#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/11/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495244 B. WING 10/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT **AUTUMN CARE OF MADISON** MADISON, VA 22727 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE F 580 Resident rights Notification of changes (F 000) INITIAL COMMENTS (F 000) An unannounced Medicare/Medicaid revisit survey to the complaint survey conducted on 1. Resident #102's 8/28/18 through 8/30/18 was conducted 10/2/18 representative was notified of through 10/3/18. Corrections are required for the new order for the Doppler. compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected Resident #108's representative deficiencies are identified within this report. was notified of the new order for Corrected deficiencies are identified on the CMS 2567 - B. the treatment. The census in this 92 certified bed facility was 76 Current residents have at the time of the survey. The survey sample the potential to be affected by consisted of 11 current resident reviews, the deficient practice. The Residents #101 through #111. (F 580) Notify of Changes (Injury/Decline/Room, etc.) Director of Nursing/ designee will {F 580} SS=D CFR(s): 483.10(g)(14)(i)-(iv)(15) review new orders for the last 30 days to ensure the resident/RP §483.10(g)(14) Notification of Changes. was notified of new orders. (i) A facility must immediately inform the resident: consult with the resident's physician; and notify, consistent with his or her authority, the resident 3. The Director of representative(s) when there is-Nursing/ Designee will educate (A) An accident involving the resident which the licensed staff that the results in injury and has the potential for requiring Resident/RP need to be notified physician intervention: (B) A significant change in the resident's physical, of new physician's orders. mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial The Director of status in either life-threatening conditions or Nursing/Designee will review 10 clinical complications): (C) A need to alter treatment significantly (that is, new orders 5 times a week for 12 a need to discontinue an existing form of weeks to ensure resident/RP treatment due to adverse consequences, or to were notified of the new orders. commence a new form of treatment); or Results of audits will be taken to (D) A decision to transfer or discharge the

5. 10/15/18 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. (Seginstructions.) 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

§483.15(c)(1)(ii),

LABORATORY

resident from the facility as specified in

DIRECTOR'S OR PROVIDED SUPPLIER REPRESENTATIVE'S SIGNATURE

QAPI committee monthly X 3 for

review and revisions as needed.

(X6) DATE

PRINTED: 10/11/2018 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 13 m	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495244	B. WING	D. C.	R-C 10/03/2018
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/05/2010
AUTUM	N CARE OF MADISON		i	NUMBER ONE AUTUMN COURT	
				MADISON, VA 22727	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIATE OF THE PROVIDER OF THE PROPRIATE OF T	BE COMPLETION DATE
{F 000}	INITIAL COMMENT	S	(F 00	of changes	ation -
	survey to the comple 8/28/18 through 8/3 through 10/3/18. Co compliance with 42 Term Care Requirer deficiencies are ider Corrected deficienci 2567 - B.	ledicare/Medicaid revisit aint survey conducted on 0/18 was conducted 10/2/18 orrections are required for CFR Part 483 Federal Long nents. Uncorrected httfied within this report. es are identified on the CMS 2 certified bed facility was 76 ovey. The survey sample		<ol> <li>Resident #102's representative was notified of the new order for the Dopple Resident #108's representative was notified of the new order the treatment.</li> <li>Current residents has represented by the second control of the new order the treatment.</li> </ol>	r. ve for
{F 580} SS=D	consisted of 11 curre Residents #101 thro	ent resident reviews, ugh #111. njury/Decline/Room, etc.)	{F 580	review new orders for the last	will   30
	consult with the resic consistent with his or representative(s) wh (A) An accident involvesults in injury and his physician intervention (B) A significant charmental, or psychosod deterioration in health status in either life-th clinical complications (C) A need to alter treatment due to advice a need to discontinue treatment due to advice (D) A decision to transcrident from the faci §483.15(c)(1)(ii).	nediately inform the resident; dent's physician; and notify, her authority, the resident en there isving the resident which has the potential for requiring in; age in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, a an existing form of erse consequences, or to m of treatment); or sfer or discharge the		days to ensure the resident/RF was notified of new orders.  3. The Director of Nursing/ Designee will educate the licensed staff that the Resident/RP need to be notified of new physician's orders.  4. The Director of Nursing/Designee will review 10 new orders 5 times a week for 10 weeks to ensure resident/RP were notified of the new orders Results of audits will be taken to QAPI committee monthly X 3 for review and revisions as needed.	d 12

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

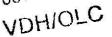
Event ID:VXYI12

Facility ID: VXQQ12; Y 2018

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5.

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10/15/18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING R-C 495244 B. WING 10/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT **AUTUMN CARE OF MADISON** MADISON, VA 22727 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) {F 580} Continued From page 1 {F 580} (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(q)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to notify the resident representative of a change in the treatment plan for two of 11 residents in the survey sample, Resident #108 and #102. 1. The facility staff failed to notify the resident representative of a new treatment order on

10/1/18 for Resident #108.

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CENTER	13 FUR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u> </u>	. 0000 0001	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			, .co	(X3) DATE SURVEY COMPLETED	
		495244	B. WING	<u> </u>		19	₹-C <b>/03/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER		<b>.</b>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF MADISON			Water morane	BER ONE AUTUMN COURT NSON, VA 22727			
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{F 580}	Continued From pa	ge 2	(F 5	80}				
	representative of a	ailed to notify the resident new order for a Doppler [blood 1/18 for Resident #102.					) 	
į	The findings include	B:		į				
		ailed to notify the resident new treatment order on at #108.						
	1/21/16 with a rece diagnoses that include depression, anxiety	admitted to the facility on nt readmission on 8/1/18, with uded but were not limited to: disorder, congestive heart teart failure [abnormal						
	and retention of sal	ized by circulatory congestion tand water by the kidneys. e, anemia and high blood						
	assessment, a qua assessment refered resident as scoring interview for menta was capable of mal	DS (minimum data set) rterly assessment, with an once date of 8/14/18, coded the "15" on the BIMS (brief I status) score, indicating she king daily cognitive decisions.	e di litteratura					
		e for most of her activities of	4					
	"Cleanse left front a	r dated, 10/1/18, documented, ankle W/ (with) WC (wound		<del>1</del> 9			1	
	antibiotic cintment). D/C (discontinue) o shift for skin integrit	layer of TAO (topical Apply protective dressing, nce healed, every evening by.* LPN #6 documented this						
	order.			- 6				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	34 - 10	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405044			R-C
		495244	B. WING		10/03/2018
	PROVIDER OR SUPPLIER N CARE OF MADISON	1	NU:	REET ADDRESS, CITY, STATE, ZIP CODE MBER ONE AUTUMN COURT IDISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
{F 580}	Review of the nurse any documentation was notified of the An interview was copractical nurse) #6	b's notes failed to evidence the resident representative new order above. onducted with LPN (licensed on 10/3/18 at 3:22 p.m. When	(F 580)		
	the new order on 10 not call the family.'  The facility policy, *documented in part Family/Responsible	the resident representative of D/1/18, LPN #6 stated, "I did Change in Resident Condition", "5. The Resident/Physician/e Party wilf be notified when A need to alter the resident's			
	administrator, and	member (ASM)#1, the ASM #2, the director of aware of the above findings o.m.	T 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		# # #
	No further informati	on was provided prior to exit.			1
		nary of Medical Terms for the er, 5th edition, Rothenberg and 8.			3
	representative of a	ailed to notify the resident new order for a Doppler [blood 1/18 for Resident #102.			
	8/7/18 with diagnos limited to: schizoph mental disorders ch distortions of reality language, perceptic [1)], anxiety disorder	admitted to the facility on es that included but were not renia [Any of a group of paracterized by gross, withdrawat of thought, on and emotional response. er, atrial fibrillation [a condition of and random contraction of			

