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 _____	R-C 10/03/2018

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 An unannounced Medicare/Medicaid revisit survey to the complaint survey conducted on 8/28/18 through 8/30/18 was conducted 10/2/18 through 10/3/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 92 certified bed facility was 76 at the time of the survey. The survey sample consisted of 11 current resident reviews, Residents #101 through #111.	{F 000}	F 580 Resident rights Notification of changes 1. Resident #102's representative was notified of the new order for the Doppler. Resident #108's representative was notified of the new order for the treatment. 2. Current residents have the potential to be affected by the deficient practice. The Director of Nursing/ designee will review new orders for the last 30 days to ensure the resident/RP 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 12 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. 5. 10/15/18	
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	{F 580}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Johnna Brantley NHA

(X6) DATE 10/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS	{F 000}	F 580 Resident rights Notification of changes	

An unannounced Medicare/Medicaid revisit survey to the complaint survey conducted on 8/28/18 through 8/30/18 was conducted 10/2/18 through 10/3/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B.

The census in this 92 certified bed facility was 76 at the time of the survey. The survey sample consisted of 11 current resident reviews, Residents #101 through #111.

{F 580} SS=D Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

{F 580}

1. Resident #102's representative was notified of the new order for the Doppler. Resident #108's representative was notified of the new order for the treatment.

2. Current residents have the potential to be affected by the deficient practice. The Director of Nursing/ designee will review new orders for the last 30 days to ensure the resident/RP 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 12 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.

5. 10/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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{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(g)(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.

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 _____	R-C 10/03/2018

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 580}	Continued From page 2	{F 580}		

2. The facility staff failed to notify the resident representative of a new order for a Doppler [blood flow studies] on 10/1/18 for Resident #102.

The findings include:

1. The facility staff failed to notify the resident representative of a new treatment order on 10/1/18 for Resident #108.

Resident #108 was admitted to the facility on 1/21/16 with a recent readmission on 8/1/18, with diagnoses that included but were not limited to: depression, anxiety disorder, congestive heart failure congestive heart failure [abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys. (1)] diabetes, stroke, anemia and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/14/18, coded the resident as scoring "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance for most of her activities of daily living.

The physician order dated, 10/1/18, documented, "Cleanse left front ankle W/ (with) WC (wound cleanser) apply thin layer of TAO (topical antibiotic ointment). Apply protective dressing, D/C (discontinue) once healed, every evening shift for skin integrity." LPN #6 documented this order.

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 _____	R-C 10/03/2018

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 580}	Continued From page 3	{F 580}		

Review of the nurse's notes failed to evidence any documentation the resident representative was notified of the new order above.

An interview was conducted with LPN (licensed practical nurse) #6 on 10/3/18 at 3:22 p.m. When asked if he notified the resident representative of the new order on 10/1/18, LPN #6 stated, "I did not call the family."

The facility policy, "Change in Resident Condition" documented in part, "5. The Resident/Physician/ Family/Responsible Party will be notified when there has been: .e. A need to alter the resident's medical treatment."

Administrative staff member (ASM)#1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 3:47 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.

2. The facility staff failed to notify the resident representative of a new order for a Doppler [blood flow studies] on 10/1/18 for Resident #102.

Resident #102 was admitted to the facility on 8/7/18 with diagnoses that included but were not limited to: schizophrenia [Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response. (1)], anxiety disorder, atrial fibrillation [a condition characterized by rapid and random contraction of

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 580}	Continued From page 4	{F 580}		

the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. (2)], high blood pressure, and depression.

The physician order dated, 10/1/18, documented, "Arterial & Venous Doppler [A non-invasive ultrasound to check the blood flow of the veins and arteries. (3)] left lower extremity in the evening for wound."

Review of the nurse's notes for 10/1/18 failed to evidence documentation the resident representative was notified of the order for the Doppler study.

An interview was conducted with LPN (licensed practical nurse) #5, the nurse who took off the order, on 10/3/18 at 11:20 a.m. When asked about the process she followed when taking off the new physician order on 10/1/18, LPN #5 stated, "I contacted the mobile radiology group to come to do the test. They came the next day. I wrote a note and called the RP (responsible party)." The nurse's notes for 10/1/18 were reviewed with LPN #5. LPN #5 stated, "Let me look into that, I swear I did that."

On 10/3/18 at 11:24 a.m., LPN #5 returned to this writer and stated, "It looks like I didn't do it (notify the resident representative). I thought I did but there is no documentation that I did it."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 3:47 p.m.

No further information was provided prior to exit.

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 _____	R-C 10/03/2018

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{F 580}	Continued From page 5 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117713/	{F 580}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	{F 656}	F 656 Implementation of the CP 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/ designee will review PRN pain meds given for the last 30 days to ensure that non pharmacological interventions are being offered and that we are following the pain scale in the physician's order.	

