nurse. I should have documented the incident but I didn't think about it."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to describe the process for reporting a resident to resident altercation with a resulting injury. ASM #2 stated, "The supervisor on the hallway will initiate the investigation, but it falls on me or the ADON (assistant director of nursing) to complete the investigation." ASM #2 was asked if there was an injury of unknown origin would a FRI be sent to the state agency. ASM #2 stated, "Yes we need to send the FRI immediately and then follow up with an investigation." ASM #2 was asked about Resident #10's injuries to her top and bottom lips. ASM #2 stated that it should have been investigated when the original resident to resident altercation occurred on 6/28/17 but that she was not notified about the incident until the daughter complained on 7/10/17 that an investigation had not been completed in regards to the bruising. When asked what happened ASM #2 stated, "Neither nurse on 6/28/17 documented about the resident to resident altercation. They should have documented and made me aware of the incident but they did not report to me and did nothing." ASM #2 what happened after the social worker spoke with the daughter on 6/29/17 in regards to the bruising. ASM #2 was unable to say what happened or why there was such a delay in reporting to the office. ASM #2 was asked what

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the staff was instructed to do to keep Resident #10 safe following the altercation. ASM #2 stated that the staff knew to keep Resident #10 away from the resident who had struck her. ASM #2 was asked whether or not Resident #10's comprehensive care plan was revised with interventions to keep Resident #10 safe. ASM #2 stated that it had not. ASM #2 was asked how staff would know what interventions were in place to protect Resident #10. ASM #2 stated that she did not know. ASM #2 was asked who would be responsible to review and revise the comprehensive care plan following an incident. ASM #2 stated, "The floor nurse working with the resident at the time of the incident would be responsible." ASM #2 was asked why the comprehensive care plan was not reviewed and revised. ASM #2 did not answer. A copy of the facility policy that addresses care plans was requested at this time.

A review of the facility policy titled "Care Plan" revealed, in part, the following documentation; "F) The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team. G) In cases of significant changes in the resident's condition. The Care Plan must be updated within seven (7) days of new full MDS. V) The MDS Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's ADL (activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on daily basis. Z) All direct care staff must always know, understand and follow their Resident's Care Plan."

On 12/14/17 at 4:00 p.m. the administrator,

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corporate nurse and director of nursing were made aware of the above concerns.

No further information was provided prior to the end of the survey.

2. The facility staff failed to review and revise Resident #15's comprehensive care plan after she struck Resident #10 in the mouth with a butter knife, causing an injury.

Resident #15 was admitted to the facility on 5/26/16 with diagnoses including, but not limited to; dementia, high blood pressure and diabetes.

Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/2/17 coded Resident #15 as scoring a three on the BIMS (brief interview for mental status) indicating that Resident #15 was severely impaired with decisions of daily living. Resident #15 was coded as having no behaviors.

A review of an incident investigation revealed, in part, the following interview conducted with CNA (certified nursing assistant) #9, an aide who had reported to nursing a resident to resident altercation involving Resident #15 and another resident; "I was working Spring Unit in dining area, when I saw (name of Resident #15) hitting (name of Resident #10) with the back of butter knife in her face. I took the knife away from (name of Resident #15) and asked her not to do so. She (Resident #15) grabbed another resident's butter knife went back to her threating (sic) with the knife again. I removed her (Resident #15) from the table with (name of Resident #10) and reported the incident to LPN

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(licensed practical nurse) (name of LPN #13)."

A review of Resident #15's comprehensive care plan did not reveal any information that provided information on how to keep Resident #15 away from Resident #10 following the resident to resident altercation on 6/28/17.

On 12/14/17 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working on Resident #15's unit at the time of the resident to resident altercation. LPN #13 was asked if he recalled the resident to resident altercation on 6/28/17. LPN #13 stated, "Not off the top of my head. I remember I was not in the area when it happened. I didn't see anything happen." LPN #13 was asked whether or not he had completed an incident report. LPN #13 stated that he had not. LPN #13 was asked whether or not he had completed a revision of the comprehensive care plan. LPN #13 stated, "I should have done it, I didn't, we got busy."