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<b>V</b> -111-	TO TOTT MEDIONING	R MEDIONID SELLATORS			OND 140. 0300-0331		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			35000 500 500000		R-C		
		495244	B. WING		10/03/2018		
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1		
AUTUM	N CARE OF MADISON		6	JMBER ONE AUTUMN COURT			
			М	ADISON, VA 22727			
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{F 580}	Continued From pa	ige 4	{F 580}		**		
		rt causing irregular beats of	' '		i		
		esulting in decreased heart	1				
		tly clot formation in the atria.	į		5		
	(2)], high blood pre	ssure, and depression.					
	The physician orde	r dated, 10/1/18, documented,					
		Doppler [A non-invasive					
		the blood flow of the veins					
	and arteries. (3)] le	ft lower extremity in the					
	evening for wound.	n .					
	Review of the nurse	e's notes for 10/1/18 failed to					
	•	evidence documentation the resident					
	1	notified of the order for the					
	Doppler study.						
	An interview was co	onducted with LPN (licensed					
		the nurse who took off the					
		t 11:20 a.m. When asked					
		she followed when taking off					
	the new physician of	order on 10/1/18, LPN #5					
		the mobile radiology group to					
		. They came the next day. I					
		alled the RP (responsible					
		notes for 10/1/18 were					
	look into that, I swe	#5. LPN #5 stated, "Let me					
	LOOK IIIKO KIIGE, I SWE	ar colu trata					
	On 10/3/18 at 11:24	a.m., LPN #5 returned to this					
į	Section and the second section is a second section of the second section section is a second section of the second section sec	t looks like I didn't do it (notify	2016		a N		
		entative). I thought I did but	ž.				
5863	there is no docume	ntation that I did it."					
	Administrative staff	member (ASM) #1, the					
		ASM #2, the director of					
	nursing, were made	aware of the above findings					
	on 10/3/18 at 3:47						
	No further informati	on was provided prior to exit.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			04000 140000000000000000000000000000000	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING _		R-C 10/03/2018
	PROVIDER OR SUPPLIER  I CARE OF MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 580}	Continued From pa	ge 5	{F <b>58</b> 6	D}	
SS=D	Non-Medical Reader Chapman, page 52: (2) Barron's Dictions Non-Medical Reader Chapman, page 55: (3) This information following website: https://www.ncbi.nlm.17713/ Develop/Implement CFR(s): 483.21(b) Compre §483.21(b) Compre §483.21(b) (1) The frimplement a compressive plan for each reresident rights set following armeds that are ident assessment. The codescribe the following in the following in the services that or maintain the resident physical, mental, an required under §483.24, §483 provided due to the under §483.10, inclustreatment under §48.10 in clustreatment und	ary of Medical Terms for the ar, 5th edition. Rothenberg and was obtained from the m.nih.gov/pmc/articles/PMC11  Comprehensive Care Plans acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable rames to meet a resident's ad mental and psychosocial ified in the comprehensive care plan must are to be furnished to attain dent's highest practicable desident's highest practicable desident's exercise of rights ding the right to refuse i3.10(c)(6). Services or specialized is the nursing facility will	{F 65€	1. Resident #109 and #105's care plan was reviewed and current.  2. Current residents have the potential to be affected by the deficient practice. The Director of Nursing/ designeer review PRN pain meds given for the last 30 days to ensure that non pharmacological interventions are being offere and that we are following the pain scale in the physician's order.	ve will or

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Event ID: VXYI12

Facility ID: VA0012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(C.S. 100) • (C.C. 100) C.C. (C.C. 100)	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495244	B. WING		R-C	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	10/03/2018	
MANIE O	THOUSE (TOTION OUT ) EIER			NUMBER ONE AUTUMN COURT		
MUTUA	CARE OF MADISON			MADISON, VA 22727		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
	findings of the PAS/rationale in the resident (iv) In consultation we resident's represent (A) The resident's gesired outcomes.  (B) The resident's performers of the resident of the requirements set for section.  This REQUIREMENT of the resident of the r	If a facility disagrees with the ARR, it must indicate its dent's medical record. In the resident and the ative(s)-coals for admission and reference and potential for incilities must document the desire to return to the essed and any referrals to es and/or other appropriate lose. In the comprehensive care, in accordance with the the in paragraph (c) of this in paragraph (c) of this in the interview, wand facility document indicated that the facility staff the comprehensive care plants in the survey sample, at 105.  Tabled to follow the plan of care in the administration of prints at the administration of prints at the administration of prints at the plan for offering interventions prior to the in medication for Resident #	{F 65	3. The Director of Nursing/ designee will educat nurses about following the C This will include offering non pharmacological intervention and following physician's ord.  4. The DON/designee audit 5 residents MARs a welfor 12 weeks to ensure pain medications were given propland non-pharmacological interventions are offered. The findings will be brought to Oxfor three months to ensure compliance.  5. 10/15/18	P. ns ler. will ek eriy	
	z.b. The facility staff	failed to implement the		200		

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Event ID: VXYI12

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OCT 19 2018

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VENTE	TO TOT MEDIONIE	G MICHICAID SERVICES			UIVI	B NO. 0936-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495244	B. WING			R-C	
COS 100		450244	B. #VIII4G			10/03/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	· · · · · · · · · · · · · · · · · · ·	
AUTUMN	CARE OF MADISON			NUMBER ONE AUTUMN COURT MADISON, VA 22727			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BI		
{F 656}		ge 7 e plan for administering pain physician order for Resident	{F 6	56}			
	The findings include	<b>3</b> :					
	9/24/17 with diagno limited to muscle we blood pressure, and Resident #109's modata set) was a qual ARD (assessment r. Resident #109 was intact in the ability to 15 out of 15 on the Mental Status) exart as requiring extensi	ras admitted to the facility on ses that included but were not eakness, atrial fibrillation, high if Parkinson's disease, ost recent MDS (minimum arterly assessment with an reference date) of 7/13/18, coded as being cognitively of make daily decisions scoring BIMS (Brief Interview for m. Resident #109 was coded we assistance from one staff ADLS (activities of daily living).					
	(Physician Order Su following order: "Tra			ī		¥ *	
	tablet by mouth eve related to Spinal Ste	et 50 mg (milligram): Give 2 ry 6 hours as needed for pain enosis."				¥	
; ;	October 2018 MAR Record) revealed th Tramadol on the foll - 9/30/18 at 7:41 a. - 9/30/18 at 1:58 p. - 10/1/18 at 7:54 a. - 10/1/18 at 2:12 p. Review of Resident medication administ	#109's September and (Medication Administration lat Resident #109 received lowing dates and times: m. for a pain level of 7 m. for a pain level of 6 m. for a pain level of 6. m. for a pain level of 6. #109's EMAR (electronic tration record) notes failed to harmacological pain					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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Time inter		495244	B. WING	· · · · · · · · · · · · · · · · · · ·	120	0/03/2018	
ĺ	PROVIDER OR SUPPLIER  N CARE OF MADISON	1		STREET ADDRESS, CITY, STATE, ZIP NUMBER ONE AUTUMN COURT MADISON, VA 22727			
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{F 656}	interventions were administration of the Further review of R revealed the following every shift related the applied and pain less on 10/1/18.  Further review of R revealed that heat the declined on 10/1/18 revealed that heat the declined	attempted prior to the le above Tramadol.  lesident #109's clinical record ling order: "Offer heating pad lo chronic pain, document if livel." This order was initiated  lesident #109's October MAR literapy was offered and	{F 6:	56}			

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Facility ID. VA0012

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	190 927	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
					R-C
		495244	B. WING	( <del></del>	10/03/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUTUM	N CARE OF MADISON			NUMBER ONE AUTUMN COURT	
Chinamic In Series vysom				MADISON, VA 22727	
(X4) ID PREF <sub>'</sub> X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRÉCEDED BY FULL  SC IDÉNTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
{F 656}	Continued From pa	5)	' {F 65€	6)	
		al interventions prior to			
		adol to Resident #109 on the	Ĭ		
		1 stated that she offers heat			
		her order. When asked if			9
		to giving the prn Tramadol, Resident #109 usually request		3	)) (3)
		rning and in the afternoon.			
		she usually offers heat			
		ings and the resident		B H	745
		ated she does not offer any		Í	
		LPN #1 stated that she just			I
		9 her afternoon dose of			
		esident's request. LPN #1			
	confirmed that she	and the Prince of the control of the			
		al pain relief interventions			
		eing given in the afternoon of			ii .
	9/30/18 and 10/1/18	3. LPN #1 could not recall if		l	
	she offered heat the	erapy or any other			
		al interventions prior to			
		ministered on 9/30/18 during			
		LPN #1 was asked the			
		plan, LPN #1 stated that the			50 50 <b>7</b> 5
		plan was to serve as a			6 9
		guide for care for each			
		ked if it was important for the			
		urate, LPN #1 stated that it			:
		there were any reasons why			
		not be followed, LPN #1			10 10 10 10
		plan should always be care plan was inaccurate and			
				3	
		ed. LPN #1 confirmed that in care plan was not followed.			
	Healdell # 1022 ba	in care plan was not lonowed.			
	On 10/3/19 at 1-55	p.m., ASM (administrative			u j
		he administrator and ASM #2,			ŀ
		of Nursing) were made aware			
	of the above conce				
	or the above colles	nie.			
	The facility policy tit	led, "Care Plan," documented		t.	i C