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 _____	R-C 10/03/2018

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 656}	Continued From page 6 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for two of 11 residents in the survey sample, Resident #109 and #105. 1. The facility staff failed to follow the plan of care and offer/attempt non-pharmacological pain relief interventions prior to the administration of prn (as needed) pain medication to Resident #109 on 9/30/18 and 10/1/18. 2 a. The facility staff failed to implement the comprehensive care plan for offering no-pharmacological interventions prior to the administration of pain medication for Resident # 105. 2.b. The facility staff failed to implement the	{F 656}	3. The Director of Nursing/ designee will educate nurses about following the CP. This will include offering non pharmacological interventions and following physician's order. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure pain medications were given properly and non-pharmacological interventions are offered. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	

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 _____	R-C 10/03/2018

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 656}	Continued From page 7	{F 656}		

comprehensive care plan for administering pain medication per the physician order for Resident #105.

The findings include:

1. Resident #109 was admitted to the facility on 9/24/17 with diagnoses that included but were not limited to muscle weakness, atrial fibrillation, high blood pressure, and Parkinson's disease. Resident #109's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/13/18. Resident #109 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #109 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living).

Review of Resident #109's most recent POS (Physician Order Summary) documented the following order: "Tramadol (1) HCL [hydrochloride] Tablet 50 mg (milligram): Give 2 tablet by mouth every 6 hours as needed for pain related to Spinal Stenosis."

Review of Resident #109's September and October 2018 MAR (Medication Administration Record) revealed that Resident #109 received Tramadol on the following dates and times:
- 9/30/18 at 7:41 a.m. for a pain level of 7
- 9/30/18 at 1:58 p.m. for a pain level of 6
- 10/1/18 at 7:54 a.m. for a pain level of 7.
- 10/1/18 at 2:12 p.m. for a pain level of 6.

Review of Resident #109's EMAR (electronic medication administration record) notes failed to evidence that non-pharmacological pain

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 656}	Continued From page 8 interventions were attempted prior to the administration of the above Tramadol. Further review of Resident #109's clinical record revealed the following order: "Offer heating pad every shift related to chronic pain, document if applied and pain level." This order was initiated on 10/1/18. Further review of Resident #109's October MAR revealed that heat therapy was offered and declined on 10/1/18 on the 7-3 shift. Review of Resident #109's most recent pain care plan documented the following intervention: "Offer/Implement non-pharmacological interventions to release the pain like Distraction techniques...additional pillow support for comfort; Re-position." On 10/3/18 at 11:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who administered Tramadol on all above dates. When asked about the process staff follows prior to administering as needed (prn) pain medication, LPN #1 stated that she would ask the resident's pain on a pain scale 1-10 (10 being worst possible pain). LPN #1 stated that she would try non-pharmacological interventions such as position changes prior to administering pain medication. LPN #1 stated that she would then reassess the resident's pain and administer pain medication if the previous interventions did not work. When asked where non-pharmacological interventions were documented, LPN #1 stated that non-pharmacological interventions attempted/offered should be documented in a nursing note. When asked if she offered	{F 656}		

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 656}	Continued From page 9	{F 656}		

non-pharmacological interventions prior to administering Tramadol to Resident #109 on the above dates, LPN #1 stated that she offers heat in the mornings per her order. When asked if heat is offered prior to giving the prn Tramadol, LPN #1 stated that Resident #109 usually request Tramadol in the morning and in the afternoon. LPN #1 stated that she usually offers heat therapy in the mornings and the resident declines. LPN #1 stated she does not offer any other interventions. LPN #1 stated that she just gives Resident #109 her afternoon dose of Tramadol per the resident's request. LPN #1 confirmed that she did not offer non-pharmacological pain relief interventions prior to Tramadol being given in the afternoon of 9/30/18 and 10/1/18. LPN #1 could not recall if she offered heat therapy or any other non-pharmacological interventions prior to Tramadol being administered on 9/30/18 during the morning. When LPN #1 was asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to serve as a reference point or a guide for care for each resident. When asked if it was important for the care plan to be accurate, LPN #1 stated that it was. When asked if there were any reasons why the care plan would not be followed, LPN #1 stated that the care plan should always be followed unless the care plan was inaccurate and needed to be updated. LPN #1 confirmed that Resident #109's pain care plan was not followed.

On 10/3/18 at 1:55 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Care Plan," documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(F 656)	Continued From page 10	(F 656)		

in part the following: "The facility must develop a comprehensive Care Plan for each resident that includes measureable objectives and timetables to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessments...All staff should be familiar with each resident's Care Plan and all approaches must be implemented."

