DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated survey was conducted 3/21/17 through 3/23/17. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 84 certified bed facility was 77 at the time of the survey. The survey sample consisted of 3 current resident reviews (Residents #2 through #4) and 1 closed record review (Resident #1).

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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for 1 of 4 residents in the survey sample; Resident #1.

The facility staff failed to monitor Resident #3's laboratory levels (PT / INR [Protime*/International Normalized Ratio**]) per the physician orders and comprehensive care plan for the use of and management of an anticoagulant(coumadin /

F282 – Services by qualified persons/per care plan

1. IDT reviewed residents #1- #4 care plans for accuracy and to reflect current problems and conditions, ensuring care plan is followed appropriately.
2. All residents receiving Coumadin, Lovenox, Heparin, Eliquis, Xarelto had care plans audited for appropriate monitoring of labs ordered and checks for bruising.
3. Education given to all nurses related to appropriate protocols for monitoring residents that are receiving anticoagulation medications as well as importance of updating and following the care plans that are written. Completed 3/6/17.
4. Audits of labs and audits of residents on Coumadin Lovenox, Heparin, Eliquis, Xarelto (as well as their care plans) are monitored 5 times/week for 12 weeks for accuracy.
5. Date of compliance 3/31/17.

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

Michelle Pyles, LNHA — 4-7-17

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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 282	Continued From page 1	F 282		

warfarin) medication.

The findings include:

Resident #1 was admitted to the facility on 12/31/16 and discharged on 2/27/17. The resident was admitted with the diagnoses of but not limited to stroke, dysphagia, diabetes, left sided below the knee amputation, high blood pressure, acute kidney failure, cataracts, and encephalopathy. The most recent MDS (Minimum Data Set) was a 5-day assessment post readmission (1/11/17 after brief rehospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for eating; and as incontinent of bowel and bladder.

A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17.

A review of the clinical record revealed an order dated 2/8/17 for a PT/INR (Protime*/International Normalized Ratio** blood tests used to monitor the effectiveness of Warfarin (Coumadin)) to be drawn on 2/9/17 or 2/10/17 (the order start date was 2/9/17 and end date was 2/10/17, indicating that during that time period, the laboratory tests were to be drawn.)

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Michelle Tyler, LNHA		4-7-17

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F 282	Continued From page 2	F 282		

A review of the clinical record revealed no results for these laboratory (lab) tests and no documentation of facility follow up.

In an interview conducted with LPN #2 (Licensed Practical Nurse #2) on 3/23/17 at 10:24 a.m., she stated that on 2/24/17 she realized the results were never obtained from the 2/10/17 draw and notified the nurse practitioner.

On 2/24/17 the nurse practitioner saw the patient and labs for PT / INR and a D-Dimer (test used to check for blood clotting problems (1)) were ordered. A review of the clinical record revealed that only the results for the D-Dimer were obtained. The results of the D-Dimer were 738. Normal range was documented as being between 0 and 243.

Further review of the record failed to reveal any evidence that the facility followed up with the lab regarding the results of the PT / INR that were drawn.

In the interview that was conducted with LPN #2 on 3/23/17 at 10:24 a.m., she stated the care plan was not followed; that the facility should have followed up on the results when they did not receive them.

On 3/22/17 at approximately 3:00 p.m., the Administrator and Director of Nursing (Administrative Staff Members #1 and #2) were notified of the concerns. No further information was provided by the end of the survey.

References:
*PT (Protime) is a blood test used in conjunction

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F 282	Continued From page 3 with the INR test to monitor the effectiveness of Warfarin (an anticoagulant medication) Information obtained from https://labtestsonline.org/understanding/analytes/pt/tab/test **INR (International Normalized Ratio) a blood test used to monitor the effectiveness of Warfarin (Coumadin). Information obtained from https://labtestsonline.org/understanding/analytes/pt/tab/test (1) D-Dimer is a lab test used to check for blood clotting problems. Information obtained from https://medlineplus.gov/ency/article/007620.htm	F 282		
F 329 SS=G	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		

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F 329	Continued From page 4	F 329		

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
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 ensure that 1 of 4 residents in the survey sample; Resident #1, was free of unnecessary medication.

Resident #1 was administered Coumadin (an anticoagulant medication) without adequate and timely monitoring of laboratory test for PT / INR (Protime/International Normalized Ratio) levels, for which dosing was dependent on. When the laboratory results were not received, the facility staff failed to follow up with the lab regarding the results, and Resident #1's Coumadin dose was not readjusted accordingly, resulting in toxic levels of the medication for the resident, that required hospitalization.

The findings include:

Past noncompliance: no plan of correction required.

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F 329	Continued From page 5	F 329		

Resident #1 was admitted to the facility on 12/31/16 and discharged on 2/27/17. The resident was admitted with the diagnoses of but not limited to stroke, dysphagia, diabetes, left sided below the knee amputation, high blood pressure, acute kidney failure, cataracts, and encephalopathy. The most recent MDS (Minimum Data Set) was a 5-day assessment post readmission (1/11/17 after brief re-hospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for eating; and as incontinent of bowel and bladder.

Review of the hospital record for the hospitalization leading to the resident's initial admission of 12/31/16 revealed the following:

A review of the hospital record dated 12/31/16 revealed a discharge summary which documented, "Principle Discharge Diagnosis: Acute Ischemic Stroke....Indication for Admission:....68 y.o. (year old) female with a history of poorly controlled DM (diabetes) c/b (complicated by) neuropathy and right BKA (below knee amputation), hypertension (high blood pressure), hyperlipidemia, breast cancer s/p (status post) lumpectomy in 2007, and recurrent DVT/PE (deep vein thrombosis, pulmonary embolism) on coumadin (anticoagulant medication (1)) who presented to the (hospital) ED (Emergency Department) after waking up with left sided weakness.....No history

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F 329	Continued From page 6	F 329		

of stroke. Reports compliance with coumadin. Takes 4 mg (milligrams) nightly (at 6 pm) but had been off all medications, including coumadin, for a year due to insurance issues....Continue full anticoagulation for history of recurrent PEs with warfarin (also known as Coumadin (2)). Check INR (International Normalized Ratio (3)) in 1-2 days after discharge. Restart warfarin at 1 mg (milligram) daily once INR is between 2-3. Continue warfarin 1 mg daily for the duration of antibiotic therapy with Bactrim (an antibiotic (4)). After Bactrim is completed, would recommend close INR monitoring and readjustment of her warfarin to higher doses."

In addition, the above dated hospital record documented that on 12/29/16, the resident's INR was 2.9 (normal range was identified as 0.9 to 1.2). The Protime (PT) level was high at 32.9. Documented normal range was 9.8 to 12.6

A review of the facility physician's orders dated 12/31/16 and 1/1/17 revealed that, per the discharge summary above, Resident #1 was not yet started on the coumadin at the time of admission to the facility on 12/31/16.

On 1/3/17, the resident was sent from the facility to the hospital for suspected heart attack related to complaints of chest pain. The hospital record for this visit contained an INR result of 1.4, which was still elevated above the normal range. The PT was documented as 15.6, which was also still above the normal range. The resident was released back to the facility the same day. The discharge paperwork documented, "Warfarin 1 mg....please wait till INR is between 2 - 3 to resume."