Event ID: VXYI12

Facility ID: VA0012

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 200 AUGUST 100000	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING		R-C 10/03/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	[1982]	D BE COMPLETION
(F 656)	comprehensive Ca includes measurea to meet resident's r and psychosocial n comprehensive assfamiliar with each r approaches must b (1) Tramadol- analysevere pain. This i	r: "The facility must develop a re Plan for each resident that ble objectives and timetables medical, nursing, and mental eeds that are identified in the sessmentsAll staff should be esident's Care Plan and all	{F 6	56)	
	comprehensive car no-pharmacologica administration of pa 105.  Resident #105 was 3/10/16 with a rece with diagnoses that to: artificial knee re- dependence withdra blood pressure. The data set) assessme assessment, with a of 7/20/18, coded the on the BIMS (brief is score, indicating, the making daily cognit was coded as being	if failed to implement the e plan for offering I interventions prior to the ain medication for Resident # admitted to the facility on at readmission on 7/11/18, included but were not limited placement, diabetes, alcohol awal, anemia, pain, and high e most recent MDS (minimum ent, a significant change in assessment reference date are resident as scoring a "15" interview for mental status) are resident was capable of ive decisions. The resident gindependent to requiring the for all of his activities of			

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETEO
		495244	B. WING	e constantent <del>e e</del> t			R-C <b>//03/2018</b>
	PROVIDER OR SUPPLIER			NUN	EET ADDRESS, CITY, STATE, ZIP CODE IBER ONE AUTUMN COURT DISON, VA 22727	1 10	100,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 656}	Continued From pa		{F 6	56}			Ĭ
	resident was coded	on N - Medications, the I as receiving opioid ren days of the lookback		5 <b>2</b> 2			8
	"Oxycodone Tablet severe pain. (1)] 10 orally every 6 hours unilateral primary o presence of artificia of 5 - 10 on a scale dated, 9/20/18, doc Tablet [used for mir 500 mg by mouth e	r dated, 9/20/18, documented, [used to treat moderate to mg (milligrams); give 1 tablet as needed for pain related to steoarthritis, right knee, at knee joint for moderate pain of 0-10." The physician order umented, "Acetaminophen for aches and pains. (2)], Give very 6 hours as needed for a for pain 1-4 on a scale of					
	and revised on 7/23 "Focus: Pain r/t (rel syndrome, chronic hospital s/p (status replacement [heale knee replacement the complicationsSur for 7/10/18 for hard The "Interventions" "Administer pain meattempt non-pharm	e care plan dated, 11/30/17 8/18, documented in part, ated to) chronic pain leg pain, re-admitted from post) R (right) knee d 1/4/18]. Resident with left hardware gical appointment scheduled ware removal from left knee." documented in part, edication as ordered. Staff to acological interventions such d or chair, added pillows for					
İ	MAR (medication a evidence the admin needed) Acetamino						
	The September 201	18 MAR documented the					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		15 3-31	A. BUILD	NG		0.000	R-CETES
		495244	B. WING			100	/03/2018
18 59 1950 B	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ON NUMBER ONE AUTUMN COURT MADISON, VA 22727	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECT:VE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
	resident received the 4:50 a.m., 2:07 p.m.  The October 2018 Is received the Oxyco- 10/2/18 at 2:00 a.m. MAR documented to Oxycodone on 10/3  Review of the nurse a.m. and 2:07 p.m. documentation of no interventions offered at 8:57 p.m. documented to enorpharmacological p.c.  The review of the nurse at 8:57 p.m. documented to enorpharmacological p.c.  The review of the nurse at 7:50 p.m. documented to enorpharmacological p.c.  An interview was continuously and the at 7:50 p.m. documented to enorpharmacological p.c.  An interview was continuously and the area that to relieve the pain wasks for pain medical "No." Resident #105 other residents but to the p.c.  An interview was continuously and the residents but the p.c.  An interview was continuously and the residents but the p.c.  An interview was continuously and the p.c.  An interview was continuo	MAR documented the resident done on 10/1/18 at 9:23 p.m., ., 2:02 p.m. and 7:50 p.m. The he resident received the /18 at 9:10 a.m.  Is notes dated 9/30/18 at 4:50 failed to evidence on-pharmacological d. The dose given on 9/30/18 at ted in part, "Repositioning is se's notes dated 10/2/18 at vidence documentation of al interventions offered. The dose administered on 10/2/18 at 10/3/18 at 9:10 a.m. failed to ation of non-pharmacological	{F 65	6}			
		he process staff follows when					Į

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY
					-		R-C
		495244	B. WING	ì <b>-</b>		10	0/03/2018
2012 A 12 PARENT A COMPANY CO. VI	PROVIDER OR SUPPLIER  I CARE OF MADISON			NU	REET ADDRESS, CITY, STATE, ZIP CODE IMBER ONE AUTUMN COURT ADISON, VA 22727		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	"First I assess their location, intensity, a non-pharmacologic doesn't work I give pain medications per asked if she had give medication, LPN #1 some this morning, non-pharmacologic stated, "No, I did not an interview was concerned in the process of the period of the	is of pain, LPN #1 stated, esident for type of pain, and pain scale. I try all interventions and if that them the PRN (as needed) or the physician orders." When we Resident #105 any pain stated, "Yes, I gave him "When asked if she offered all interventions, LPN #1 of the comprehensive stated it's the plan of care for cortant for the care plan to be ked is there any reason not to LPN #3 stated, "Only if it d with new orders or wise it should be followed."  In the care of the director of aware of the above findings of the ab	{F 6	::			
		2f694-4d63-4c56-8737-fae31f					

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PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

OFILE	10 1 OI THE DIONIE	A MEDICAID SERVICES		VARIENCE		IAID IAC	7. 0300-0031	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CAN DEPENDENCE		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495244	B. WING			4	R-C	
		495244	B. WING			10	/03/2018	
NAME OF E	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
ALITHIAL	CARE OF MADISON			NUI	MBER ONE AUTUMN COURT			
AUTOMIN	CARE OF MADISON	•		MA	DISON, VA 22727			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) CCMPLETION DATE	
{F <b>6</b> 56}	Continued From pa	ge 14	{F 6	56}				
	comprehensive car	if failed to implement the e plan for administering pain physician order for Resident	i .					
	"Oxycodone Tablet tablet orally every 6 related to unilateral knee, presence of a	r dated, 9/20/18, documented, 10 mg (milligrams); give 1 hours as needed for pain primary osteoarthritis, right artificial knee joint for - 10 on a scale of 0-10."		1				
50	and revised on 7/23 "Focus: Pain r/t (rel syndrome, chronic hospital s/p (status replacement [heale knee replacement the complicationsSur	e care plan dated, 11/30/17 3/18, documented in part, ated to) chronic pain leg pain, re-admitted from post) R (right) knee d 1/4/18]. Resident with left hardware gical appointment scheduled ware removal from left knee."						
		documented in part, edication as ordered."	: :		es.			
	medication orders. documented the res	MAR (medication rd) documented the above On 10/2/18, the MAR sident received the Oxycodone ocumented pain level of "4."					,	
3		urse's notes for 10/2/18 at evidence the documentation of						
	practical nurse) #1	onducted with LPN (licensed on 10/3/18 at 11:10 a.m. The codone was reviewed with		9				