(1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

2 a. The facility staff failed to implement the comprehensive care plan for offering no-pharmacological interventions prior to the administration of pain medication for Resident # 105.

Resident #105 was admitted to the facility on 3/10/16 with a recent readmission on 7/11/18, with diagnoses that included but were not limited to: artificial knee replacement, diabetes, alcohol dependence withdrawal, anemia, pain, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating, the resident was capable of making daily cognitive decisions. The resident was coded as being independent to requiring extensive assistance for all of his activities 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 _____	R-C 10/03/2018

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 656}	Continued From page 11	{F 656}		

daily living. In Section N - Medications, the resident was coded as receiving opioid medications on seven days of the lookback period.

The physician order dated, 9/20/18, documented, "Oxycodone Tablet [used to treat moderate to severe pain. (1)] 10 mg (milligrams); give 1 tablet orally every 6 hours as needed for pain related to unilateral primary osteoarthritis, right knee, presence of artificial knee joint for moderate pain of 5 - 10 on a scale of 0-10." The physician order dated, 9/20/18, documented, "Acetaminophen Tablet [used for minor aches and pains. (2)], Give 500 mg by mouth every 6 hours as needed for pain related to PAIN for pain 1-4 on a scale of 0-10."

The comprehensive care plan dated, 11/30/17 and revised on 7/23/18, documented in part, "Focus: Pain r/t (related to) chronic pain syndrome, chronic leg pain, re-admitted from hospital s/p (status post) R (right) knee replacement [healed 1/4/18]. Resident with left knee replacement hardware complications...Surgical appointment scheduled for 7/10/18 for hardware removal from left knee." The "Interventions" documented in part, "Administer pain medication as ordered. Staff to attempt non-pharmacological interventions such as re-positing in bed or chair, added pillows for support/comfort. "

The review of the September and October 2018 MAR (medication administration record) failed to evidence the administration of the PRN (as needed) Acetaminophen.

The September 2018 MAR documented 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 _____	R-C 10/03/2018

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 656}	Continued From page 12	{F 656}		

resident received the Oxycodone on 9/30/18 at 4:50 a.m., 2:07 p.m. and 8:57 p.m.

The October 2018 MAR documented the resident received the Oxycodone on 10/1/18 at 9:23 p.m., 10/2/18 at 2:00 a.m., 2:02 p.m. and 7:50 p.m. The MAR documented the resident received the Oxycodone on 10/3/18 at 9:10 a.m.

Review of the nurse's notes dated 9/30/18 at 4:50 a.m. and 2:07 p.m. failed to evidence documentation of non-pharmacological interventions offered. The dose given on 9/30/18 at 8:57 p.m. documented, "positioning ineffective."

The review of the nurse's notes dated, 10/1/18 at 9:23 p.m. documented in part, "Repositioning is ineffective." The nurse's notes dated 10/2/18 at 2:00 a.m. failed to evidence documentation of non-pharmacological interventions offered. The nurse's note for the dose administered on 10/2/18 at 7:50 p.m. documented, "Repositioned." The nurse's note dated, 10/3/18 at 9:10 a.m. failed to evidence documentation of non-pharmacological interventions offered.

An interview was conducted with Resident #105 o 10/3/18 at 11:07 a.m. When asked if the staff offer to reposition you or give you a back rub or massage the area that is hurting to try something to relieve the pain without medications, when he asks for pain medication, Resident #105 stated, "No." Resident #105 stated, "They may be asking other residents but they sure aren't asking me."

An interview was conducted with LPN (licensed practical nurse) #1, on 10/3/18 at 11:10 a.m. When asked about the process staff follows when

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 _____	R-C 10/03/2018

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 656)	Continued From page 13	(F 656)		

a resident complains of pain, LPN #1 stated, "First I assess the resident for type of pain, location, intensity, and pain scale. I try non-pharmacological interventions and if that doesn't work I give them the PRN (as needed) pain medications per the physician orders." When asked if she had given Resident #105 any pain medication, LPN #1 stated, "Yes, I gave him some this morning." When asked if she offered non-pharmacological interventions, LPN #1 stated, "No, I did not."

An interview was conducted with LPN (licensed practical nurse) #3 on 10/3/18 at 11:55 a.m. When asked the purpose of the comprehensive care plan, LPN #3 stated it's the plan of care for the resident. It's important for the care plan to be accurate. When asked is there any reason not to follow the care plan, LPN #3 stated, "Only if it needs to be updated with new orders or interventions, otherwise it should be followed."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 1:55 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/
(2) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7

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 _____	R-C 10/03/2018

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 656}	Continued From page 14	{F 656}		

2.b. The facility staff failed to implement the comprehensive care plan for administering pain medication per the physician order for Resident #105.