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F 329	Continued From page 7	F 329		

On 1/4/17 the facility obtained an INR level, which the results were 1.5. The facility's laboratory ranges for this documented normal range as being 0.80 to 3.50. A PT result was documented as 12.1. The facility's laboratory documented normal range as being 10.5 to 12.0. [NOTE: variances in normal ranges and results vary by laboratory, based on equipment used, procedures used, laboratory policy, and standard deviation. (6)]. The nurse practitioner notated the lab results on 1/5/17. There were no further labs or medication changes until 1/9/17. Up to this date, the facility had not ordered any coumadin / warfarin for the resident. In the approximately 10 days the resident was in the facility, the PT and INR had been checked twice (1/3/17 at the hospital and 1/4/17 at the facility).

Review of the clinical record revealed that on 1/9/17, Resident #1 was again sent to the hospital, for altered mental status related to hypoglycemia. Resident #1 was admitted, and was discharged back to the facility on 1/11/17. The hospital record documented the following: PT normal ranges 9.6 to 11.0. INR normal ranges (not provided). On 1/8/17 the resident's PT was 11.5 and INR was 1.12. On 1/10/17 the PT was 12.7 and the INR was 1.22. On 1/11/17 the PT was 13.9 and the INR was 1.34. The hospital record further documented, "Discussion:....5. DVT/PE (deep vein thromboses/pulmonary embolus) history. Patient not currently on anticoagulation despite being continued at discharge recently; will start a heparin (7) bridge to warfarin."

The resident was readmitted to the facility on 1/11/17.

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F 329	Continued From page 8	F 329		

A physician's order dated 1/12/17 documented "Warfarin 4 mg in the evening."

A review of the MAR (Medication Administration Record) for the month of January 2017 revealed that Resident #1 received Warfarin, 4 mg every evening through 1/19/17. There were no further labs for PT / INR obtained until 1/19/17. On 1/19/17, a PT / INR were drawn. The results were: PT 13.5 (normal ranges 10.0 - 12.0) and INR 1.28 (normal ranges 0.80 - 3.5).

Review of the clinical record revealed that on 1/20/17 a PT / INR were drawn. The results were PT 12.8 and INR 1.22. The nurse practitioner documented on the lab results to check (labs) on Monday (1/23/17) and to increase the Coumadin to 6 mg every evening. A review of the physician's orders revealed one dated 1/20/17 for "Warfarin 6 mg in the evening." A review of the MAR for January 2017 revealed the resident received this medication as prescribed each evening from 1/20/17 through 1/26/17.

On 1/23/17 a PT / INR were drawn. The results were: PT 14.0 and INR 1.33. The nurse practitioner documented on the results on 1/25/17 to check (labs) on Friday (1/27/17) and to increase the Coumadin to 8 mg. A review of the physician's orders revealed no new orders at this time. The medication dose did not change. Review of the MARs revealed the resident remained on the previous dose of 6 mg every evening through 1/26/17.

On 1/25/17 a PT / INR were drawn. The results were: PT 16.9 and INR 1.59. It was unclear as to why the results were drawn on this date as there

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F 329	Continued From page 9	F 329		

was not an order to do so. However, the nurse practitioner initialed the results on 1/26/17 and hand written on the results was a notation to increase the Coumadin to 8 mg and recheck the INR on 2/1/17. A review of the physician's orders revealed one dated 1/27/17 for Coumadin 4 mg tabs, give 2 tabs (8 mg) every morning.

A review of Resident #1's January MAR revealed no dose of Coumadin was administered on 1/27/17. Up to this point, the medication was being administered at night. On 1/27/17, when the above order was written for 4 mg Coumadin, give 2 tabs (8 mg) in the morning, it was before the resident's evening dose was due, thus an order for the medication was not in effect for the resident to receive an evening dose for 1/27/17. A review of the MAR for January 2017 revealed the resident received the 8 mg for the remaining days of January 2017.

On 2/1/17 a PT / INR were drawn. The results were PT 13.4 and INR 1.28. The nurse practitioner initialed the results on 2/2/17 and handwritten on the results was the notation for "12 mg tonight (2/1/17), 10 mg Thurs (Thursday, 2/2/17) and recheck the labs on Monday (2/6/17). A review of the physician's orders revealed one dated 2/1/17 for "Coumadin 12 mg one time only" and an order also dated 2/1/17 for Coumadin 10 mg in the evening." A review of Resident #1's February MAR revealed the resident received the 12 mg on 2/1/17 and 10 mg on 2/2/17 through 2/8/17. It was noted that this order was, once again, scheduling the medication for an evening administration.

On 2/6/17 a PT and INR were drawn. The results were: PT 24.1 and INR 2.24. Hand written on the

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F 329	Continued From page 10	F 329		

results was "Now 10 mg Coumadin" and "check Wednesday (2/8/17). The nurse practitioner initialed the results on 2/8/17. There was no evidence of an order written for this one time dose, or evidence the resident received this one time dose. It was unclear if that was the intent of the notation, as the resident was already on 10 mg every evening at that time.

On 2/8/17 a PT / INR were drawn. The results were: PT 41.1 and INR 3.74. The nurse practitioner wrote on the results to decrease (Coumadin) to 8 mg and "hold x 2dy" (it was unclear if this meant "today" or for "2 days.) A review of Resident #1's physician's orders revealed one dated 2/8/17 that documented, "Coumadin 8 mg in the evening, start 2/10/17." A review of Resident #1's February 2017 MAR revealed the resident received 10 mg on 2/8/17, none on 2/9/17, and started the 8 mg dose on 2/10/17 as ordered; indicating that one day was held. The physician's orders did not specify to hold any doses even though the notation on the lab results documented to hold x 2 days. Further review of the MAR revealed Resident #1 continued to receive 8 mg of Coumadin through the date of discharge to the hospital on 2/27/17, each date from 2/10/17 through 2/27/17 contained initials indicating the medication was administered.

Review of the clinical record failed to reveal the results of the PT / INR that were to be drawn on 2/10/17. A review of the facility lab order sheet revealed that a PT / INR were ordered to be drawn on 2/10/17 and the lab tech (technician) initialed that the labs were drawn. However, to date of the survey (3/23/17), the results were never provided to the facility from the lab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 11	F 329		

company. There was no evidence the facility attempted to follow up with the lab regarding this lab test results until after Resident #1 was discharged to the hospital for Warfarin toxicity on 2/27/17.

On 2/15/17 (a Wednesday) the nurse practitioner saw the resident. The NP note dated 2/15/17 did not document anything regarding the missing PT/INR results that were drawn on 2/10/17. A notation was made that documented "INR on Wednesdays" indicating that the lab was performed on Wednesdays. There were no orders written dated 2/15/17 for a PT/INR to be drawn, or for a dose change in the medication.

On 2/21/17 Resident #1 was transferred to a different unit in the facility. Review of the February 2017 MAR revealed that after the transfer, Resident #1 continued to receive 8 mg of Coumadin every day that she was already ordered to be taking since 2/10/17. There were no further PT / INR orders obtained until 2/24/17.

On 2/23/17 the NP saw the resident. The note documented, "(illegible) INR still (illegible)." Review of the physician's orders revealed one dated 2/23/17 for "CBC (complete blood count (15)), BMP (basic metabolic panel (16)), Mag (magnesium (17)) level, Phos (phosphorous (18)) level and d-dimer (test used to check for blood clotting problems (8)) in A.M." Also dated 2/23/17 was an order for a "PT/INR Friday" (2/24/17).