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Facility ID: VA0012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING		R-C 10/03/2018
201007449-102-003-003-00	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COUNUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
{F 656}	LPN #1. When asked nurse give the Oxyc LPN #1 stated, "No An interview was controlled practical nurse) #3 When asked the pure #3 stated it's the plaimportant for the ca	ge 15 ed, per the order, could a codone for a pain level of "4," that's not per the order." enducted with LPN (licensed on 10/3/18 at 11:55 a.m. rpose of the care plan, LPN in of care for the resident. It's re plan to be accurate. When the eason not to follow the care	, {F 65	56}	
{F 658}	plan, LPN #3 stated updated with new or otherwise it should to Administrative staff administrator, and A nursing, were made on 10/3/18 at 1:55 p	, "Only if it needs to be ders or interventions, be followed."  member (ASM) #1, the SM #2, the director of aware of the above findings	{F <del>6</del> 5(	F 658 Following Pro Standards 83	rfessional
SS=D	S483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professional This REQUIREMEN by: Based on observation record review it was failed to follow profession one of 11 resident Resident #104.	prehensive Care Plans and or arranged by the facility, imprehensive care plan, standards of quality.  To is not met as evidenced on, staff interview, and clinical determined that facility staff assional standards of practice its in the survey sample, accility staff failed to clarify an	į, soc	<ol> <li>Resident # 104's or abductor pillow hat clarified.</li> <li>Current residents has potential to be affed deficient practice. I will review resident for devices to ensure clarified per recommend.</li> </ol>	s been  lave the lected by the DON/Designee lts with orders re orders are

CENTE	HS FUR MEDICARE	& MEDICAID SERVICES	_,		OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495244	B. WING	·	R-C 10/03/2018
NAME OF	PROVIDER OR SUPPLIER	1865 - 187 - 183 - 184 - 185 - 184 - 185 - 184 - 185 - 184 - 185 -	t Nis	STREET ADDRESS, CITY, STATE, ZIP C	
AUTUM	N CARE OF MADISON			NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
{F 658}	Continued From pa	ge 16	· {F 6	58}	
	Resident #104 was admitted to the facility on 7/14/18 and readmitted on 8/19/18 with diagnoses that included but were not limited to one-sided weakness following stroke, type two diabetes, cognitive communication deficit, and chronic kidney disease. Resident #104's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 9/28/18. Resident #104 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the			3. The DON/designee	will educate
industrial and indust				nurses on orders fo clarifying orders per recommendations.	7 20 200 100
				4. The DON/designee	
				residents with device 12 weeks to ensure	MANAGEMENT CHANGE TO THE CONTROL OF
				The findings will be b	rought to QAPI
	BIMS (Brief Interview	w for Mental Status) exam.  coded as requiring extensive		for three months to e compliance.	ensure
;	assistance from one toileting, and person assistance from two	e person with dressing, eating, hal hygiene; extensive plus persons with bed ependence on staff with		5. 10/15/18	
1		#104's most recent POS nmary) revealed the following			
8 8		ure that abduction wedge is nees at all times, remove q k skin."	14 15 13 13 14		9
	On 10/2/18 through 10/3/18, several observations were made of Resident #104.				
		p.m., Resident #104 was elchair. His abduction wedge air next to him.			
		o.m., Resident #104 was elchair. His abduction wedge	1		

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLTA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		495244	B WING			14.00000000	R-C <b>/03/2018</b>
	PROVIDER OR SUPPLIER			NU	REET ADDRESS, CITY, STATE, ZIP CODE MBER ONE AUTUMN COURT IDISON, VA 22727	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLET ON DATE
{F 658}	sitting up in his whe was sitting in the character was sitting in the char	a.m., Resident #104 was elechair. His abduction wedge hair across the room.  #104's ADL (activities of daily ted 8/20/18, with a revised on tumented the following ctor Wedge to be placed as er was written on 9/25/18.  #104's nursing aide kardex llowing intervention: "Abductor d as directed."  #104's occupational therapy B revealed that OT py) had picked up Resident seload for an abductor wedge goals were written: Short term: strate correct anatomical bed with use of wedge cushion wedge in order to reduce ease risk of wounds and esition/reposition self in bed."  B from the occupational ed in part the following: t in high back WC as ROHO [pressure reduction on and head support. Elevating Patient not demonstrating leg rotation of hips, did not place	{F 6:	58}			
	conducted with LPN Resident #104's nu	4 a.m., an interview was N (licensed practical nurse) #3, rse. When asked how nursing evices need to be in place		1			1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		THE PROPERTY OF THE PROPERTY O	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILL	DING	R-C
		495244	B. WING	<u> </u>	10/03/2018
AUTUMN CARE OF MADISON			STREET ADDRESS, CITY, STATE, 2 NUMBER ONE AUTUMN COURT MADISON, VA 22727	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		TION SHOULD BE COMPLETION DATE
{F 658}	such as a splint, w LPN #3 stated that written for devices, needed an abducte stated that he need place at all times, p that when Residen morning he had his LPN #3 stated that now. LPN #3 state Resident #104 a sl nursing aides woul be put into place, L written on their plat LPN #3 confirmed wedge was sitting	age 18 edge etc. for each resident, an order usually has to be When asked if Resident #104 or wedge in place, LPN #3 ded an abductor wedge in ber his order. LPN #3 stated t #104 was in bed earlier that a abductor wedge in place. she was not sure if it was on d that the aides had just given nower. When asked how d know what devices need to .PN #3 stated that it should be n of care but was not sure. that Resident #104's abductor n in a chair across the room g up in his wheelchair.	; {F 6	558)	
	conducted with CN #1, Resident #104' nursing aides know for each resident s CNA #1 stated that When asked if she could use to give h resident needs, CN kardex that was the resident. When asked if he i #1 stated, "We don CNA #1 stated that the abductor wedge wheelchair.  On 10/3/18 at 1:00 conducted with OS	B a.m., and interview was A (certified nursing assistant) is CNA. When asked how what devices to put into place uch as a splint, wedge etc, she would ask the nurse. had a reference that she er a guide on what each IA #1 stated that they used a explan of care for each ked if Resident #104 used an NA #1 stated, "He does." is to wear, it at all times, CNA it put it on in the wheelchair." therapy had told her not to put explan on while he was in the p.m., an interview was M (other staff member) #1, the pist. When asked if she was			

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	and the same of th	& MEDICAID SERVICES			OMB NO. 0938-039				
	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 March 1960 A 447 Color	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495244	B. WING		R-C 10/03/2018				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE					
AUTUMN CARE OF MADISON			NUMBER ONE AUTUMN COL	PRT					
	TO THE OF MINDIOON		287	MADISON, VA 22727					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE				
{F 658}	familiar with Reside she has worked wit stated that his abdu	ant #104, OSM #1 stated that h him on and off. OSM #1 uctor wedge was to be worn	√ {F 6	58)					
	while he was in the she had been trialir and felt that he did because he was no stated that in the padeveloped wounds wheelchair and that in place for prevent abductor wedge wahe had elevated foo When asked if there OSM #1 stated that nursing to write ord When asked why his	bed only. OSM #1 stated that me him for the abductor wedge not need it in his wheelchair at crossing his legs. OSM #1 ast Resident #104 had from crossing his legs in the athey put the abductor wedge ion. OSM #1 stated that the is not comfortable for him and otrests currently in place, apy writes orders for trials, they do not recommended ers until the trial is completed, is current order states to wear e, OSM #1 stated, "That is a		7 1 3 3					
	good question." Wh was supposed to we the wheelchair when with him, OSM #1 s off the resident afte sure because of the not aware of the abo	en asked if Resident #104 ear the abductor wedge up in therapy was not working tated that she left the wedge rhis last session but was not current order. OSM #1 was ove order.							
	conducted with OSM OSM #2 stated mar Resident #104 was was in the wheelchapressure ulcer. OSM guessing that happe stated that it was de	o.m., an interview was M #2, the Director of Therapy. By therapy sessions ago, that crossing his legs while he air, which had caused a M #2 stated that she was ened a year ago. OSM #2 worlded to put the abductor							
	legs. OSM #2 stated was asked by the ur	revent him from crossing his I that a few weeks ago she hit manager to provide a new							