The physician order dated, 9/20/18, documented, "Oxycodone Tablet 10 mg (milligrams); give 1 tablet orally every 6 hours as needed for pain related to unilateral primary osteoarthritis, right knee, presence of artificial knee joint for moderate pain of 5 - 10 on a scale of 0-10."

The comprehensive care plan dated, 11/30/17 and revised on 7/23/18, documented in part, "Focus: Pain r/t (related to) chronic pain syndrome, chronic leg pain, re-admitted from hospital s/p (status post) R (right) knee replacement [healed 1/4/18]. Resident with left knee replacement hardware complications...Surgical appointment scheduled for 7/10/18 for hardware removal from left knee." The "Interventions" documented in part, "Administer pain medication as ordered."

The October 2018 MAR (medication administration record) documented the above medication orders. On 10/2/18, the MAR documented the resident received the Oxycodone at 2:00 a.m. for a documented pain level of "4."

The review of the nurse's notes for 10/2/18 at 2:00 a.m. failed to evidence the documentation of the pain scale.

An interview was conducted with LPN (licensed practical nurse) #1 on 10/3/18 at 11:10 a.m. The above order for Oxycodone was reviewed with

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 _____	R-C 10/03/2018

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 656}	Continued From page 15 LPN #1. When asked, per the order, could a nurse give the Oxycodone for a pain level of "4," LPN #1 stated, "No that's not per the order." An interview was conducted with LPN (licensed practical nurse) #3 on 10/3/18 at 11:55 a.m. When asked the purpose of the care plan, LPN #3 stated it's the plan of care for the resident. It's important for the care plan to be accurate. When asked is there any reason not to follow the care plan, LPN #3 stated, "Only if it needs to be updated with new orders or interventions, otherwise it should be followed." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 1:55 p.m. No further information was provided prior to exit.	{F 656}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review it was determined that facility staff failed to follow professional standards of practice for one of 11 residents in the survey sample, Resident #104. For Resident #104, facility staff failed to clarify an order for an abductor wedge.	{F 658}	F 658 Following Professional Standards 1. Resident # 104's order for the abductor pillow has been clarified. 2. Current residents have the potential to be affected by the deficient practice. DON/Designee will review residents with orders for devices to ensure orders are clarified per recommendations.	

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 _____	R-C 10/03/2018

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 658}	Continued From page 16 The findings include: 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 BIMS (Brief Interview for Mental Status) exam. Resident #104 was coded as requiring extensive assistance from one person with dressing, eating, toileting, and personal hygiene; extensive assistance from two plus persons with bed mobility; and total dependence on staff with transfers, and bathing. Review of Resident #104's most recent POS (physician order summary) revealed the following order: "Nurse to ensure that abduction wedge is between residents knees at all times, remove q hs (at night) to check skin." On 10/2/18 through 10/3/18, several observations were made of Resident #104. On 10/2/18 at 12:15 p.m., Resident #104 was sitting up in his wheelchair. His abduction wedge was sitting in the chair next to him. On 10/2/18 at 4:15 p.m., Resident #104 was sitting up in his wheelchair. His abduction wedge was sitting in the chair next to him.	{F 658}	3. The DON/designee will educate nurses on orders for devices and clarifying orders per recommendations. 4. The DON/designee will 5 residents with devices a week for 12 weeks to ensure compliance. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	

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 _____	R-C 10/03/2018

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) COMPLET ON DATE
{F 658}	Continued From page 17	{F 658}		

On 10/3/18 at 11:15 a.m., Resident #104 was sitting up in his wheelchair. His abduction wedge was sitting in the chair across the room.

Review of Resident #104's ADL (activities of daily living) care plan dated 8/20/18, with a revised on date of 10/2/18 documented the following intervention: "Abductor Wedge to be placed as directed." This order was written on 9/25/18.

Review of Resident #104's nursing aide kardex documented the following intervention: "Abductor Wedge to be placed as directed."

Review of Resident #104's occupational therapy noted dated 9/30/18 revealed that OT (occupational therapy) had picked up Resident #104 on therapy caseload for an abductor wedge trial. The following goals were written: Short term: "Patient will demonstrate correct anatomical alignment while in bed with use of wedge cushion and knee abductor wedge in order to reduce pressure and decrease risk of wounds and enable patient to position/reposition self in bed."

A note dated 10/1/18 from the occupational therapist documented in part the following: "...reposition patient in high back WC (wheelchair), shifting hips and shoulders to midline. Patient has ROHO [pressure reduction cushion. (1)] cushion and head support. Elevating leg rests in place. Patient not demonstrating leg crossing or internal rotation of hips, did not place wedge at this time."