In an interview conducted with LPN #2 (Licensed Practical Nurse #2) on 3/23/17 at 10:24 a.m., she stated that on 2/23/17 she realized the results were never obtained from the 2/10/17 PT/INR lab draw and notified the nurse practitioner. LPN #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 12	F 329		

stated the nurse practitioner saw the resident and ordered Labs for PT / INR and a D-Dimer (8).

A review of the labs dated 2/24/17 revealed that the d-dimer could not be performed due to a problem with the sample and was going to be redrawn. There was no evidence the PT/INR was drawn with the other labs drawn the morning of 2/24/17.

A review of the lab order slips revealed one dated 2/24/17 that documented "PT/INR, d-dimer, re-collect."

On 2/24/17 the NP saw the resident again. The note documented, "INR (illegible) .....INR still not in (illegible) ...INR results (illegible) 2-3 ..."

On 3/22/17 at 3:28 p.m., in an interview with LPN #3, she stated that the lab called her on 2/24/17 regarding labs drawn that morning and reported that there was something wrong with the sample for the d-dimer and PT/INR and that they would be back later that day to redraw these labs.

On 3/22/17 at 4:57 p.m., an interview was conducted with LPN #4. She stated that she worked evening shift on 2/24/17 and saw the lab tech in the building and going into Resident #1's room to redraw the labs. LPN #4 stated that she inquired of the lab tech about the labs she was drawing because she was not made aware from day shift, to be expecting any labs to be drawn that evening. She stated the lab tech was drawing a PT/INR and d-dimer.

A review of the labs drawn 2/24/17 revealed the d-dimer was 738. The normal range documented on the lab results was 0-243. Further review of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 13	F 329		

the clinical record failed to reveal any evidence that the facility followed up with the lab regarding the results of the PT / INR that were drawn.

Review of the nurses' notes documented the following entries:

- 2/25/17 at 11:00 a.m., documented the resident's skin tone was normal, and warm and dry, and that stool was soft and formed.

- 2/26/17 at 10:30 a.m., documented the resident's skin tone was normal and skin was warm and dry.

- 2/26/17 at 5:15 p.m., "Resident c/o pain dramatically crying out into hall. She c/o pain in ribs, neck, and arms. When I took the resident some Tylenol (9) down she refused it stating, "I am not going to even take it anymore, it doesn't help." She stopped crying out as soon as I left the room. Note left for MD (medical doctor) to evaluate her pain. Will continue to monitor...."

- 2/27/17 at 3:30 a.m., documented, "...Resident skin tone is normal. Skin is warm and dry.....Last BM (bowel movement) 02/26/17. Stool appearance is soft and formed...."

- 2/27/17 at 10:34 a.m., documented, "Resident c/o chest pain at 08:40 A.M. Crying out during the episode. V/S (vital signs) are 97.6 (temperature), 75 (pulse), 17 (respirations), 159/85 (blood pressure) with an 02 sat (oxygen saturation) of 95% on RA (room air). Took her meds and is calmer at this time.

A note by the nurse practitioner on 2/27/17 at 11:26 a.m., documented, "f/u (follow up) CP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 14	F 329		

(complaints of pain), with elevated dimer, no inc [sic - INR] as of yet, getting stat today as not returned prior per report to me, pt (patient) declining ED (emergency department) visit as I stated multiple times that she should be evaluated, is oriented and able to make decisions, ekg (electrocardiogram) looked ok, no nausea, no bleeding, no sob (shortness of breath)....Physical Exam:....Skin: no rash, turgor normal, warm, dry....A/P: (assessment/plan) 1. CP improved, pt awake and alert, could suspect PE (pulmonary embolus), need INR returned asap (as soon as possible), nurse to call me, pt (patient) declines ED visit and understands risks. 2. CVA/debility, cont LTC (continue long term care). 3. URI (upper respiratory infection), on antibiotic.

A nurse's note dated 2/27/17 at 6:15 p.m., documented the resident was given Tylenol 2 tabs for pain, and a follow up note documented that the medication was ineffective.

A routine weekly skin assessment completed on 2/27/17 at 4:14 p.m., documented no changes in skin condition or areas of concern.

A nurse's note dated 2/27/17 at 6:43 p.m., documented, "Lab called with PT INR results which the lab states are too high to read on their machine. (Nurse Practitioner) called and she gave an order to give 5 Mg Vit (vitamin) K (used to reverse the effects of blood thinning medications when too much is given (10)) IM stat (5 milligrams of Vitamin K, via intramuscularly injection immediately). Order written, noted and faxed to the pharmacy. Resident vomited coffee ground material (vomit having the appearance and consistency of coffee grounds because of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 15	F 329		

blood mixed with gastric contents*) at 17:25 (5:25 p.m.). (Nurse Practitioner) notified. She gave an order to give 40 mg of Prilosec (used to treat reflux and ulcers (10)) stat (immediately) and then cont. (continue) the order BID (twice daily). Prilosec given as ordered. her daughter (name) was notified. Resident was instructed that if she had more emesis then she would need to go to the hospital. She stated that she didn't want to go to hospital as she didn't want to loose [sic] her bed."

A nurse's note dated 2/27/17 at 11:30 p.m., documented, "Staff notified writer that resident was not feeling well and acting differently. Writer assessed resident, found resident to be confused, disoriented, skin tone appeared light yellow all over, large purple bruises noted to Rt (right) upper arm, a large raised hematoma to Rt forearm. Resident c/o (complained of) Rt arm being weak, more than normal. Writer had received in report, resident had vomited x1 dark brown, coffee ground looking emesis earlier in the evening. CNA (certified nursing assistant) reported to writer that resident had vomited again, just before writer entered room, x2. CNA described emesis as dark brown coffee grounds. Resident said she was unable to eat any food, vomited from drinking a sip of water. Resident said she wanted to go to ER (emergency room). POA (Power of Attorney) notified of change, and agreed that she wanted her mom to be sent to the ER. Placed call to 911, resident sent via squad to (hospital).

A nurse's note dated 2/28/17 at 2:42 a.m., documented, "SBAR: Situation: Change in condition, symptoms or signs I am calling about is/are: Altered mental status Functional decline

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 16	F 329		

(worsening function and/or mobility) Nausea/Vomiting. This started on 02/27/2017 and the time of day Afternoon. Background: Resident is in the nursing home for long term care... (resident diagnoses were listed). Medication changes in the past week: d/c (discontinue) coumadin, metoperolo [sic]. Assessment/Appearance: Vitals: BP (blood pressure) 107/54 - 2/27/17 00:48 (12:48 a.m.) Position: Lying r/arm. P (pulse) 85 - 2/27/2017 00:49 (12:49 a.m.) Pulse Type: Regular. R (respirations) 17 - 2/27/17 00:50 (12:50 a.m.). T (temperature) 99.4 - 2/27/2017 19:19 (7:19 p.m.) Route: Oral. W (weight) 210.8 lb (pounds) - 2/15/2017 13:18 (1:18 p.m.) Scale: Lift Scale. O2 (oxygen) 94% - 2/27/2017 19:20 (7:20 p.m.) Method: Room air, BS (blood sugar) 271 - 2/27/2017 00:51 (12:51 a.m.) Pain: 0. Resident has increased confusion (e.g. disorientation). Resident has general weakness, no behavioral changes observed. no [sic] respiratory changes observed. Resident noted to be Jaundice Blood [sic] noted in stool or vomitus c/o [sic] of nausea. Vomiting noted. appetite [sic] diminished No [sic] Urinary changes observed. Other neurological symptoms observed. Skin Changes: Discoloration. Disoriented, confused, c/o (complained of) weakness. Resident c/o not feeling well, asked to go to ER....Request: Reported to primary care clinician. No, d/t (due to) time of night, on. [sic] Orders obtained: (none listed). Name of Family/healthcare agent notified: (name) residents [sic] daughter. on 02/27/2017 11:30 PM."