plan and that they could not find the abductor

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	2.100000.000000000000000000000000000000	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495244	B. WING			R-C 1 <b>/03/2018</b>
BANKATTANATAN BERMELA	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COONUMBER ONE AUTUMN COURT MADISON, VA 22727		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
(F 658)	Resident #104 still the unit manager a just to be sure Res she had therapy picevaluate the need #2 stated that occutrialing the wedge wheelchair. OSM # have written the order worn at all times a final decision on worn. OSM #2 stated that usua wedges etc., and through the wedges etc., and through through through the wedges etc., and through throu	tated that she did not think needed the wedge but gave new one. OSM #2 stated that ident #104 needed the wedge; ick him up on 9/30/18 to for the abductor wedge. OSM spational therapy had been while he was in the bed and 2 stated that nursing must der for the abductor wedge to so but that therapy hadn't made how the wedge should be ed that therapy was not aware or the wedge until now. OSM silly after a trial for splints, nerapy will communicate with ded orders as a result of the did that the above order should be ed that the ed that the above order should be ed that the ed that the above order should be ed that the ed that the above order should be ed that the ed tha	(F 65			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIEA/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495244	B. WING	503 (MINISTERIOR) X	R-C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/03/2018
AUTUM	N CARE OF MADISON		5330	NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE COMPLETION
{F 658}	Continued From pa	ge 21 n.nih.gov/pmc/articles/PMC32	{F 6	*	
	18078/.			F 684 Following Physici	an's
	Quality of Care CFR(s): 483.25		{F 6	84} Orders	
	applies to all treatm facility residents. Bat assessment of a residents received accordance with pro- practice, the comprison of the re- care plan, and the re- This REQUIREMENT by: Based on staff inter- review, and clinical determined the facil- one of 11 residents (Resident #105), re- accordance with pro-	fundamental principle that ent and care provided to used on the comprehensive sident, the facility must ensure the treatment and care in offessional standards of ehensive person-centered		<ol> <li>Nurse that did follow physician's order Resident #105 will have education.</li> <li>Current reside the potential to be affect the deficient practice. To DON/Designee will revie Director of Nursing/ desireview PRN pain meds githe last 30 days to ensur medications are given pephysician's orders.</li> </ol>	nts have ted by he will be will ven for that
	The facility staff faile order for the administor Resident #105.  The findings include	ed to follow the physician stration of a pain medication		<ol> <li>The DON/desig educate the licensed staf regarding given pain med physician's orders to inclu</li> </ol>	s per
	3/10/16 with a recen with diagnoses that to: artificial knee rep	admitted to the facility on it readmission on 7/11/18, included but were not limited lacement, diabetes, alcohol lwal, anemia, pain, and high		pain scale.  4. The DON/design audit 5 residents MARs and for 12 weeks to ensure particular productions were given productions.	ee will veek in

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
					] (	R-C
		495244	B. WING			/03/2018
	PROVIDER OR SUPPLIES		3	STREET ADDRESS, CITY, STATE, ZII NUMBER ONE AUTUMN COURT MADISON, VA 22727	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 684}	assessment, a sig with an assessme coded the residen (brief interview for indicating, the residally cognitive decas being independ assistance for all of Section N - Medicas receiving opioid the lookback period The physician ord "Oxycodone Table severe pain. (1)] 1 orally every 6 hou unilateral primary	MDS (minimum data set) phificant change assessment, ent reference date of 7/20/18, it as scoring a "15" on the BIMS mental status) score, ident was capable of making cisions. The resident was coded dent to requiring extensive of his activities of daily living. In ations, the resident was coded d medications on seven days of od.  er dated, 9/20/18, documented, et [used to treat moderate to 0 mg (milligrams); give 1 tablet rs as needed for pain related to osteoarthritis, right knee, ital knee joint for moderate pain	{F 68	the medications were signed off per physicia. The findings will be br QAPI for three month compliance.  5. 10/15/18	ans orders. ought to	
	administration recomedication. On 10 the resident receive for a documented. The review of the 2:00 a.m. failed to the pain scale.  The comprehensionand revised on 7/2 "Focus: Pain r/t (resyndrome, chronic hospital s/p (status replacement [heal knee replacement.]	nurse's notes for 10/2/18 at evidence the documentation of ve care plan dated, 11/30/17 23/18, documented in part, elated to) chronic pain c leg pain, re-admitted from s post) R (right) knee led 1/4/18]. Resident with left				

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-03				
STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495244	B. WING	i		R-C 10/03/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	10/03/2016	
MUTUA	N CARE OF MADISON			NUMBER ONE AUTUMN COURT MADISON, VA 22727			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING :NFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 684}	The "Interventions" "Administer pain me An interview was copractical nurse) #1 above order for OxyLPN #1. When askenurse give the OxycLPN #1 stated, "No An interview was comanager, on 10/3/1 The above order for with LPN #4. When nurse give the OxycLPN #4 stated, "No ordered for a pain leorder for Tylenol [uspains (3)]."  The facility policy, "Chedication Administration, at the croute, at the correct the correct resident. Administrator, and Anursing, were made on 10/3/18 at 1:55 p	ware removal from left knee." documented in part, edication as ordered."  Inducted with LPN (licensed on 10/3/18 at 11:10 a.m. The redone was reviewed with ed, per the order, could a codone for a pain level of "4," that's not per the order."  Inducted with LPN #4, the unit 8 at approximately 11:15 a.m. Oxycodone was reviewed asked, per the order, could a codone for a pain level of "4," they should try what is evel of 4. Normally there is an ed to treat minor aches and  General Dose Preparation and tration" documented in part, ould: verify each time a histered that it is the correct orrect dose, at the correct rate, at the correct time for		84}			
	"Each time you adm that you give the rig	inister a medication, be sure ht client the right medication, the right route, and the right		n N N		B	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B WING		R-C
0.1400	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD NUMBER ONE AUTUMN COURT MADISON, VA 22727	10/03/2018 E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
{F 684}	Continued From pa	ge 24	{F 68	4)	
	(1) This information following website: https://www.ncbi.nlr T0001326/ (2) Fundamentals of Lippincott, Williams (3) This information following website: https://dailymed.nlm	on was provided prior to exit.  was obtained from the  n.nih.gov/pubmedhealth/PMH  f Nursing, 5th edition, & Wilkins, page 564.  was obtained from the  n.nih.gov/dailymed/fda/fdaDru 2f694-4d63-4c56-8737-fae31f	{F 697	F 697 Non pharmacolog interventions	gical
	The facility must en provided to resident consistent with profit the comprehensive and the residents' g. This REQUIREMEN by: Based on resident facility document review, it was determoffer non-pharmacouthe administration on 11 residents in the signal #105 and #109.	sure that pain management is s who require such services, essional standards of practice, person-centered care plan, oals and preferences. IT is not met as evidenced interview, staff interview, view and clinical record mined the facility staff failed to logical interventions prior to t pain medications for two of survey sample, Residents		<ol> <li>Nurse that did non pharmacological interventions for reside and Resident #109 had education.</li> <li>Current reside the potential to be affective deficient practice. Director of Nursing/ dereview PRN pain meds at the last 30 days to ensure other residents were afthe deficient practice+.</li> </ol>	ent #105 1:1  ents have cted by The signee will given for ire that no fected by