On 10/3/18 at 11:54 a.m., an interview was conducted with LPN (licensed practical nurse) #3, Resident #104's nurse. When asked how nursing would know what devices need to be in place

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 _____	R-C 10/03/2018

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 658}	Continued From page 18	{F 658}		

such as a splint, wedge etc. for each resident, LPN #3 stated that an order usually has to be written for devices. When asked if Resident #104 needed an abductor wedge in place, LPN #3 stated that he needed an abductor wedge in place at all times, per his order. LPN #3 stated that when Resident #104 was in bed earlier that morning he had his abductor wedge in place. LPN #3 stated that she was not sure if it was on now. LPN #3 stated that the aides had just given Resident #104 a shower. When asked how nursing aides would know what devices need to be put into place, LPN #3 stated that it should be written on their plan of care but was not sure. LPN #3 confirmed that Resident #104's abductor wedge was sitting in in a chair across the room while he was sitting up in his wheelchair.

On 10/3/18 at 11:58 a.m., and interview was conducted with CNA (certified nursing assistant) #1, Resident #104's CNA. When asked how nursing aides know what devices to put into place for each resident such as a splint, wedge etc, CNA #1 stated that she would ask the nurse. When asked if she had a reference that she could use to give her a guide on what each resident needs, CNA #1 stated that they used a kardex that was the plan of care for each resident. When asked if Resident #104 used an abductor wedge, CNA #1 stated, "He does." When asked if he is to wear, it at all times, CNA #1 stated, "We don't put it on in the wheelchair." CNA #1 stated that therapy had told her not to put the abductor wedge on while he was in the wheelchair.

On 10/3/18 at 1:00 p.m., an interview was conducted with OSM (other staff member) #1, the occupational therapist. When asked if she was

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 _____	R-C 10/03/2018

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 658}	Continued From page 19	{F 658}		

familiar with Resident #104, OSM #1 stated that she has worked with him on and off. OSM #1 stated that his abductor wedge was to be worn while he was in the bed only. OSM #1 stated that she had been trialing him for the abductor wedge and felt that he did not need it in his wheelchair because he was not crossing his legs. OSM #1 stated that in the past Resident #104 had developed wounds from crossing his legs in the wheelchair and that they put the abductor wedge in place for prevention. OSM #1 stated that the abductor wedge was not comfortable for him and he had elevated footrests currently in place. When asked if therapy writes orders for trials, OSM #1 stated that they do not recommended nursing to write orders until the trial is completed. When asked why his current order states to wear the wedge at all time, OSM #1 stated, "That is a good question." When asked if Resident #104 was supposed to wear the abductor wedge up in the wheelchair when therapy was not working with him, OSM #1 stated that she left the wedge off the resident after his last session but was not sure because of the current order. OSM #1 was not aware of the above order.

On 10/3/18 at 1:20 p.m., an interview was conducted with OSM #2, the Director of Therapy. OSM #2 stated many therapy sessions ago, that Resident #104 was crossing his legs while he was in the wheelchair, which had caused a pressure ulcer. OSM #2 stated that she was guessing that happened a year ago. OSM #2 stated that it was decided to put the abductor wedge in place to prevent him from crossing his legs. OSM #2 stated that a few weeks ago she was asked by the unit manager to provide a new abductor wedge because it was still on his care plan and that they could not find the abductor

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 _____	R-C 10/03/2018

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 658)	Continued From page 20	(F 658)		

wedge. OSM #2 stated that she did not think Resident #104 still needed the wedge but gave the unit manager a new one. OSM #2 stated that just to be sure Resident #104 needed the wedge; she had therapy pick him up on 9/30/18 to evaluate the need for the abductor wedge. OSM #2 stated that occupational therapy had been trialing the wedge while he was in the bed and wheelchair. OSM #2 stated that nursing must have written the order for the abductor wedge to be worn at all times but that therapy hadn't made a final decision on how the wedge should be worn. OSM #2 stated that therapy was not aware of nursing's order for the wedge until now. OSM #2 stated that usually after a trial for splints, wedges etc., and therapy will communicate with nursing recommended orders as a result of the trial. OSM #2 stated that the above order should have been clarified.

On 10/3/18 at 1:55 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that the facility used Lippincott as a professional standard.

According to "Lippincott Manual of Nursing Practice", Eighth Edition: Lippincott Williams & Wilkins, pg. 15, document the following in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

(1) This information was obtained from The National Institutes of Health.

