STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495196	A. BUILDING ______ B. WING ______	04/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/25/17 through 4/26/17. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 111 certified bed facility was 99 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents # 1 through 17) and three closed record reviews (Residents # 18 through 20).	F 000	The statements on this plan of correction are not an admission to; do not constitute an agreement with the alleged deficiencies stated. The plan of correction constitutes the facilities allegation of compliance. RECEIVED MAY 08 2017 VDH/OLC	
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280	FTag 280 Care plans for resident number one and number nine were updated to reflect interventions for the areas cited for each. Residents with weight loss and or elopement are at risk. 100% audit of residents with weight loss by MDS/dietary manager by 5/12/17, and or elopement by ADON, DON, or Unit manager by 5/12/17. Nursing staff, MDS staff, dietary manager have been re-educated by DON, ADON on 5/4/17 and 5/9/17 concerning the expectation that care plans must be updated when a resident experiences weight loss or has an elopement attempt. An audit of care plans of residents who have experienced weight loss or have attempted elopement will be completed to ensure that current interventions are care planned by MDS, dietary manager, ADON/DON.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christi R. Thomas   TITLE: admin.   (X6) DATE: 5/5/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (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	F 280	The interdisciplinary team will review care plans of each resident when a weight loss is identified or elopement attempted during the daily clinical meeting to ensure that the care plan was updated appropriately. This monitoring will be documented daily for four weeks and once a week for four weeks by DON or designee. DON will report results of monitoring at quarterly QAPI meeting for review and recommendations. Date of completions 5/25/17.	

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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 and clinical record review the facility staff failed to review and revise the CCP (comprehensive care plan) for two of 20 residents in the survey sample, Resident # 1 and Resident # 9.

1. The facility staff failed to review and revise the CCP for Resident # 1 for weight loss.

2. The facility staff failed to review and the revise the CCP for Resident # 9 for weight loss and for elopement risk.

Findings include:

1. The facility staff failed to review and revise the CCP for Resident # 1 for weight loss.

Resident # 1 was admitted to the facility on 09/29/15. Diagnoses for Resident # 1 included, but were not limited to: anemia, hypothyroidism, dementia with behaviors, hypokalemia (low

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potassium in the blood), renal insufficiency and hyperlipidemia.

The most current full MDS (minimum data set) was a significant change assessment dated 11/21/16. This MDS assessed the resident with a cognitive score of 2, indicating the resident had severe impairment in daily decision making skills. The resident also triggered in the CAAS section of this MDS for nutrition.

During clinical record review on 04/25/17 and 04/26/17, Resident # 1's weight records were reviewed. Resident # 1 had a weight loss 10.6 lbs (pounds) between 11/01/16 and 12/01/16.

Resident # 1's physician's orders, dietary and RD (registered dietitian) notes were reviewed and revealed that interventions were put in place for Resident # 1.

Resident # 1's CCP was reviewed and revealed that no interventions regarding nutrition and/or weight loss had been added to the CCP since 04/14/16.

On 04/25/17 at approximately 2:30 p.m., the DON (director of nursing) and the administrator were made aware of the above findings.

No further information and or documentation was presented prior to the exit conference on 04/26/17 at 2:15 p.m.

2. The facility staff failed to review and the revise the CCP for Resident # 9 for weight loss and for elopement risk.

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Resident # 9 was admitted to the facility on 08/29/16. Diagnoses for Resident # 9 included, but were not limited to: colon cancer, high blood pressure, Alzheimer's, dementia, depression, psychotic disorder, cognitive communication deficit and history of UTI (urinary tract infections).

The most current full MDS (minimum data set) was an admission assessment dated 09/05/16. This MDS assessed the resident with a cognitive score of 1, indicating the resident had severe impairment in daily decision making skills. The resident also triggered in the CAAS section of this MDS for nutrition and behaviors.

During clinical record review on 04/25/17 and 04/26/17, Resident # 9's weight records were reviewed. Resident # 9 had a weight loss 15 lbs (pounds) between 10/03/16 and 01/17/17.

Resident # 9's physician's orders, dietary and RD (registered dietitian) notes were reviewed and revealed that interventions were put in place for Resident # 9 regarding weight loss and nutrition.

Resident # 9's CCP was reviewed and revealed that no interventions regarding nutrition and/or weight loss had been added to the CCP since 09/13/16.

Resident # 9's progress notes were reviewed and revealed that Resident # 9 had exit seeking behaviors with 6 documented incidences where Resident # 9 exited out of the facility door. Resident # 9 was redirected back to the facility each time without injury.