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING		R-C
NAME OF	PAOVIDER OR SUPPLIER	130214	J. Willia	STREET ADDRESS, CITY, STATE, ZIP CODE	10/03/2018
AUTUM	N CARE OF MADISON			NUMBER ONE AUTUMN COURT MADISON, VA 22727	100
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
	prior to the adminis Tramadol to Reside 10/1/18.  The findings include  1. Resident #105 was 3/10/16 with a recent with diagnoses that to: artificial knee repidependence withdrast blood pressure.  The most recent MI assessment, a signi	ailed to offer al pain relief interventions Iration of prn (as needed) nt #109, on 9/30/18 and	(F 69	<ol> <li>The Director of Nursing/ designee will educa nurses about offering non pharmacological intervention and following physician's ord</li> <li>The DON/designee audit 5 residents MARs a weefor 12 weeks to ensure pain medications were given propand non-pharmacological interventions are offered. The findings will be brought to Q</li> </ol>	ns ier. will ek perly
	coded the resident a (brief interview for mindicating, the residedaily cognitive decises being independent assistance for all of Section N - Medicat	as scoring a "15" on the BIMS nental status) score, ent was capable of making ions. The resident was coded nt to requiring extensive his activities of daily living. In ions, the resident was coded medications on seven days of		for three months to ensure compliance.  5. 10/15/18	
,	"Oxycodone Tablet [ severe pain. (1)] 10 orally every 6 hours unilateral primary os presence of artificial of 5 - 10 on a scale dated, 9/20/18, docu Tablet [used for mine 500 mg by mouth ev	dated, 9/20/18, documented, used to treat moderate to mg (milligrams); give 1 tablet as needed for pain related to teoarthritis, right knee, knee joint for moderate pain of 0-10." The physician order mented, "Acetaminophen or aches and pains. (2)], Give rery 6 hours as needed for for pain 1-4 on a scale of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495244	B. WING	N		R-C <b>/03/2018</b>	
NAME OF	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP		/03/2016	
ACITUM	N CARE OF MADISO	NAI .		NUMBER ONE AUTUMN COURT			
ACTOM	TOARE OF MADISC		86 745	MADISON, VA 22727			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5; COMPLETION DATE	
(F 697)	Continued From p	page 26	{F 6	97}			
	0-10."	~	G				
	MAR (medication evidence the admineded) Acetamin The September 2 resident received 4:50 a.m., 2:07 p. The October 2011 received the Oxyc 10/2/18 at 2:00 a. MAR documented Oxycodone on 10 Review of the nut a.m. and 2:07 p.m. documentation of interventions offe at 8:57 p.m. document admined the control of t	018 MAR documented the the Oxycodone on 9/30/18 at					
	9:23 p.m. documineffective." The 2:00 a.m. failed to non-pharmacolog nurse's note for that 7:50 p.m. documerse's note date evidence docume interventions offer.  The comprehens and revised on 7/1 "Focus: Pain r/t (	enurse's notes dated, 10/1/18 at ented in part, "Repositioning is nurse's notes dated 10/2/18 at devidence documentation of pical interventions offered. The he dose administered on 10/2/18 imented, "Repositioned." The ed, 10/3/18 at 9:10 a.m. failed to entation of non-pharmacological ered.  live care plan dated, 11/30/17 (23/18, documented in part, related to) chronic pain ic leg pain, re-admitted from					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING	***	\$ 1000 miles	R-C 10/03/2018
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	10/03/2018
ALITURAN	CARE OF MADISON			NUM	IBER ONE AUTUMN COURT	ļ
AUTOMI	CARE OF MADISON	<u> </u>		MA	DISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 697}	SERVICE CONTRACTOR OF SERVICE CONTRACTOR CON	W <del>-1</del> 000 1900	{F 6	97}		E A
	hospital s/p (status replacement [heale knee replacement] for 7/10/18 for hard The "Interventions" "Administer pain mattempt non-pharmas re-positing in be support/comfort."  An interview was controlled to the support of the support	post) R (right) knee of 1/4/18]. Resident with left				
	Protocol" documer	"Pain Management and Pain Ited in part, "3. cal intervention will be				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		TÉ SURVEY MPLETED
		495244	B. WING		10.5	R-C
NAME OF I	PROVIDER OR SUPPLIER	733277	3	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	/03/2018
	CARE OF MADISON			NUMBER ONE AUTUMN COURT MADISON, VA 22727		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFII TAG		D BE	COMPLETION DATE
{F 697}	Continued From pa	ge 28	{F 69	97)		
	medications, When pain will need phare Documentation of a	ne administration of PRN pain it is determined the resident's macological interventions; a. administration of medication ne Medication Administration				
	administrator, and	member (ASM) #1, the ASM #2, the director of a aware of the above findings p.m.				
	No further informat	ion was obtained prior to exit.				
	following website:	was obtained from the m.nih.gov/pubmedhealth/PMH				
		was obtained from the	•	3 1		
: •	https://dailymed.nlm	n.nih.gov/dailymed/fda/fdaDru 22f694-4d63-4c56-8737-fae31f				
	prior to the adminis	failed to offer tal pain relief interventions stration of prn (as needed) ent #109, on 9/30/18 and		n n		1
	9/24/17 with diagnoral limited to muscle will blood pressure, and Resident #109's middata set) was a qua ARD (assessment	admitted to the facility on oses that included but were not reakness, atrial fibrillation, high d Parkinson's disease. Ost recent MDS (minimum arterly assessment with an reference date) of 7/13/18.	i			T I I I I I I I I I I I I I I I I I I I
		o make daily decisions scoring				

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AND PLAN OF CORRECTION INFORMATION NUMBERS		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495244	B. WING		R-C 10/03/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
	Mental Status) exar as requiring extensis member with most and as requiring extensis member with most and as requiring extensis. Review of Resident October 2018 MAR Record) revealed the Tramadol on the fol - 9/30/18 at 7:41 a 9/30/18 at 7:54 a 10/1/18 at 2:12 p.  Review of Resident October 2018 MAR Record) revealed the following extension of the following extension of the following extension administration of the Further review of Revealed the following extension in 10/1/18.  Further review of Revealed that heat the following extension of the follow	BIMS (Brief Interview for m. Resident #109 was coded ve assistance from one staff ADLS (activities of daily living).  #109's most recent POS ammary) documented the amadol HCL [hydrochloride] ram): Give 2 tablet by mouth reded for pain related to Spinal #109's September and (Medication Administration hat Resident #109 received lowing dates and times: m. for a pain level of 7 m. for a pain level of 6 m. for a pain level of 6.  #109's EMAR (electronic tration record) notes failed to charmacological pain attempted prior to the endove Tramadol.  esident #109's clinical recording order: "Offer heating padochronic pain, document if vel." This order was initiated esident #109's October MAR herapy was offered and	{F 69	)7}	

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	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	#-C000000000000000000000000000000000000	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495244	B. WING		503000	R-C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C NUMBER ONE AUTUMN COURT MADISON, VA 22727	Annahama and a san a	/03/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 697}	1	<del></del>	{F 69	97}		SI .
	interventions to rele	on-pharmacological ease the pain like Distraction nal pillow support for comfort;				46
	conducted with LPN the nurse who adm	a.m., an interview was I (licensed practical nurse) #1, inistered Tramadol on all asked the process staff				
	follows prior to adm LPN #1 stated that pain on a pain scale possible pain). LPN	inistering prn pain medication, she would ask the resident's a 1-10 (10 being worst N #1 stated that she would try				
	position changes promedication. LPN #1	al interventions such as ior to administering pain stated that she would then ent's pain and administer pain				
	work. When asked interventions were	evious interventions did not where non-pharmacological documented, LPN #1 stated ogical interventions				
	attempted/offered s nursing note. Wher non-pharmacologic	hould be documented in a asked if she offered al interventions prior to	8			
	above dates, LPN # in the mornings per heat is offered prior	adol to Resident #109 on the 1 stated that she offers heat her order. When asked if to giving the prn Tramadol,				-
	Tramadol in the mo LPN #1 stated that	Resident #109 usually request ming and in the afternoon. she usually offers heat ings and the resident				
	declines. LPN #1 st other interventions, gives Resident #10	ated she does not offer any LPN #1 stated that she just 9 her afternoon dose of	5			
	confirmed that she non-pharmacologic	esident's request. LPN #1 did not offer al pain relief interventions eing given in the afternoon of				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495244	B. WING		R-C 10/03/2018
	PROVIDER OR SUPPLIER I CARE OF MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	147425.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	she offered heat the non-pharmacologic Tramadol being adrithe morning.  On 10/3/18 at 1:55 staff member) #1, the DON (Director of the above concervas presented prior (1) Tramadol- analysevere pain. This in Davis's Drug Guide 1197.  Free from Unnec Pace (1) \$483.45(c)(3) A psy affects brain activities processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compreses and the facility \$483.45(e)(1) Resident, the facility \$483.45(e)(1) Residents the medication of the process the medication of the process the medication of the process of the psychotropic drugs unless the medication of the process of the psychotropic drugs unless the medication of the process of the psychotropic drugs unless the medication of the process of the psychotropic drugs unless the medication of the process of the psychotropic drugs unless the medication of the process of the psychotropic drugs unless the medication of the psychotropic drugs unless the psychotr	B. LPN #1 could not recall if erapy or any other all interventions prior to ministered on 9/30/18 during p.m., ASM (administrative he administrator and ASM #2, of Nursing) were made aware rns. No further information r to exit.  Jesic used to treat moderate to information was obtained from for Nurses, 11th edition p.  Sychotropic Meds/PRN Use B)(e)(1)-(5)  ropic Drugs. Inchotropic drug is any drug that the associated with mental avior. These drugs include, or, drugs in the following disconsive assessment of a	{F 69		id I for on