A nurse's note dated 3/1/17, documented as a "Late entry for 2-23-17" documented, "NP (nurse practitioner) notified of resident not receiving PT/INR since 2-8-17 NP with order for PT/INR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 17	F 329		

next day 2-24-17. Resident transferred to Unit 1 Lab slip taken down to south unit manager. Resident aware of lab orders for next day."

A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17.

A review of the facility policy for "Anticoagulation Protocol" documented, "....b. The nurse will obtain an order from the physician for any pertinent labs for monitoring of the anticoagulant therapy ...."

Additional interviews conducted with staff as follows:

In an interview conducted on 3/22/17 at 1:18 with LPN (licensed practical nurse) #2, she stated that at the time of this resident (Resident #1), she was the unit manager for the skilled unit. LPN #2 stated that the nurses were responsible to ensure that labs were received and reported to the physician. She could not provide further explanation as to how it fell through the cracks that this resident's PT/INR that was drawn on 2/10/17 was never followed up on for the results.

In a follow up interview that was conducted with LPN #2 on 3/23/17 at 10:24 a.m., she stated that as the unit manager she should have ensured that the lab results were received. In addition LPN #2 stated that the care plan for monitoring the labs as ordered was not followed. LPN #2 stated that as the unit manager, she would bring to the morning meetings, any information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 18	F 329		

regarding abnormal labs, but that whether or not a lab result was actually received was not part of the process at the time. LPN #2 stated that aside from the nurses, the physician/nurse practitioner should also have followed up; asking about lab results that he/she had ordered was expecting to receive.

In an interview conducted 3/22/17 at 2:02 p.m., with LPN #1 (Licensed Practical Nurse) she stated that she received the resident from the other unit on 2/21/17 and that everything was going ok with the resident. LPN #1 stated that a couple days later, the unit manager from the other unit brought over the PT/INR flow sheet (which had not been initiated until 1/20/17) and that the unit manager told her she just realized that the resident had not had a PT/INR drawn since about 2/8/17. LPN #1 stated the nurse practitioner was notified and orders were obtained to get a PT/INR on "Friday" (which was 2/24/17). She stated that during the approximately 1 week the resident was on her unit, there were no noted issues with the resident until the events of 2/27/17.

On 3/22/17 at 5:00 an interview was conducted with OSM (Other Staff Member) #1, the pharmacist. She stated that until a resident is stable, that labs should be monitored frequently, at least weekly. She stated that if a resident has Coumadin toxicity, that the effects of that could be significant bleeding related issues (i.e., brain bleed, gastrointestinal bleed, etc.)

On 3/23/17 at 11:20 a.m., in an interview with the Director of Nursing (DON) (Administrative Staff Member #2 - ASM #2) she stated that ever since this situation occurred, she has been in contact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 19	F 329		

with the lab and that results from Resident #1's PT/INR draw on 2/10/17 could not be located by the lab company either. She stated that the lab company followed up with the hospital laboratory facility that they utilize and that it would appear the hospital lab did not perform the testing. In addition, ASM #2 stated a similar scenario occurred with the stat testing that was done on 2/24/17 wherein the lab collected was for a D-Dimer and a PT/INR but the hospital laboratory failed to perform the PT/INR. Therefore, the lab company only had results for the D-Dimer to return to the facility. The facility had failed to follow up with the lab company regarding the results for the PT/INR for either of these dates Resident #1's levels went unchecked and Resident #1 continued to receive 8 mg of Coumadin without monitoring and was sent to the emergency room on 2/27/17 and was hospitalized for Coumadin/Warfarin toxicity.

On 3/23/17 at approximately 8:30 a.m., the Administrator stated that the nurse practitioner had been out sick but was expecting my call; and that the physician was expecting my call specifically at 10:00 a.m. On 3/23/17 at 9:58 a.m., and 10:05 a.m., attempts were made to contact the physician, without success. Attempts to contact the nurse practitioner were made on 3/23/17 at 10:11 a.m. and 10:20 a.m. The nurse practitioner did not answer the call.

A review of the hospital discharge summary dated 3/14/17 documented in part the following: "Acute blood loss anemia (source unknown), in setting of Warfarin toxicity/fluctuation (resolved) ...."

On 3/22/17 at approximately 3:00 p.m., the Administrator and Director of Nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 20	F 329		

notified of the concern for harm. The following plan of correction was presented:

1. Incident: 2/27/17 - resident with a high PT/INR [with a result of] - (unable to read); bruising noted; emesis x1 coffee ground in color - (inconsistency of labs)): resident evaluated by NP, labs ordered, PT/INR elevated; Vit K given; resident to hospital and admitted.
2. 100% audit of residents receiving Coumadin, Lovenox (12), Heparin, Eliquis (13), Xarelto (14) audited for pertinent labs and bruising/bleeding and relating care plans.
3. Education to nursing staff on anticoagulant policy to include signs and symptoms; education to licensed nurses on anticoagulant policy and lab process by DON/designee
4. Audits of labs and audits of resident on Coumadin, Lovenox, Heparin, Eliquis, Xarelto audited 5 times a week for 12 weeks for lab orders/completion/ MD/RP notification by DON/designee. Results of audits will be taken to QAPI monthly x 3 months for review and revision as needed.
5. Date of compliance: March 6, 2017.

A review of the plan of correction revealed that 100% of the nursing staff was educated. Audits to date were reviewed. All current residents on Coumadin or Warfarin who were also in the facility at the time the resident was in the facility were reviewed by the surveyor. There were no discrepancies identified with these residents' labs and Coumadin dosing at the time Resident #1 was in the facility or since then up to the date of survey.

No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 21	F 329		

Complaint Deficiency past noncompliance.