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 _____	R-C 10/03/2018

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 658}	Continued From page 21 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3218078/.	{F 658}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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 ensure that one of 11 residents in the survey sample, (Resident #105), received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. The facility staff failed to follow the physician order for the administration of a pain medication for Resident #105. The findings include: Resident #105 was admitted to the facility on 3/10/16 with a recent readmission on 7/11/18, with diagnoses that included but were not limited to: artificial knee replacement, diabetes, alcohol dependence withdrawal, anemia, pain, and high blood pressure.	{F 684}	F 684 Following Physician's Orders 1. Nurse that did not follow physician's orders for Resident #105 will have 1:1 education. 2. Current residents have the potential to be affected by the deficient practice. The DON/Designee will review The Director of Nursing/ designee will review PRN pain meds given for the last 30 days to ensure that medications are given per physician's orders. 3. The DON/designee will educate the licensed staff regarding given pain meds per physician's orders to include the pain scale. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure pain medications were given properly,	

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 _____	R-C 10/03/2018

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 684}	Continued From page 22 The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating, the resident was capable of making daily cognitive decisions. The resident was coded as being independent to requiring extensive assistance for all of his activities of daily living. In Section N - Medications, the resident was coded as receiving opioid medications on seven days of the lookback period. The physician order dated, 9/20/18, documented, "Oxycodone Tablet [used to treat moderate to severe pain. (1)] 10 mg (milligrams); give 1 tablet orally every 6 hours as needed for pain related to unilateral primary osteoarthritis, right knee, presence of artificial knee joint for moderate pain of 5 - 10 on a scale of 0-10." The October 2018 MAR (medication administration record) documented the above medication. On 10/2/18, the MAR documented the resident received the Oxycodone at 2:00 a.m. for a documented pain level of "4." The review of the nurse's notes for 10/2/18 at 2:00 a.m. failed to evidence the documentation of the pain scale. The comprehensive care plan dated, 11/30/17 and revised on 7/23/18, documented in part, "Focus: Pain r/t (related to) chronic pain syndrome, chronic leg pain, re-admitted from hospital s/p (status post) R (right) knee replacement [healed 1/4/18]. Resident with left knee replacement hardware complications...Surgical appointment scheduled	{F 684}	the medications were given and signed off per physicians orders. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	

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 _____	R-C 10/03/2018

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 684}	Continued From page 23	{F 684}		

for 7/10/18 for hardware removal from left knee." The "Interventions" documented in part, "Administer pain medication as ordered."

An interview was conducted with LPN (licensed practical nurse) #1 on 10/3/18 at 11:10 a.m. The above order for Oxycodone was reviewed with LPN #1. When asked, per the order, could a nurse give the Oxycodone for a pain level of "4," LPN #1 stated, "No that's not per the order."

An interview was conducted with LPN #4, the unit manager, on 10/3/18 at approximately 11:15 a.m. The above order for Oxycodone was reviewed with LPN #4. When asked, per the order, could a nurse give the Oxycodone for a pain level of "4," LPN #4 stated, "No, they should try what is ordered for a pain level of 4. Normally there is an order for Tylenol [used to treat minor aches and pains (3)]."

The facility policy, "General Dose Preparation and Medication Administration" documented in part, "4.1 Facility staff should: verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time for the correct resident."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 1:55 p.m. ASM #2 stated that the facility used Lippincott as a professional standard.

"Each time you administer a medication, be sure that you give the right client the right medication, in the right dose, by the right route, and the right time. (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 _____	R-C 10/03/2018

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 684}	Continued From page 24 No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/ (2) Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 564. (3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7	{F 684}		
{F 697} SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to offer non-pharmacological interventions prior to the administration of pain medications for two of 11 residents in the survey sample, Residents #105 and #109. 1. The facility staff failed to offer non-pharmacological interventions prior to the administration of pain medications for Resident #105.	{F 697}	F 697 Non pharmacological interventions 1. Nurse that did not offer non pharmacological interventions for resident #105 and Resident #109 had 1:1 education. 2. Current residents have the potential to be affected by the deficient practice. The Director of Nursing/ designee will review PRN pain meds given for the last 30 days to ensure that no other residents were affected by the deficient practice+.	

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 _____	R-C 10/03/2018

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.697}	Continued From page 25 2. The facility staff failed to offer non-pharmacological pain relief interventions prior to the administration of prn (as needed) Tramadol to Resident #109, on 9/30/18 and 10/1/18. The findings include: 1. Resident #105 was admitted to the facility on 3/10/16 with a recent readmission on 7/11/18, with diagnoses that included but were not limited to: artificial knee replacement, diabetes, alcohol dependence withdrawal, anemia, pain, and high blood pressure. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/20/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating, the resident was capable of making daily cognitive decisions. The resident was coded as being independent to requiring extensive assistance for all of his activities of daily living. In Section N - Medications, the resident was coded as receiving opioid medications on seven days of the lookback period. The physician order dated, 9/20/18, documented, "Oxycodone Tablet [used to treat moderate to severe pain. (1)] 10 mg (milligrams); give 1 tablet orally every 6 hours as needed for pain related to unilateral primary osteoarthritis, right knee, presence of artificial knee joint for moderate pain of 5 - 10 on a scale of 0-10." The physician order dated, 9/20/18, documented, "Acetaminophen Tablet [used for minor aches and pains. (2)], Give 500 mg by mouth every 6 hours as needed for pain related to PAIN for pain 1-4 on a scale of	{F 697}	3. The Director of Nursing/ designee will educate nurses about offering non pharmacological interventions and following physician's order. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure pain medications were given properly and non-pharmacological interventions are offered. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	