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	HARL BOOKS AND S	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
						R-C
	ne.	495244	B. WING			10/03/2018
NAME OF	PROVIDER OR SUPPLIER		İ	STREET ADDRESS, CITY, S	37	
AUTUMN	CARE OF MADISON			NUMBER ONE AUTUMN	COURT	
				MADISON, VA 22727		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPR FICIENCY)	BE COMPLETION
F 758	Continued From pa		F 7	58		97 97
	in the clinical record	<b>;</b>		2. C	urrent residents	have
	§483.45(e)(2) Resid	dents who use psychotropic		to potentia	I to be affected	by the
		al dose reductions, and		ASSESSMENT OF GUIDANCE DATE	actice. The Dire	N10.431
		ions, unless clinically an effort to discontinue these	1	50 SANGEROUS AND	designee will re	
	drugs;	an enouge to discontinue mese			tropic medicati	
		)		504000000 -00400 -0040000000000000000000	e last 30 days to	SECTION IN
	§483.45(e)(3) Resid			The All Annual Control of the Contro	MARKET SEPARABANAN TERMINANDAN PROPERTY OF THE	
		pursuant to a PRN order ion is necessary to treat a	;		non pharmaco	
		condition that is documented		interventio	ns are being off	ered.
	in the clinical record		! 	3. TI	ne Director of	
			1		esignee will educ	rate
		orders for psychotropic drugs s. Except as provided in		₩	ut offering non	Cate
		attending physician or				
	prescribing practitio	ner believes that it is		pnarmacoic	ogical interventi	ons.
		PRN order to be extended		4. Tł	ne DON/designe	e will
		or she should document their ident's medical record and			dents MARs a w	
	indicate the duration			for 12 week	STATES AND STATES AND ADDRESS OF THE STATES	
	90 (23.00 (50.00 10 0.00 (50.0				ic medications v	voro
i		orders for anti-psychotic 14 days and cannot be		65 PACOS PAR POR POR POR POR POR POR POR POR POR PO	erly and non-	, TOTO
		attending physician or		150		
		ner evaluates the resident for		Tale according to	ogical intervention	Part of the same o
	the appropriateness	of that medication.			. The findings w	rill be
		IT is not met as evidenced		No.	QAPI for three	
	by: Resed on staff inter	view, facility document		months to e	ensure compliar	ice.
		record review, it was		F 1/	7/45/40	
		lity staff failed to ensure		5. 10	0/15/18	
	residents were from	unnecessary psychotropic				
lu l		of 11 residents in the survey				
	sample, Resident #	103.		8		
	For Resident #103	facility staff failed to attempt		39		
		al pain interventions prior to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	Miles		ONSTRUCTION		E SURVEY IPLETED	
		405244	B. WING	AND DESCRIPTION OF THE PARTY OF		7777999	R-C	
	PROVIDER OR SUPPLIER	495244	В. ЖИКС	STREE	ET ADDRESS, CITY, STATE, ZIP CODE BER ONE AUTUMN COURT ISON, VA 22727	<u>  10/</u>	/03/2018	
(X4) ID PREFIX TAG	(EACH DEF;CIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECT: VE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 758	Resident #103 was 12/5/16 and readm that included but w depressive disorded disturbance, high by (chronic obstructive Resident #103's m data set) assessment with a date) of 7/13/18. Reseverely impaired out of possible 15 Mental Status) exa Section N (Medica medications.  Review of Resident order summary (Porder: "Ativan Tablet every 12 hourelated to Anxiety cinitiated on 7/31/18. Review of Resident (medication admin Resident #103 recodate and time: 10/17. The following EMA administration recommends as Anxiety Disorder, to the sident with the severy 12 hours as Anxiety Disorder, to the sident with th	e:  admitted to the facility on litted on 9/6/16 with diagnoses ere not limited to major er, dementia with behavioral plood pressure, and COPD er pulmonary disease). Ost recent MDS (minimum ent was a quarterly in ARD (assessment reference esident #103 was coded as in cognitive function scoring 03 on the BIMS (Brief Interview for am. Resident #103 coded in tion) as receiving anti-anxiety at #103's most recent physician OS) revealed the following et 0.5 mg (milligrams) Give 1 ars as needed for anxiety disorder." This order was 3.  It #103's October 2018 MAR istration record) revealed that eived Ativan on the following		758				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DO:CO		R-C
		495244	B. WING	3 2 3 3 3 <del>3 4 <b>3 4 3 4 3 1</b> 3</del> 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	10/03/2018
NAME OF F	PROVIDER OR SUPPLIER	30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30 to 30	2010 100	STREET ADDRESS, CITY, STATE, ZIP CODE	
				NUMBER ONE AUTUMN COURT	
AUTUMN	I CARE OF MADISON			MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	DBE COMPLETION
F 758	Continued From pa	ge 34	' F7	58	
		al interventions were he administration of the above			
	use, care plan date intervention to atter	t #103's psychotropic drug d 2/5/18, did not address an npt non-pharmacological o the administration of prn tions.			
	conducted with LPN When asked about to administering pro	a.m., an interview was N (licensed practical nurse) #1. The process staff follows prior n anti-anxiety medication, LPN es should first try other			e e
	interventions such a LPN #1 stated there	as redirecting the resident. e was usually a behavior grid as used to document the			e u
	attempted. LPN #1	and the intervention that was showed this surveyor			8
	shift, it was docume not have behaviors	havior grid for 10/1/18. On 7-3 ented that Resident #103 did and therefore did not need	!		
	LPN #1 stated that	al interventions for anxiety. this grid was filled out per shift ay have not had behaviors		8	
	when the nurse sig confirmed that ther	ned the MAR. LPN #1 e was no evidence that			
	attempted prior to a at 09:31 a.m. LPN	al interventions were administering Ativan on 10/1/18 #1 stated, "If it was not	ň		
	documented, then	it wasn't done."			
NO.		ninistered the Ativan on re reached for an interview.			
	staff member) #1, t	p.m., ASM (administrative the administrator and ASM #2, of Nursing) were made aware			•

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Mary Mary Company	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49524 <del>4</del>	B. WING _		R-C 10/03/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY. STATE. ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 812 SS=E	did not address offi interventions prior in needed anti-anxiety. No further informat.  (1) Ativan is a centration was observed information was observed institutes of Health https://www.ncbi.nl T0010988/?report=Food Procurement CFR(s): 483.60(i) (1) §483.60(i) Food sa The facility must-\$483.60(i) (1) - Procuper or considerate or local authority) in this may include from local producer and local laws or region of facilities from using gardens, subject to safe growing and form of this provision of the control of this provision of the control o	tled, "Behavior Management," ering non-pharmacological to the administration of as y medication.  ion was presented prior to exit.  rat nervous system depressant anxiety disorders. This tained from The National m.nih.gov/pubmedhealth/PMH edetails.  "Store/Prepare/Serve-Sanitary.)(2)  fety requirements.  cure food from sources lered satisfactory by federal, rities.  a food items obtained directly as, subject to applicable State egulations.  oes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices.  loes not preclude residents	F 81	F 812 Food Safety requirements procurement, storage,	
	§483.60(i)(2) - Stor	e, prepare, distribute and dance with professional service safety.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY
		495244	B. WING		A4400000	I-C 03/2018
100 March 190 (190 (190 (190 (190 (190 (190 (190	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	by: Based on observat document review, it staff failed to serve the main dining roo. The dietary staff me steam table failed to net. The findings include Observation was me served in the main 12:32 p.m. Other steering the food frow handing it to the nut to serve to resident properly covering hines was at the level the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of her ears. Level of the top of your ears to the your ears to the your ears to the your ears to the your ears to the your ears to yo	ion, staff interview and facility was determined the facility food in a sanitary manner in m.  ember serving the food off the or have a properly fitting hair  e:  ade of the lunch meal being dining room on 10/2/18 at aff member (OSM) #5 was m the steam table and ring staff in the dining room s. OSM #5's hair net was not er hair. The bottom of the hair equal around her head, to None of the hair below the er ears was covered.  Inducted with OSM #4, the 8:30 a.m. When asked how a worn, OSM #4 stated, "It your hair." When asked if it is your hair." When asked if it is your hairnet at the level, equal ars with all of the hair below M #4 stated, "No, Ma'am."	F 8	3. Dietary Manager/designee will educate staff on serving food in a san manner.  4. The Dietary Manager/designee will obser meals a week for 12 weeks to ensure proper sanitary meas are in place. Findings will be brought to QAPI for 3 month ensure compliance.  5. 10/15/18	ve 5 o ures	
	OSM #3 provided the policy on 10/3/18 at		N			