References:

(1) Coumadin is a medication that helps keep your blood from clotting. Information obtained from https://medlineplus.gov/ency/patientinstructions/000255.htm

(2) Warfarin is another name for Coumadin (see 1 above)

(3) INR (International Normalized Ratio) a blood test used to monitor the effectiveness of Warfarin (Coumadin). Information obtained from https://labtestsonline.org/understanding/analytes/pt/tab/test

(4) Bactrim is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a684026.html

(5) PT (Protime) is a blood test used in conjunction with the INR test to monitor the effectiveness of Warfarin (see 3 above)

(6) While accuracy of laboratory testing has significantly evolved over the past few decades, some lab-to-lab variability can occur due to differences in testing equipment, chemical reagents used, and analysis techniques. Consequently, for most lab tests, there is no universally applicable reference value. Information obtained from https://labtestsonline.org/understanding/features/ref-ranges/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 22	F 329		

(7) Heparin is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a682826.html

(8) D-Dimer is a lab test used to check for blood clotting problems. Information obtained from https://medlineplus.gov/ency/article/007620.htm

(9) Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

(10) Vitamin K is used to reverse the effects of blood thinning medications when too much is given. Information obtained from https://medlineplus.gov/druginfo/natural/983.html

(11) Prilosec is. Information obtained from https://medlineplus.gov/druginfo/meds/a693050.html

(12) Lovenox is used to prevent blood clots in the legs of patients who are on bedrest, or who are having hip replacement, knee replacement, or stomach surgery. Information obtained from https://medlineplus.gov/druginfo/meds/a601210.html

(13) Eliquis is used to prevent strokes and blood clots in people who have atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

(14) Xarelto is used to treat deep vein thrombosis or pulmonary embolism. Information obtained from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 23	F 329		

https://medlineplus.gov/druginfo/meds/a611049.html

(15) According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques.

(16) A BMP (Basic metabolic panel) is a group of blood tests that provides information about your body's metabolism....This test can be used to evaluate kidney function, blood acid/base balance, and your levels of blood sugar, and electrolytes. Depending on which lab you use, a basic metabolic panel may also check your levels of calcium and a protein called albumin. Information obtained from http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm

(17) According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 1042, an MG level (Magnesium) is "a blood test used to determine the level of magnesium, an electrolyte that is critical in nearly all metabolic processes. Abnormal levels may indicate renal insufficiency, chronic renal disease, uncontrolled diabetes, diabetic acidosis, Addison's disease, hypothyroidism, malnutrition, malabsorption, hypoparathyroidism, and alcoholism."

(18) Phosphorus tests are most often ordered along with other tests ...to help diagnose and/or monitor treatment of various conditions ..." Information obtained from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 329	Continued From page 24 https://labtestsonline.org/understanding/analytes/phosphorus/tab/test *This information was obtained from the website: coffee-ground vomit	F 329		
F 502 SS=G	483.50(a)(1) ADMINISTRATION (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, facility document review, and clinical record review, it was determined that the facility staff failed to provide timely lab services to meet the resident's needs for 1 of 4 residents in the survey sample; Resident #1. For Resident #1, the facility staff failed to ensure timely results of a laboratory test for PT / INR levels, for which an anticoagulant medication dosing was dependent on. When the laboratory results were not received, the facility staff failed to follow up with the lab regarding the results, and therefore, the medication dose was not readjusted accordingly, resulting in toxic levels of the medication for the resident, that required hospitalization. The findings include:	F 502	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 25	F 502		

Resident #1 was admitted to the facility on 12/31/16 and discharged on 2/27/17. The resident was admitted with the diagnoses of but not limited to stroke, dysphagia, diabetes, left sided below the knee amputation, high blood pressure, acute kidney failure, cataracts, and encephalopathy. The most recent MDS (Minimum Data Set) was a 5-day assessment post readmission (1/11/17 after brief re-hospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for eating; and as incontinent of bowel and bladder.

Review of the hospital record for the hospitalization leading to the resident's initial admission of 12/31/16 revealed the following:

A review of the hospital record dated 12/31/16 revealed a discharge summary which documented, "Principle Discharge Diagnosis: Acute Ischemic Stroke....Indication for Admission:....68 y.o. (year old) female with a history of poorly controlled DM (diabetes) c/b (complicated by) neuropathy and right BKA (below knee amputation), hypertension (high blood pressure), hyperlipidemia, breast cancer s/p (status post) lumpectomy in 2007, and recurrent DVT/PE (deep vein thrombosis, pulmonary embolism) on coumadin (anticoagulant medication (1)) who presented to the (hospital) ED (Emergency Department) after waking up with left sided weakness.....No history

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 26	F 502		

of stroke. Reports compliance with coumadin. Takes 4 mg (milligrams) nightly (at 6 pm) but had been off all medications, including coumadin, for a year due to insurance issues....Continue full anticoagulation for history of recurrent PEs with warfarin (also known as Coumadin (2)). Check INR (International Normalized Ratio (3)) in 1-2 days after discharge. Restart warfarin at 1 mg (milligram) daily once INR is between 2-3. Continue warfarin 1 mg daily for the duration of antibiotic therapy with Bactrim (an antibiotic (4)). After Bactrim is completed, would recommend close INR monitoring and readjustment of her warfarin to higher doses.

In addition, the above dated hospital record documented that on 12/29/16, the resident's INR was 2.9 (normal range was identified as 0.9 to 1.2). The Protime (PT) level was high at 32.9. Documented normal range was 9.8 to 12.6

A review of the facility physician's orders dated 12/31/16 and 1/1/17 revealed that, per the discharge summary above, Resident #1 was not yet started on the coumadin at the time of admission to the facility on 12/31/16.

On 1/3/17, the resident was sent from the facility to the hospital for suspected heart attack related to complaints of chest pain. The hospital record for this visit contained an INR result of 1.4, which was still elevated above the normal range. The PT was documented as 15.6, which was also still above the normal range. The resident was released back to the facility the same day. The discharge paperwork documented, "Warfarin 1 mg....please wait till INR is between 2 - 3 to resume."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 27	F 502		

On 1/4/17 the facility obtained an INR level, which the results were 1.5. The facility's laboratory ranges for this documented normal range as being 0.80 to 3.50. A PT result was documented as 12.1. The facility's laboratory documented normal range as being 10.5 to 12.0. [NOTE: variances in normal ranges and results vary by laboratory, based on equipment used, procedures used, laboratory policy, and standard deviation. (6)]. The nurse practitioner notated the lab results on 1/5/17. There were no further labs or medication changes until 1/9/17. Up to this date, the facility had not ordered any coumadin / warfarin for the resident. In the approximately 10 days the resident was in the facility, the PT and INR had been checked twice (1/3/17 at the hospital and 1/4/17 at the facility).

Review of the clinical record revealed that on 1/9/17, Resident #1 was again sent to the hospital, for altered mental status related to hypoglycemia. Resident #1 was admitted, and was discharged back to the facility on 1/11/17. The hospital record documented the following: PT normal ranges 9.6 to 11.0. INR normal ranges (not provided). On 1/8/17 the resident's PT was 11.5 and INR was 1.12. On 1/10/17 the PT was 12.7 and the INR was 1.22. On 1/11/17 the PT was 13.9 and the INR was 1.34. The hospital record further documented, "Discussion:....5. DVT/PE (deep vein thromboses/pulmonary embolus) history. Patient not currently on anticoagulation despite being continued at discharge recently; will start a heparin (7) bridge to warfarin."

The resident was readmitted to the facility on 1/11/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 28	F 502		

A physician's order dated 1/12/17 documented "Warfarin 4 mg in the evening."

A review of the MAR (Medication Administration Record) for the month of January 2017 revealed that Resident #1 received Warfarin, 4 mg every evening through 1/19/17. There were no further labs for PT / INR obtained until 1/19/17. On 1/19/17, a PT / INR were drawn. The results were: PT 13.5 (normal ranges 10.0 - 12.0) and INR 1.28 (normal ranges 0.80 - 3.5).