On 12/14/17 at 1:15 p.m. an interview was conducted with LPN #14, a floor nurse working on Resident #15's unit at the time of the resident to resident altercation. LPN #14 was asked whether or not she remembered the incident where Resident #15 struck another resident in the face. LPN #14 stated, "The CNA (certified nurse assistant) came to me and told me about it. We separated the two residents. I didn't know to report, I did tell the unit manager and reported the incident to the oncoming night nurse. I should have documented the incident but I didn't think about it."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing.

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ASM #2 was asked to describe the process for reporting a resident to resident altercation with a resulting injury. ASM #2 stated, "The supervisor on the hallway will initiate the investigation, but it falls on me or the ADON (assistant director of nursing) to complete the investigation." ASM #2 was asked if there was an injury of unknown origin would a FRI be sent to the state agency. ASM #2 stated, "Yes we need to send the FRI immediately and then follow up with an investigation." When asked what happened when Resident #15 was observed to strike another resident in the face with a butter knife. ASM #2 stated, "Neither nurse on 6/28/17 documented about the resident to resident altercation. They should have documented and made me aware of the incident but they did not report to me and did nothing." ASM #2 was asked what happened after the social worker spoke with the daughter on 6/29/17 in regards to the bruising that was observed on Resident #10's (the resident struck by Resident #15). ASM #2 was unable to say what happened or why there was such a delay in reporting to the office. ASM #2 was asked what the staff was instructed to do to keep Resident #15 away from the resident she had struck. ASM #2 stated that the staff knew to keep Resident #15 away from the resident she had struck. ASM #2 was asked whether or not Resident #15's comprehensive care plan was revised with interventions to protect other residents. ASM #2 stated that it had not. ASM #2 was asked how staff would know what interventions were in place to ensure that Resident #15 would not strike other residents. ASM #2 stated that she did not know. ASM #2 was asked who would be responsible to review and revise the comprehensive care plan following an incident. ASM #2 stated, "The floor nurse

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working with the resident at the time of the incident would be responsible." ASM #2 was asked why the comprehensive care plan was not reviewed and revised. ASM #2 did not answer. A copy of the facility policy that addresses care plans was requested at this time.

On 12/14/17 at 4:00 p.m. the administrator, corporate nurse and director of nursing were made aware of the above concerns.

No further information was provided prior to the end of the survey.

3. Facility staff failed to review and revise the care plan after Resident #1 was struck by Resident #14.

Resident #1 was admitted to the facility on 10/6/16 with diagnoses that included but were not limited to: fractured leg, irregular heart beat, falls, anxiety and dementia. Review of the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/27/17 coded the resident as having a three out of 15 on the BIMS (brief interview of mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the meal was prepared.

Resident #14 was admitted to the facility on 4/27/15 and readmitted on 12/11/17 with diagnoses that included but were not limited to: dementia, depression and high blood pressure. The most recent MDS, a quarterly assessment, with an ARD of 11/20/17 coded the resident as requiring assistance from staff for activities of daily living except for eating which the resident

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could perform after the meal was prepared.

On 12/13/17 at 5:00 p.m. a request was made for all fall investigations for Resident #1 from ASM (administrative staff member) #2, the director of nursing.

On 12/14/17 at 7:30 a.m. the investigations were received. Included in the investigations was an investigation dated 9/8/17 at 3:21 p.m. which documented, "Incident Description. Nursing Description: Writer was notified by CNA (certified nursing assistant) that resident had been hit by another resident. Witnesses. CNA (name of staff) stated that she saw resident get hit on the right leg by another resident."

Review of the nurse's note dated 9/8/17 at 3:21 p.m. documented, "Occurrence Details: Resident was sitting in her wheelchair in the nurses (sic) station when another resident punched her in the right leg. No injuries noted. RP (responsible party) and MD (medical doctor) notified. Immediate Intervention: residents separated....Resident displayed no pain or discomfort."