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		495244	B. WING_		R-C 10/03/2018	
NAME OF PROVIDER OR SUPPLIER  AUTUMN CARE OF MADISON				STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727	100002010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE COMPLETION	
(F 880)	documented in paclean clothes."  Administrative state administrator, was concern on 10/3/1. No further informal Infection Preventic CFR(s): 483.80(a) §483.80 Infection The facility must elemented in facility must elemente	"Employee Sanitary Practices" rt, "1. Wear hair restraints and if member (ASM) #1, the made aware of the above 8 at 8:45 a.m.  tion was provided prior to exit. in & Control (1)(2)(4)(e)(f)  Control stablish and maintain an in and control program e a safe, sanitary and inment and to help prevent the transmission of communicable stablish an infection prevention in (IPCP) that must include, at lowing elements:  stem for preventing, identifying, ating, and controlling infections e diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; ten standards, policies, and program, which must include,	F 81	1. The Licensed Nurs 1:1 education regarding infe control during the medication pass.  2. Current residents the potential to be affected	ection on have by  re e will will or 12 otrol	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA :DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495244	B. WING	No.		507	R-C <b>/03/2018</b>	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MADISON				NUN	STREET ADDRESS, CITY, STATE, ZIP CODE NUMBER ONE AUTUMN COURT MADISON, VA 22727			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE	(X5) COMPLETION DATE	
(F 880)	Continued From page 38  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism			O}				
	least restrictive po circumstances. (v) The circumstar must prohibit emp disease or infected contact with reside contact will transm (vi)The hand hygie	that the isolation should be the ssible for the resident under the nees under which the facility loyees with a communicable d skin lesions from direct ents or their food, if direct lit the disease; and the procedures to be followed						
	§483.80(a)(4) A sy identified under the corrective actions §483.80(e) Linens Personnel must ha	restem for recording incidents as facility's IPCP and the taken by the facility.  andle, store, process, and as to prevent the spread of		13				
	§483.80(f) Annual The facility will cor IPCP and update t	review. nduct an annual review of its heir program, as necessary. :NT is not met as evidenced					·	

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		495244	B. WING			R-C 0/03/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO NUMBER ONE AUTUMN COURT MADISON, VA 22727		305/201G	
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(F 880)	document review, a was determined the infection control pro (Resident #111) du administration observer de la control pro (Resident #111), the rim and inside of from the nurse's basensure gloved hand scrub pockets prior (The findings including the control of t	tion, staff interview, facility and clinical record review, it at facility staff failed to follow actices for one of two residents ring a medication ervation.  facility staff failed to ensure of the medication cup was free are fingers; and failed to dis were free from the nurse's to administering eardrops.	{F 88	30}			
	9/10/18 and readm diagnoses that incl muscle weakness, cellulitis (infection of tissues) (1) of the r recent MDS (miniman admission asset (assessment refere #111 was coded as ability to make daily	admitted to the facility on itted on 9/20/18 with uded but were not limited to fracture of the left femur, and of skin and deep underlying ight ear. Resident #111's most rum data set) assessment was essment with an ARD ruce date) of 9/27/18. Resident being cognitively intact in the redecisions scoring 15 out of ief Interview for Mental Status)					
	LPN (licensed prac observed preparing 1) Cymbalta 60 mg	a.m., medication ervation was conducted with lical nurse) #2. LPN #2 was the following medications:  1 tablet; [indicated for the depressive disorder (MDD).					
VS - 25%		tablet; [used to treat too much . (3)]					

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			A. BEILDING		F	R-C	
		495244	B. WING		10	/03/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO NUMBER ONE AUTUMN COURT MADISON, VA 22727	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(XS) COMPLETION DATE	
{F 880}	[supplement used to 4) Colace 100 mg 15) Ofloxacin OTC Stor right ear celluliti (6)] 6) Oxycodone 5 mg 1 to 250 mg	imin D 400 1 tablet; or prevent osteoporosis. (4)] capsule; [stool softener. (5)] fol. 0.3 percent ear gtt (drop) is; [anti-infective for ear use. If 1 tablet; [opioid pain reliever rate to severe pain. (7)] ablet for right ear cellulitis; img, 1 tablet. [Helps relieve erve disorders and controls in preparing the above opped each pill into the same er bare fingers were on the rime was popping each pill into en grabbed the eardrop in her scrub pocket and ion cup to Resident #111's	{F84	30}			
	inside of the medic the cup on top of R LPN #2 then put or hands in both pock container. LPN #2 if from her left scrub eardrop to Residen same gloves that si LPN #2 then remov Resident #111 is me Resident #111 plac cup to take her med her hands.	her right index finger on the ation cup as she was placing esident #111's over bed table. I clean gloves and placed her ets to find the eardrop container pocket and administered the t #111's right ear with the he had placed in her pockets. The red her gloves and handed edication cup to the resident. Ed her lips on the rim of the dications. LPN #2 then washed	•			Ţ	
	conducted with LPI	7 a.m., an interview was  § #2. When asked how to control during medication pass.		8 1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				the state of the s	R-C
		495244	B. WING		10/03/2018
NAME OF	PROVIDER OR SUPPLIER		\$1	FREET ADDRESS, CITY, STATE, ZIP CODE	-
AUTUMN	CARE OF MADISON	1	N	UMBER ONE AUTUMN COURT	
KO ( ONI)	TOAITE OF MADIOON		M	ADISON, VA 22727	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
{F 880}	LPN #2 stated that each medication is before preparing m she would also put a pill. When asked be held while poppi transporting the me	she would wash hands after given and use the sanitizer edications. LPN #2 stated that on gloves if she had to touch how medication cups should ng out medications and edication to the residents'	{F 880}		
	the bottom of the m why she should hol LPN #2 stated, "To the top where the re go." When asked if inside her scrub po medications, LPN #	ed that her hands should be on dedication cup. When asked the cup from the bottom, keep fingers from being on esident's mouth is going to gloved hands should ever gooket prior to administering \$2\$ stated that she should not \$N\$ \$42\$ stated it was an infection			!
	staff member) #1, t	p.m., ASM (administrative he administrator and ASM #2, of Nursing) were made aware rns.			
	not address the abo	eled, "General Dose edication Administration," did ove concerns. No further esented prior to exit.	ļ		
	National Institutes of https://medlineplus.	gov/cellulitis.html.			N a
140100.000	National Institutes of https://dailymed.nln	was obtained from The If Health. In.nih.gov/dailymed/drugInfo.cf -50d3-40c1-98ca-0e344c76b2	,		в
	(3) This information National Institutes of	was obtained from The if Health. n.nih.gov/pubmedhealth/PMH	x ¥		1

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		495244	B. WING			R-C 10/03/2018	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MADISON				STREET ADDRESS, CITY, STATE. ZIP COD NUMBER ONE AUTUMN COURT MADISON, VA 22727		03/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	IX5) COMPLETION DATE	
3	National Institutes of https://www.bones.ihealth/nutrition/calcivery-age. (5) This information National Institutes of https://www.ncbi.nlr T0010877/. (6) This information National Institutes of https://dailymed.nlmm?setid=8db221b18. (7) This information National Institutes of https://pubchem.ncl odone#section=Top (8) This information National Institutes of https://aidsinfo.nih.gpatient. (9) This information National Institutes of National Institutes of https://aidsinfo.nih.gpatient.	was obtained from The of Health.  nih.gov/health-info/bone/bone-ium-and-vitamin-d-important-e was obtained from The of Health.  m.nih.gov/pubmedhealth/PMH  was obtained from The of Health.  n.nih.gov/dailymed/drugInfo.cf-32f3-f6ca-e404-71f56a860d0  was obtained from The of Health.  bi.nlm.nih.gov/compound/oxycompound	{F8	80)			
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