Review of the clinical record revealed that on 1/20/17 a PT / INR were drawn. The results were PT 12.8 and INR 1.22. The nurse practitioner documented on the lab results to check (labs) on Monday (1/23/17) and to increase the Coumadin to 6 mg every evening. A review of the physician's orders revealed one dated 1/20/17 for "Warfarin 6 mg in the evening." A review of the MAR for January 2017 revealed the resident received this medication as prescribed each evening from 1/20/17 through 1/26/17.

On 1/23/17 a PT / INR were drawn. The results were: PT 14.0 and INR 1.33. The nurse practitioner documented on the results on 1/25/17 to check (labs) on Friday (1/27/17) and to increase the Coumadin to 8 mg. A review of the physician's orders revealed no new orders at this time. The medication dose did not change. Review of the MARs revealed the resident remained on the previous dose of 6 mg every evening through 1/26/17.

On 1/25/17 a PT / INR were drawn. The results were: PT 16.9 and INR 1.59. It was unclear as to why the results were drawn on this date as there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 29	F 502		

was not an order to do so. However, the nurse practitioner initialed the results on 1/26/17 and hand written on the results was a notation to increase the Coumadin to 8 mg and recheck the INR on 2/1/17. A review of the physician's orders revealed one dated 1/27/17 for Coumadin 4 mg tabs, give 2 tabs (8 mg) every morning.

A review of Resident #1's January MAR revealed no dose of Coumadin was administered on 1/27/17. Up to this point, the medication was being administered at night. On 1/27/17, when the above order was written for 4 mg Coumadin, give 2 tabs (8 mg) in the morning, it was before the resident's evening dose was due, thus an order for the medication was not in effect for the resident to receive an evening dose for 1/27/17. A review of the MAR for January 2017 revealed the resident received the 8 mg for the remaining days of January 2017.

On 2/1/17 a PT / INR were drawn. The results were PT 13.4 and INR 1.28. The nurse practitioner initialed the results on 2/2/17 and handwritten on the results was the notation for "12 mg tonight (2/1/17), 10 mg Thurs (Thursday, 2/2/17) and recheck the labs on Monday (2/6/17). A review of the physician's orders revealed one dated 2/1/17 for "Coumadin 12 mg one time only" and an order also dated 2/1/17 for Coumadin 10 mg in the evening." A review of Resident #1's February MAR revealed the resident received the 12 mg on 2/1/17 and 10 mg on 2/2/17 through 2/8/17. It was noted that this order was, once again, scheduling the medication for an evening administration.

On 2/6/17 a PT and INR were drawn. The results were: PT 24.1 and INR 2.24. Hand written on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 30	F 502		

results was "Now 10 mg Coumadin" and "check Wednesday (2/8/17). The nurse practitioner initialed the results on 2/8/17. There was no evidence of an order written for this one time dose, or evidence the resident received this one time dose. It was unclear if that was the intent of the notation, as the resident was already on 10 mg every evening at that time.

On 2/8/17 a PT / INR were drawn. The results were: PT 41.1 and INR 3.74. The nurse practitioner wrote on the results to decrease (Coumadin) to 8 mg and "hold x 2dy" (it was unclear if this meant "today" or for "2 days.) A review of Resident #1's physician's orders revealed one dated 2/8/17 that documented, "Coumadin 8 mg in the evening, start 2/10/17." A review of Resident #1's February 2017 MAR revealed the resident received 10 mg on 2/8/17, none on 2/9/17, and started the 8 mg dose on 2/10/17 as ordered; indicating that one day was held. The physician's orders did not specify to hold any doses even though the notation on the lab results documented to hold x 2 days. Further review of the MAR revealed Resident #1 continued to receive 8 mg of Coumadin through the date of discharge to the hospital on 2/27/17, each date from 2/10/17 through 2/27/17 contained initials indicating the medication was administered.

Review of the clinical record failed to reveal the results of the PT / INR that were to be drawn on 2/10/17. A review of the facility lab order sheet revealed that a PT / INR were ordered to be drawn on 2/10/17 and the lab tech (technician) initialed that the labs were drawn. However, to date of the survey (3/23/17), the results were never provided to the facility from the lab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 31	F 502		

company. There was no evidence the facility attempted to follow up with the lab regarding this lab test results until after Resident #1 was discharged to the hospital for Warfarin toxicity on 2/27/17.

On 2/15/17 (a Wednesday) the nurse practitioner saw the resident. The NP note dated 2/15/17 did not document anything regarding the missing PT/INR results that were drawn on 2/10/17. A notation was made that documented "INR on Wednesdays" indicating that the lab was performed on Wednesdays. There were no orders written dated 2/15/17 for a PT/INR to be drawn, or for a dose change in the medication.

On 2/21/17 Resident #1 was transferred to a different unit in the facility. Review of the February 2017 MAR revealed that after the transfer, Resident #1 continued to receive 8 mg of Coumadin every day that she was already ordered to be taking since 2/10/17. There were no further PT / INR orders obtained until 2/24/17.

On 2/23/17 the NP saw the resident. The note documented, "(illegible) INR still (illegible)." Review of the physician's orders revealed one dated 2/23/17 for "CBC (complete blood count (15)), BMP (basic metabolic panel (16)), Mag (magnesium (17)) level, Phos (phosphorous (18)) level and d-dimer (test used to check for blood clotting problems (8)) in A.M." Also dated 2/23/17 was an order for a "PT/INR Friday" (2/24/17).

In an interview conducted with LPN #2 (Licensed Practical Nurse #2) on 3/23/17 at 10:24 a.m., she stated that on 2/23/17 she realized the results were never obtained from the 2/10/17 PT/INR lab draw and notified the nurse practitioner. LPN #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 32	F 502		

stated the nurse practitioner saw the resident and ordered Labs for PT / INR and a D-Dimer (8).

A review of the labs dated 2/24/17 revealed that the d-dimer could not be performed due to a problem with the sample and was going to be redrawn. There was no evidence the PT/INR was drawn with the other labs drawn the morning of 2/24/17.

A review of the lab order slips revealed one dated 2/24/17 that documented "PT/INR, d-dimer, re-collect."

On 2/24/17 the NP saw the resident again. The note documented, "INR (illegible) .....INR still not in (illegible) ...INR results (illegible) 2-3 ..."

On 3/22/17 at 3:28 p.m., in an interview with LPN #3, she stated that the lab called her on 2/24/17 regarding labs drawn that morning and reported that there was something wrong with the sample for the d-dimer and PT/INR and that they would be back later that day to redraw these labs.

On 3/22/17 at 4:57 p.m., an interview was conducted with LPN #4. She stated that she worked evening shift on 2/24/17 and saw the lab tech in the building and going into Resident #1's room to redraw the labs. LPN #4 stated that she inquired of the lab tech about the labs she was drawing because she was not made aware from day shift, to be expecting any labs to be drawn that evening. She stated the lab tech was drawing a PT/INR and d-dimer.

A review of the labs drawn 2/24/17 revealed the d-dimer was 738. The normal range documented on the lab results was 0-243. Further review of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 33	F 502		

the clinical record failed to reveal any evidence that the facility followed up with the lab regarding the results of the PT / INR that were drawn.

Review of the nurses' notes documented the following entries:

- 2/25/17 at 11:00 a.m., documented the resident's skin tone was normal, and warm and dry, and that stool was soft and formed.