Review of Resident #1's care plan did not evidence documentation regarding the incident.

An interview was conducted on 12/14/17 at 8:20 a.m. with OSM (other staff member) #2, the social worker. When asked the social worker's role, OSM #2 stated, "We meet them on admission to see if they need anything." When asked are they notified if there is a resident to resident altercation, OSM #2 stated, "Yes. We do a one on one with them." When asked why they did that, OSM #2 stated, "To make sure they're okay, emotionally, physically, everything." When

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asked if this would be documented, OSM #2 stated, "I would hope so." When asked if this would be care planned, OSM #2 stated, "Gosh, I don't know." When asked if she was aware of the incident between Resident #1 and Resident #14, OSM #2 stated that they were not on her units.

An interview was conducted on 12/14/17 at 8:35 a.m. with LPN (licensed practical nurse) #1, the resident's nurse. When asked the process staff followed when there was a resident to resident altercation, LPN #1 stated, "We do an incident report and it triggers our assessment and we document it." When asked what possible consequences could occur after a resident was struck by another resident, LPN #1 stated, "Physical injury." When asked if there could be a psychological issue, LPN #1 stated, "'Definitely. We have residents who have PTSD (post traumatic stress disorder)." When asked if this would be care planned, LPN #1 stated, "I don't know the protocol on that. I would have to check with my unit manager."

An interview was conducted on 12/14/17 at 9:30 a.m. with OSM #3, the social worker for Resident #1. When asked if she would be notified if there was a resident to resident altercation, OSM #3 stated, "The would call me to talk to the resident to see if they were okay. If it kept happening we would put them on separate units." When asked if that would be documented, OSM #3 stated, "Yes." When asked about the altercation between Resident #1 and Resident #14 OSM #3 stated, "I don't think I was told about that."

An interview was conducted on 12/14/17 at 10:50 a.m. with RN (registered nurse) #2, the resident's nurse. When asked why residents had care

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plans, RN #2 stated, "So we can have a plan for their care.. So everyone can follow and everyone can have input. I've only been over here (Resident #1's unit) for two weeks and the care plans have been a lifesaver." When asked when a care plan was updated, RN #2 stated, "Falls, changes in condition." When asked if a resident might have a negative psychological outcome after being struck by another resident, RN #2 stated, "Well that's a good question. We would ask her. We would know if she was upset." When asked if this would be added to the care plan, RN #2 stated, "Absolutely."

An interview was conducted on 12/14/17 at 11:10 a.m. with ASM #2, the director of nursing. When asked why a resident had a care plan, ASM #2 stated, "So staff know how to care for the resident and we're aware of any actual or potential concerns." When asked if the care plan would be reviewed and revised after a resident to resident altercation, ASM #2 stated it would be updated for the resident who struck the other resident. When asked if the care plan would be updated for the resident who was struck ASM #2 did not respond. ASM #2 was made aware of the findings at that time.

Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. PROCEDURE: A) 'The facility must develop a comprehensive Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive

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F 657	Continued From page 40 assessments.' G) In cases of significant changes in the resident's condition, The Care Plan must be updated within seven (7) days of new full MDS'. No further information was provided prior to exit.	F 657		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		1/12/18

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F 842	Continued From page 41 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to maintain a	F 842	F842 1. Resident #10 no longer resides in the facility. The medical records of residents	