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 _____	R-C 10/03/2018

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 697}	Continued From page 26 0-10." The review of the September and October 2018 MAR (medication administration record) failed to evidence the administration of the PRN (as needed) Acetaminophen. The September 2018 MAR documented the resident received the Oxycodone on 9/30/18 at 4:50 a.m., 2:07 p.m. and 8:57 p.m. The October 2018 MAR documented the resident received the Oxycodone on 10/1/18 at 9:23 p.m., 10/2/18 at 2:00 a.m., 2:02 p.m. and 7:50 p.m. The MAR documented the resident received the Oxycodone on 10/3/18 at 9:10 a.m. Review of the nurse's notes dated 9/30/18 at 4:50 a.m. and 2:07 p.m. failed to evidence documentation of non-pharmacological interventions offered. The dose given on 9/30/18 at 8:57 p.m. documented, "positioning ineffective." The review of the nurse's notes dated, 10/1/18 at 9:23 p.m. documented in part, "Repositioning is ineffective." The nurse's notes dated 10/2/18 at 2:00 a.m. failed to evidence documentation of non-pharmacological interventions offered. The nurse's note for the dose administered on 10/2/18 at 7:50 p.m. documented, "Repositioned." The nurse's note dated, 10/3/18 at 9:10 a.m. failed to evidence documentation of non-pharmacological interventions offered. The comprehensive care plan dated, 11/30/17 and revised on 7/23/18, documented in part, "Focus: Pain r/t (related to) chronic pain syndrome, chronic leg pain, re-admitted from	{F 697}		

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 _____	R-C 10/03/2018

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 697}	Continued From page 27	{F 697}		

hospital s/p (status post) R (right) knee replacement [healed 1/4/18]. Resident with left knee replacement hardware complications...Surgical appointment scheduled for 7/10/18 for hardware removal from left knee." The "Interventions" documented in part, "Administer pain medication as ordered. Staff to attempt non-pharmacological interventions such as re-positing in bed or chair, added pillows for support/comfort. "

An interview was conducted with Resident #105 o 10/3/18 at 11:07 a.m. When asked when he asks for pain medication, do the staff offer to reposition you or give you a back rub or massage the area that is hurting to try something to relieve the pain without medications, Resident #105 stated, "No, they may be asking other residents but they sure aren't asking me."

An interview was conducted with LPN (licensed practical nurse) #1, on 10/3/18 at 11:10 a.m. When asked about the process staff follows when a resident complains of pain, LPN #1 stated, "First I assess the resident for type of pain, location, intensity, and pain scale. I try non-pharmacological interventions and if that doesn't work I give them the PRN (as needed) pain medications per the physician orders." When asked if she had given Resident #105 any pain medication, LPN #1 stated, "Yes, I gave him some this morning." When asked if she offered non-pharmacological interventions prior to administering the medication, LPN #1 stated, "No, I did not."

The facility policy, "Pain Management and Pain Protocol" documented in part, "3. Non-pharmacological intervention will be

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 _____	R-C 10/03/2018

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 697}	Continued From page 28	{F 697}		

attempted prior to the administration of PRN pain medications. When it is determined the resident's pain will need pharmacological interventions: a. Documentation of administration of medication will be located on the Medication Administration Record."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 10/3/18 at 1:55 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7
2. The facility staff failed to offer non-pharmacological pain relief interventions prior to the administration of prn (as needed) Tramadol to Resident #109, on 9/30/18 and 10/1/18.