Resident # 9's CCP was reviewed for behaviors, wandering and/or elopement. The resident had

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F 280	Continued From page 5 documented elopements dated 11/02/16, 11/15/16 and 11/22/16. The CCP revealed that the resident had was an elopement risk and had a wanderguard at all times. No interventions had been added to the CCP since 09/14/16, which documented, "...Provide tasks/distractions..." On 04/25/17 at approximately 2:30 p.m., the DON (director of nursing) and the administrator were made aware of the above findings and that the resident's CCP had not reviewed and revised to show the interventions in place or the lack, thereof for Resident # 9 in the areas of weight loss and elopement risk. No further information and or documentation was presented prior to the exit conference on 04/26/17 at 2:15 p.m.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review, the facility staff failed to implement care and services as outlined on the comprehensive care plan for one of 20 residents, Resident # 12.	F 282	FTag 282 All interventions were implemented for the resident as soon as their absence was noted. The non-skid strips were clarified in the care plan to be a landing strip at bedside. Residents with interventions for protective equipment in their care plan are at risk. 100% audit of residents with protective equipment to be completed by 5/12/17 by unit manager, DON, ADON or designee.	

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F 282	Continued From page 6 Resident #12 did not have elbow protectors, geri-sleeves, fall strips at the side of her bed or sheepskin applied to the arms of her wheelchair as outlined in her comprehensive care plan. Findings were: Resident #12 was most recently admitted to the facility on 05/09/2016 with the following diagnoses, but not limited to: Hypertension, anxiety, vascular dementia with behavioral disturbances, anemia, and macular degeneration. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/07/2017. Resident #12 was assessed as having difficulty with both long and short term memory, as well as being severely impaired with daily decision making skills. On 04/25/2017, the electronic record, including the care plan, was reviewed. The following intervention was listed for the focus area, "Risk for falls characterized by history of falls, injury, and/or multiple risk factors related to: Use of psychotropic medications, unsteady gait, poor decision making skills, dementia, impaired cognition...Non skid strip to floor next to bed..." Another focus area, "At risk for skin breakdown elated to: Decreased mobility, weakness, incontinent of bow and bladder", had the following interventions listed but not limited to: "Elbow protectors applied; Ensure sheepskin is on the arms of the w/c [wheelchair]; Geri-sleeves on in AM off in PM". On 04/25/2017 at approximately 4:45 p.m., Resident #12 was observed in the hallway. There	F 282	An audit will be performed by ADON, DON, and Unit Manager to identify which residents have interventions for protective equipment in their care plan and verify that they are in place and listed on Kardex and equipment list by 5/12/17. The interdisciplinary team will ensure when care plan updated with intervention for protective equipment that the Kardex and equipment list is also updated. This will occur during the daily clinical meeting. DON, ADON, Unit Manager will make rounds to ensure interventions for protective equipment are in place as care planned. DON or designee will document monitoring daily for four weeks and once a week for four weeks during clinical review. Results of monitoring will be reported by DON at quarterly QAPI meeting for review and recommendations.	

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were no elbow protectors in place. The arms of her wheelchair were not covered in sheepskin. LPN (Licensed practical nurse) #1 was in the hallway, giving meds. She was asked if she was caring for (Name of Resident #12), she stated, "Yes." LPN #1 was asked if Resident #12 was suppose to have sheepskin on her wheelchair arms. She looked in the computer and stated, "I don't see it in my treatments."

On 04/26/2017 at approximately 8:00 a.m., Resident #12 was observed in her room sitting in her wheelchair eating breakfast. Non-skid strips were not observed on the floor on either side of her bed. Her wheelchair arms were not covered in sheepskin, she was not wearing elbow protectors or geri-sleeves.

At approximately 8:20 a.m., the DON (director of nursing) accompanied this surveyor to Resident #12's room. Resident #12 was sitting in the hallway. CNA (certified nursing assistant) #1 was cleaning up spilled milk from the floor in Resident #12's room. She was asked if Resident #12 was dressed and ready for the day. She stated, "Yes." She was asked if Resident #12 was going to the shower. She stated,"She's already had her shower... she's dressed but I will probably need to change her soon." CNA #1 was asked about the geri-sleeves and elbow. She stated, "They were dirty and I sent them to the laundry, I've never seen her with elbow protectors." The DON stated, "She should have another pair. The arms of the wheelchair were pointed out to the DON. She stated, "We'll get the sheepskin on there."

A copy of the CNA Kardex (care plan) was obtained. The elbow protectors were not listed on the Kardex as an intervention.

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A meeting was held with the DON and the administrator on 04/26/2017 at approximately 8:55 a.m. The above information was discussed. The DON stated, "Nursing interventions are not on the treatment records. The elbow protectors are being added to the Kardex." The DON and the administrator were asked how the nursing staff knew what items were to be in place for the residents since the care plan interventions did not show up on the treatment records for the nurses. The DON stated, "They have the care plan, the Kardex, the shift report and an equipment list at the nurse's station that tells them what to look for."