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F 842	Continued From page 42 complete and accurate clinical record for three of 15 residents in the survey sample, Resident #1, Resident #10, and Resident #15. 1. For Resident #1, facility staff failed to document that mouth care was provided on the ADL (activities of daily living) tracker in June 2017. 2. The facility staff failed to document when a resident hit Resident #10 in the mouth with a butter knife. 3. The facility staff failed to document when Resident #15 hit another resident in the mouth with a butter knife. The findings include: 1. Resident #1 was admitted to the facility on 10/21/16 with diagnoses that included but were not limited to history of falls at home with fracture of unspecified neck of right femur, Non-Alzheimer's Dementia, anemia, anxiety disorder, age related osteoporosis and atrial fibrillation. Resident #1's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/27/17. Resident #1 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 03 out of a possible 15 on the BIMS (brief interview for mental status) exam. Resident #1 was coded as requiring extensive assistance with one staff member for most ADLS (activities of daily living). Review of Resident #1's ADL (activities of daily living) log dated June 2017, revealed multiple "holes" blank spaces under ADL task "Mouth	F 842	#1 and #15 cannot be corrected. 2. Residents with medical records have the potential to be affected by this deficient practice. 3. The DON or designee in-serviced CNAs and nurses on accurate and timely documentation. 4. Audits of ADL, and nursing documentation will be conducted five times weekly for twelve weeks to assure compliance. Results of audits will be taken to the QAPI meeting monthly for three months for review and revision. 5. Date of compliance: January 16, 2018.	

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Care." The follow dates and shifts did not have signatures indicating that mouth care was provided:

6/12/17 through 6/15/17 and 6/20/17 7-3 (7 a.m. through 3 p.m.) shift;
6/18/17 through 6/19/17 3-11 (three p.m. through 11 p.m.) shift.

When asked who was responsible for providing oral care, CNA #3 stated that CNAs provide oral care in the morning and at night. CNA #3 stated that nursing aides will assist Resident #1 with brushing her teeth. CNA #3 had never heard of concerns with Resident #1 not receiving oral care. CNA #3 stated that she always provides oral care to Resident #1. When asked where oral care is documented, CNA #3 stated that oral care is documented under the ADL charting. When asked what blanks meant on the ADL report, CNA #3 stated that blanks could mean that the nursing aide forgot to document that oral care was provided. CNA # 3 stated that the nursing aides should never leave areas blank on the ADL report.

On 12/14/17 at 1:41 p.m., an interview was conducted with RN #6. When asked how nurses and she would know if oral care is being provided if there are blanks on the ADL report, RN #6 stated, "I wouldn't know unless they documented in the chart." RN #6 stated that all care should be documented. RN #6 could not recall the above allegation.

On 12/14/17 at approximately 12:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above

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concerns. No further information was presented prior to exit. A policy could not be provided regarding maintaining an accurate clinical record.

2. The facility staff failed to document when a resident hit Resident #10 in the mouth with a butter knife.

Resident #10 was admitted to the facility on 2/12/17 with the following diagnoses; swelling in the legs, depression, difficulty with swallowing, pain and stroke. Resident #10 was discharged from the facility on 8/4/17.

Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/17 coded Resident #10 as scoring a four on the BIMS (brief interview for mental status) indicating that Resident #10 was severely impaired with decisions of daily living. Resident #10 was also coded as requiring maximum assistance of one person with activities of daily living and set up assistance with eating.

A review of Resident #10's clinical record did not reveal any documentation regarding an incident that occurred on 6/28/17 when another resident struck her in the mouth with a butter knife causing a bruise to Resident #10's lips.

A review of Resident #10's incident reports (not part of the clinical record) revealed, in part, the following incident dated 6/30/2017: "Incident Description: Resident noted with bruising to

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medial upper lip on the inside of mouth with bite marks noted to inside of mouth. Resident also noted with redish (sic) purple bruising to medial lower lip that is a mirror image to top lip. When resident asked to describe incident resident stated I think somebody hit me and it was you. Referring to this staff member. When staff member asked when resident stated that she did not no (sic) and proceeded to state that no maybe it was not you. Resident noted with confusion at baseline is alert to self only. Injuries Observed at Time of Incident: Injury Type: Bruise. Injury Location: Face. Witnesses: No Witnesses found."