- 2/26/17 at 10:30 a.m., documented the resident's skin tone was normal and skin was warm and dry.

- 2/26/17 at 5:15 p.m., "Resident c/o pain dramatically crying out into hall. She c/o pain in ribs, neck, and arms. When I took the resident some Tylenol (9) down she refused it stating. "I am not going to even take it anymore, it doesn't help." She stopped crying out as soon as I left the room. Note left for MD (medical doctor) to evaluate her pain. Will continue to monitor...."

- 2/27/17 at 3:30 a.m., documented, "...Resident skin tone is normal. Skin is warm and dry.....Last BM (bowel movement) 02/26/17. Stool appearance is soft and formed...."

- 2/27/17 at 10:34 a.m., documented, "Resident c/o chest pain at 08:40 A.M. Crying out during the episode. V/S (vital signs) are 97.6 (temperature), 75 (pulse), 17 (respirations), 159/85 (blood pressure) with an 02 sat (oxygen saturation) of 95% on RA (room air). Took her meds and is calmer at this time.

A note by the nurse practitioner on 2/27/17 at 11:26 a.m., documented, "f/u (follow up) CP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 34	F 502		

(complaints of pain), with elevated dimer, no inc [sic - INR] as of yet, getting stat today as not returned prior per report to me, pt (patient) declining ED (emergency department) visit as I stated multiple times that she should be evaluated, is oriented and able to make decisions, ekg (electrocardiogram) looked ok, no nausea, no bleeding, no sob (shortness of breath)....Physical Exam:....Skin: no rash, turgor normal, warm, dry....A/P: (assessment/plan) 1. CP improved, pt awake and alert, could suspect PE (pulmonary embolus), need INR returned asap (as soon as possible), nurse to call me, pt (patient) declines ED visit and understands risks. 2. CVA/debility, cont LTC (continue long term care). 3. URI (upper respiratory infection), on antibiotic.

A nurse's note dated 2/27/17 at 6:15 p.m., documented the resident was given Tylenol 2 tabs for pain, and a follow up note documented that the medication was ineffective.

A routine weekly skin assessment completed on 2/27/17 at 4:14 p.m., documented no changes in skin condition or areas of concern.

A nurse's note dated 2/27/17 at 6:43 p.m., documented, "Lab called with PT INR results which the lab states are too high to read on their machine. (Nurse Practitioner) called and she gave an order to give 5 Mg Vit (vitamin) K (used to reverse the effects of blood thinning medications when too much is given (10)) IM stat (5 milligrams of Vitamin K, via intramuscularly injection immediately). Order written, noted and faxed to the pharmacy. Resident vomited coffee ground material (vomit having the appearance and consistency of coffee grounds because of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 35	F 502		

blood mixed with gastric contents*) at 17:25 (5:25 p.m.). (Nurse Practitioner) notified. She gave an order to give 40 mg of Prilosec (used to treat reflux and ulcers (10)) stat (immediately) and then cont. (continue) the order BID (twice daily). Prilosec given as ordered. her daughter (name) was notified. Resident was instructed that if she had more emesis then she would need to go to the hospital. She stated that she didn't want to go to hospital as she didn't want to loose [sic] her bed."

A nurse's note dated 2/27/17 at 11:30 p.m., documented, "Staff notified writer that resident was not feeling well and acting differently. Writer assessed resident, found resident to be confused, disoriented, skin tone appeared light yellow all over, large purple bruises noted to Rt (right) upper arm, a large raised hematoma to Rt forearm. Resident c/o (complained of) Rt arm being weak, more than normal. Writer had received in report, resident had vomited x1 dark brown, coffee ground looking emesis earlier in the evening. CNA (certified nursing assistant) reported to writer that resident had vomited again, just before writer entered room, x2. CNA described emesis as dark brown coffee grounds. Resident said she was unable to eat any food, vomited from drinking a sip of water. Resident said she wanted to go to ER (emergency room). POA (Power of Attorney) notified of change, and agreed that she wanted her mom to be sent to the ER. Placed call to 911, resident sent via squad to (hospital).

A nurse's note dated 2/28/17 at 2:42 a.m., documented, "SBAR: Situation: Change in condition, symptoms or signs I am calling about is/are: Altered mental status Functional decline

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 36	F 502		

(worsening function and/or mobility) Nausea/Vomiting. This started on 02/27/2017 and the time of day Afternoon. Background: Resident is in the nursing home for long term care... (resident diagnoses were listed). Medication changes in the past week: d/c (discontinue) coumadin, metoperolo [sic]. Assessment/Appearance: Vitals: BP (blood pressure) 107/54 - 2/27/17 00:48 (12:48 a.m.) Position: Lying r/arm. P (pulse) 85 - 2/27/2017 00:49 (12:49 a.m.) Pulse Type: Regular. R (respirations) 17 - 2/27/17 00:50 (12:50 a.m.). T (temperature) 99.4 - 2/27/2017 19:19 (7:19 p.m.) Route: Oral. W (weight) 210.8 lb (pounds) - 2/15/2017 13:18 (1:18 p.m.) Scale: Lift Scale. O2 (oxygen) 94% - 2/27/2017 19:20 (7:20 p.m.) Method: Room air, BS (blood sugar) 271 - 2/27/2017 00:51 (12:51 a.m.) Pain: 0. Resident has increased confusion (e.g. disorientation). Resident has general weakness, no behavioral changes observed. no [sic] respiratory changes observed. Resident noted to be Jaundice Blood [sic] noted in stool or vomitus c/o [sic] of nausea. Vomiting noted. appetite [sic] diminished No [sic] Urinary changes observed. Other neurological symptoms observed. Skin Changes: Discoloration. Disoriented, confused, c/o (complained of) weakness. Resident c/o not feeling well, asked to go to ER....Request: Reported to primary care clinician. No, d/t (due to) time of night, on. [sic] Orders obtained: (none listed). Name of Family/healthcare agent notified: (name) residents [sic] daughter. on 02/27/2017 11:30 PM."

A nurse's note dated 3/1/17, documented as a "Late entry for 2-23-17" documented, "NP (nurse practitioner) notified of resident not receiving PT/INR since 2-8-17 NP with order for PT/INR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 37	F 502		

next day 2-24-17. Resident transferred to Unit 1 Lab slip taken down to south unit manager. Resident aware of lab orders for next day."

A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17.

A review of the facility policy for "Anticoagulation Protocol" documented, "....b. The nurse will obtain an order from the physician for any pertinent labs for monitoring of the anticoagulant therapy ...."

Additional interviews conducted with staff as follows:

In an interview conducted on 3/22/17 at 1:18 with LPN (licensed practical nurse) #2, she stated that at the time of this resident (Resident #1), she was the unit manager for the skilled unit. LPN #2 stated that the nurses were responsible to ensure that labs were received and reported to the physician. She could not provide further explanation as to how it fell through the cracks that this resident's PT/INR that was drawn on 2/10/17 was never followed up on for the results.