At approximately 9:35 a.m., LPN #2 and LPN #3 were interviewed regarding the equipment list at the nurse's station. They both stated that they did not know what that was. Both LPN's were asked how they knew what interventions/devices were to be in place for each resident. Both LPN's stated that they look at the treatment record. LPN #2 also stated, "I look at the care plans if I have time." She was asked if she looked at the Kardex care plans. She stated, "No."

CNA #1 was interviewed at approximately 9:50 a.m. She was asked how she knew what to do for her residents. She stated, "I get report and I look at the Kardex... I haven't had time to look at any of the Kardex's today."

At approximately 1:00 p.m., the DON was asked if there was a policy regarding how the nurse's determined what equipment/devices/nursing interventions were to be in place for each resident. She stated, "It's in their job description to check the care plans." The job description was

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obtained. Under essential job functions, the following was listed: Ability to follow an accurate comprehensive care plan based on each resident's comprehensive assessment."

No further information was obtained prior to the exit conference on 04/26/2017.

F 502 SS=D 483.50(a)(1) ADMINISTRATION F 502

(a) Laboratory Services

(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to obtain physician ordered labs for one of 20 in the survey sample, Resident # 15. Depakote (an anti-seizure medication) levels and Phenobarbital (an anti-seizure medication) levels were not done in August 2016 or February 2017 as ordered by the physician.

Findings include:

Resident # 15 was admitted to the facility 9/5/14 with diagnoses to include, but not limited to: anemia, high blood pressure, and seizure disorder. Resident # 15 was assessed as being cognitively intact.

The electronic medical record (EMR) was reviewed 4/26/17 at 11:30 a.m. The current POS (physician order summary) included an order carried forward from 2/23/16 for "Depakote and

FTag 502

MD was notified of failure to obtain labs cited as ordered. New order obtained 5/1/17 to draw labs and repeat every six months. No concerns.

Resident with labs ordered by a MD are at risk for this issue. 100% review of Residents orders for labs by 5/12/17 by unit manager, DON, ADON, or designee.

Current lab orders were received to ensure that they are scheduled to be obtained by unit manager, DON, ADON or designee. Licensed nursing staff was reeducated by DON/ADON on 5/4/17 and the process to schedule/obtain labs as ordered by the MD. DON or designee will review labs ordered and obtained during daily clinical meeting to ensure that labs ordered have been obtained.

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F 502	Continued From page 10 Phenobarbital levels every 6 months- February and August." The lab section of the EMR was then reviewed, but the results for the levels were not located. On 4/26/17 at 11:45 a.m. RN (Registered Nurse) # 1 was asked for assistance in locating the labs. RN # 1 stated she would see what she could find and get back to the surveyor. On 4/26/17 at 12:50 p.m. the DON (Director of Nursing) came into the conference room and told this surveyor "Those labs weren't done. The order to schedule them didn't get put in the new system when we transitioned over." No further information was provided prior to the exit conference.	F 502	DON or designee will document review of labs during daily clinical meeting for four weeks and once a week for four weeks. DON will report the results of the monitoring to the quarterly QAPI committee meeting for review and recommendations. Date of completion 5/25/17.	
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician's order prior to obtaining labs for one of 20 residents in the survey sample, Resident # 15. Findings include:	F 504	FTag 504 MD made aware of the lab drawn without an order for resident #15. No new orders or concerns given. Current residents are at risk for this issue. 100% review of lab orders by 5/12/17 by unit manager, DON, ADON or designee. Licensed nursing staff will be re-educated by DON and ADON on 5/4/17 to obtain a lab only if there is an MD order. DON or designee will review lab results received at the next daily clinical meeting and verify that there was an order in place for the lab to be drawn.	

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AUTUMN CARE OF ALTAVISTA	1317 LOLA AVE ALTAVISTA, VA 24517

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F 504	Continued From page 11 Resident # 15 was admitted to the facility 9/5/14 with diagnoses to include, but not limited to: anemia, high blood pressure, and seizure disorder. Resident # 15 was assessed as being cognitively intact. The electronic medical record (EMR) was reviewed 4/26/17 at 11:30 a.m. During review of the lab section, two results for a Depakote level and Phenobarbital level was recorded as being done 12/2/16 and 12/6/16. Further review of the EMR failed to reveal a physician order for the labs. On 4/26/17 at 11:45 a.m. RN (Registered Nurse) # 1 was asked for assistance in locating a physician order for the labs done. RN # 1 stated she would see what she could find and get back to the surveyor. On 4/26/17 at 12:50 p.m. the DON (Director of Nursing) came into the conference room and told this surveyor "There was no order we can find for those labs." No further information was provided prior to the exit conference.	F 504	DON or designee will document review of lab orders during each clinical meeting daily for four weeks and once a week for four weeks. DON will report results of monitoring to the quarterly QAPI committee meeting for review and recommendations. Date of completion 5/25/17.	

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