A review of the facility FRIs (facility reported incidents) revealed, in part, a FRI completed on 7/18/17 with an investigation into the bruising found on Resident #10's mouth on 6/30/17. The conclusion of the investigative process revealed that Resident #10 had been struck in the mouth with a butter knife.

On 12/14/17 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working on Resident #10's unit at the time of the resident to resident altercation. LPN #13 was asked if he recalled a resident to resident altercation between Resident #10 and another resident on 6/28/17. LPN #13 stated, "Not off the top of my head. I remember I was not in the area when it happened. I didn't see anything happen." LPN #13 was asked whether or not he had completed an incident report. LPN #13 stated that he had not. LPN #13 was asked whether or not he had documented anything in the progress notes. LPN #13 stated, "I should have done it, I didn't, we got busy."

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On 12/14/17 at 1:15 p.m. an interview was conducted with LPN #14, a floor nurse working on Resident #10's unit at the time of the resident to resident altercation. LPN #14 was asked whether or not she remembered the incident where Resident #10 was struck in the face by another resident. LPN #14 stated, "The CNA (certified nurse assistant) came to me and told me about it. We separated the two residents. I didn't know to report, I did tell the unit manager and reported the incident to the oncoming night nurse. I should have documented the incident but I didn't think about it."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked whether or not the nursing staff should have documented the incident between Resident #10 and another resident in the progress notes. ASM #2 stated that the incident should have been documented and it was not. A copy of the facility policy that addresses documenting in the clinical record/complete clinical record was requested at this time.

On 12/14/17 at 4:00 p.m. the administrator, corporate nurse and director of nursing were made aware of the above concerns.

No further information was provided prior to the end of the survey.

3. The facility staff failed to document when Resident #15 hit another resident in the mouth with a butter knife.

Resident #15 was admitted to the facility on

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5/26/16 with diagnoses including, but not limited to; dementia, high blood pressure and diabetes.

Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/2/17 coded Resident #15 as scoring a three on the BIMS (brief interview for mental status) indicating that Resident #15 was severely impaired with decisions of daily living. Resident #15 was coded as having no behaviors.

A review of Resident #15's clinical record did not reveal any documentation regarding an incident that occurred on 6/28/17 when she struck another resident in the mouth with a butter knife during dinner causing an injury to the other resident.

There were no incident reports related to Resident #15 striking another resident.

A review of the facility FRIs (facility reported incidents) revealed, in part, a FRI completed on 7/18/17 with a corresponding investigation related to Resident #15 striking another resident on 6/28/17 with a butter knife during dinner.

On 12/14/17 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #13, a floor nurse working on Resident #15's unit at the time of the resident to resident altercation. LPN #13 was asked if he recalled a resident to resident altercation between Resident #15 and another resident on 6/28/17. LPN #13 stated, "Not off the top of my head. I remember I was not in the area when it happened. I didn't see anything happen." LPN #13 was asked whether or not he had completed an incident report. LPN #13 stated that he had not. LPN #13 was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842	Continued From page 48	F 842		

whether or not he had documented anything in the progress notes. LPN #13 stated, "I should have done it, I didn't, we got busy."

On 12/14/17 at 1:15 p.m. an interview was conducted with LPN #14, a floor nurse working on Resident #15's unit at the time of the resident to resident altercation. LPN #14 was asked whether or not she remembered the incident where a resident was struck in the face by Resident #15. LPN #14 stated, "The CNA (certified nurse assistant) came to me and told me about it. We separated the two residents. I didn't know to report, I did tell the unit manager and reported the incident to the oncoming night nurse. I should have documented the incident but I didn't think about it."

On 12/14/17 at 2:00 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked whether or not the nursing staff should have documented the incident between Resident #15 and another resident in the progress notes. ASM #2 stated that the incident should have been documented and it was not. A copy of the facility policy that addresses documenting in the clinical record/complete clinical record was requested at this time.

On 12/14/17 at 4:00 p.m. the administrator, corporate nurse and director of nursing were made aware of the above concerns.

No further information was provided prior to the end of the survey.