In a follow up interview that was conducted with LPN #2 on 3/23/17 at 10:24 a.m., she stated that as the unit manager she should have ensured that the lab results were received. In addition LPN #2 stated that the care plan for monitoring the labs as ordered was not followed. LPN #2 stated that as the unit manager, she would bring to the morning meetings, any information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 38	F 502		

regarding abnormal labs, but that whether or not a lab result was actually received was not part of the process at the time. LPN #2 stated that aside from the nurses, the physician/nurse practitioner should also have followed up; asking about lab results that he/she had ordered was expecting to receive.

In an interview conducted 3/22/17 at 2:02 p.m., with LPN #1 (Licensed Practical Nurse) she stated that she received the resident from the other unit on 2/21/17 and that everything was going ok with the resident. LPN #1 stated that a couple days later, the unit manager from the other unit brought over the PT/INR flow sheet (which had not been initiated until 1/20/17) and that the unit manager told her she just realized that the resident had not had a PT/INR drawn since about 2/8/17. LPN #1 stated the nurse practitioner was notified and orders were obtained to get a PT/INR on "Friday" (which was 2/24/17). She stated that during the approximately 1 week the resident was on her unit, there were no noted issues with the resident until the events of 2/27/17.

On 3/22/17 at 5:00 an interview was conducted with OSM (Other Staff Member) #1, the pharmacist. She stated that until a resident is stable, that labs should be monitored frequently, at least weekly. She stated that if a resident has Coumadin toxicity, that the effects of that could be significant bleeding related issues (i.e., brain bleed, gastrointestinal bleed, etc.)

On 3/23/17 at 11:20 a.m., in an interview with the Director of Nursing (DON) (Administrative Staff Member #2 - ASM #2) she stated that ever since this situation occurred, she has been in contact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 39	F 502		

with the lab and that results from Resident #1's PT/INR draw on 2/10/17 could not be located by the lab company either. She stated that the lab company followed up with the hospital laboratory facility that they utilize and that it would appear the hospital lab did not perform the testing. In addition, ASM #2 stated a similar scenario occurred with the stat testing that was done on 2/24/17 wherein the lab collected was for a D-Dimer and a PT/INR but the hospital laboratory failed to perform the PT/INR. Therefore, the lab company only had results for the D-Dimer to return to the facility. The facility had failed to follow up with the lab company regarding the results for the PT/INR for either of these dates Resident #1's levels went unchecked and Resident #1 continued to receive 8 mg of Coumadin without monitoring and was sent to the emergency room on 2/27/17 and was hospitalized for Coumadin/Warfarin toxicity.

On 3/23/17 at approximately 8:30 a.m., the Administrator stated that the nurse practitioner had been out sick but was expecting my call; and that the physician was expecting my call specifically at 10:00 a.m. On 3/23/17 at 9:58 a.m., and 10:05 a.m., attempts were made to contact the physician, without success. Attempts to contact the nurse practitioner were made on 3/23/17 at 10:11 a.m. and 10:20 a.m. The nurse practitioner did not answer the call.

A review of the hospital discharge summary dated 3/14/17 documented in part the following: "Acute blood loss anemia (source unknown), in setting of Warfarin toxicity/fluctuation (resolved) ...."

On 3/22/17 at approximately 3:00 p.m., the Administrator and Director of Nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 40	F 502		

notified of the concern for harm. The following plan of correction was presented:

1. Incident: 2/27/17 - resident with a high PT/INR [with a result of] - (unable to read); bruising noted; emesis x1 coffee ground in color - (inconsistency of labs)): resident evaluated by NP, labs ordered, PT/INR elevated; Vit K given; resident to hospital and admitted.
2. 100% audit of residents receiving Coumadin, Lovenox (12), Heparin, Eliquis (13), Xarelto (14) audited for pertinent labs and bruising/bleeding and relating care plans.
3. Education to nursing staff on anticoagulant policy to include signs and symptoms; education to licensed nurses on anticoagulant policy and lab process by DON/designee
4. Audits of labs and audits of resident on Coumadin, Lovenox, Heparin, Eliquis, Xarelto audited 5 times a week for 12 weeks for lab orders/completion/ MD/RP notification by DON/designee. Results of audits will be taken to QAPI monthly x 3 months for review and revision as needed.
5. Date of compliance: March 6, 2017.

A review of the plan of correction revealed that 100% of the nursing staff was educated. Audits to date were reviewed. All current residents on Coumadin or Warfarin who were also in the facility at the time the resident was in the facility were reviewed by the surveyor. There were no discrepancies identified with these residents' labs and Coumadin dosing at the time Resident #1 was in the facility or since then up to the date of survey.

No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 41	F 502		

Complaint Deficiency past noncompliance.

References:

(1) Coumadin is a medication that helps keep your blood from clotting. Information obtained from https://medlineplus.gov/ency/patientinstructions/000255.htm

(2) Warfarin is another name for Coumadin (see 1 above)

(3) INR (International Normalized Ratio) a blood test used to monitor the effectiveness of Warfarin (Coumadin). Information obtained from https://labtestsonline.org/understanding/analytes/pt/tab/test

(4) Bactrim is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a684026.html

(5) PT (Protime) is a blood test used in conjunction with the INR test to monitor the effectiveness of Warfarin (see 3 above)

(6) While accuracy of laboratory testing has significantly evolved over the past few decades, some lab-to-lab variability can occur due to differences in testing equipment, chemical reagents used, and analysis techniques. Consequently, for most lab tests, there is no universally applicable reference value. Information obtained from https://labtestsonline.org/understanding/features/ref-ranges/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 42	F 502		

(7) Heparin is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a682826.html

(8) D-Dimer is a lab test used to check for blood clotting problems. Information obtained from https://medlineplus.gov/ency/article/007620.htm

(9) Tylenol is used to relieve mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

(10) Vitamin K is used to reverse the effects of blood thinning medications when too much is given. Information obtained from https://medlineplus.gov/druginfo/natural/983.html

(11) Prilosec is. Information obtained from https://medlineplus.gov/druginfo/meds/a693050.html

(12) Lovenox is used to prevent blood clots in the legs of patients who are on bedrest, or who are having hip replacement, knee replacement, or stomach surgery. Information obtained from https://medlineplus.gov/druginfo/meds/a601210.html

(13) Eliquis is used to prevent strokes and blood clots in people who have atrial fibrillation. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

(14) Xarelto is used to treat deep vein thrombosis or pulmonary embolism. Information obtained from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 43	F 502		

https://medlineplus.gov/druginfo/meds/a611049.html

(15) According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques.

(16) A BMP (Basic metabolic panel) is a group of blood tests that provides information about your body's metabolism....This test can be used to evaluate kidney function, blood acid/base balance, and your levels of blood sugar, and electrolytes. Depending on which lab you use, a basic metabolic panel may also check your levels of calcium and a protein called albumin. Information obtained from http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm

(17) According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 1042, an MG level (Magnesium) is "a blood test used to determine the level of magnesium, an electrolyte that is critical in nearly all metabolic processes. Abnormal levels may indicate renal insufficiency, chronic renal disease, uncontrolled diabetes, diabetic acidosis, Addison's disease, hypothyroidism, malnutrition, malabsorption. hypoparathyroidism, and alcoholism."

(18) Phosphorus tests are most often ordered along with other tests ...to help diagnose and/or monitor treatment of various conditions ..." Information obtained from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(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 502	Continued From page 44 https://labtestsonline.org/understanding/analytes/phosphorus/tab/test *This information was obtained from the website: coffee-ground vomit	F 502		