Resident #109 was admitted to the facility on 9/24/17 with diagnoses that included but were not limited to muscle weakness, atrial fibrillation, high blood pressure, and Parkinson's disease. Resident #109's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/13/18. Resident #109 was coded as being cognitively intact in the ability to make daily decisions scoring

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 _____	R-C 10/03/2018

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 697}	Continued From page 29 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #109 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Review of Resident #109's most recent POS (Physician Order Summary) documented the following order: "Tramadol HCL [hydrochloride] Tablet 50 mg (milligram): Give 2 tablet by mouth every 6 hours as needed for pain related to Spinal Stenosis." Review of Resident #109's September and October 2018 MAR (Medication Administration Record) revealed that Resident #109 received Tramadol on the following dates and times: - 9/30/18 at 7:41 a.m. for a pain level of 7 - 9/30/18 at 1:58 p.m. for a pain level of 6 - 10/1/18 at 7:54 a.m. for a pain level of 7. - 10/1/18 at 2:12 p.m. for a pain level of 6. Review of Resident #109's EMAR (electronic medication administration record) notes failed to evidence that non-pharmacological pain interventions were attempted prior to the administration of the above Tramadol. Further review of Resident #109's clinical record revealed the following order: "Offer heating pad every shift related to chronic pain, document if applied and pain level." This order was initiated on 10/1/18. Further review of Resident #109's October MAR revealed that heat therapy was offered and declined on 10/1/18 7-3 shift. Review of Resident #109's most recent pain care plan documented the following intervention:	{F 697}		

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 _____	R-C 10/03/2018

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 697}	Continued From page 30 "Offer/Implement non-pharmacological interventions to release the pain like Distraction techniques...additional pillow support for comfort; Re-position." On 10/3/18 at 11:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who administered Tramadol on all above dates. When asked the process staff follows prior to administering prn pain medication, LPN #1 stated that she would ask the resident's pain on a pain scale 1-10 (10 being worst possible pain). LPN #1 stated that she would try non-pharmacological interventions such as position changes prior to administering pain medication. LPN #1 stated that she would then reassess the resident's pain and administer pain medication if the previous interventions did not work. When asked where non-pharmacological interventions were documented, LPN #1 stated that non-pharmacological interventions attempted/offered should be documented in a nursing note. When asked if she offered non-pharmacological interventions prior to administering Tramadol to Resident #109 on the above dates, LPN #1 stated that she offers heat in the mornings per her order. When asked if heat is offered prior to giving the prn Tramadol, LPN #1 stated that Resident #109 usually request Tramadol in the morning and in the afternoon. LPN #1 stated that she usually offers heat therapy in the mornings and the resident declines. LPN #1 stated she does not offer any other interventions. LPN #1 stated that she just gives Resident #109 her afternoon dose of Tramadol per the resident's request. LPN #1 confirmed that she did not offer non-pharmacological pain relief interventions prior to Tramadol being given in the afternoon of	{F 697}		

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 _____	R-C 10/03/2018

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 697}	Continued From page 31 9/30/18 and 10/1/18. LPN #1 could not recall if she offered heat therapy or any other non-pharmacological interventions prior to Tramadol being administered on 9/30/18 during the morning. On 10/3/18 at 1:55 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit. (1) Tramadol- analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.	{F 697}		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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	F 758	F 758 Unnecessary psychotropic meds/PRN use 1. Licensed staff that did not offer non pharmacological for resident# 103 had 1:1 education on offering nonpharmacological for PRN psychotropic medications.	

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 _____	R-C 10/03/2018

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 758	Continued From page 32 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure residents were from unnecessary psychotropic medications for one of 11 residents in the survey sample, Resident #103. For Resident #103, facility staff failed to attempt non-pharmacological pain interventions prior to	F 758	2. Current residents have to potential to be affected by the deficient practice. The Director of Nursing/ designee will review PRN psychotropic medication given for the last 30 days to ensure that non pharmacological interventions are being offered. 3. The Director of Nursing/ designee will educate nurses about offering non pharmacological interventions. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure psychotropic medications were given properly and non-pharmacological interventions are offered. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	

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 _____	R-C 10/03/2018

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 758	Continued From page 33	F 758		

the administration of as needed (PRN) Ativan (1).

The findings include:

Resident #103 was admitted to the facility on 12/5/16 and readmitted on 9/6/16 with diagnoses that included but were not limited to major depressive disorder, dementia with behavioral disturbance, high blood pressure, and COPD (chronic obstructive pulmonary disease). Resident #103's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 7/13/18. Resident #103 was coded as severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #103 coded in Section N (Medication) as receiving anti-anxiety medications.

Review of Resident #103's most recent physician order summary (POS) revealed the following order: "Ativan Tablet 0.5 mg (milligrams) Give 1 tablet every 12 hours as needed for anxiety related to Anxiety disorder." This order was initiated on 7/31/18.

Review of Resident #103's October 2018 MAR (medication administration record) revealed that Resident #103 received Ativan on the following date and time: 10/1/18 at 09:31 a.m.

The following EMAR (electronic medication administration record) note was documented: "Ativan 1 tablet 0.5 MG Give 1 tablet by mouth every 12 hours as needed for anxiety related to Anxiety Disorder, unspecified. Increased anxiety."

There was no evidence in the clinical record that

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 _____	R-C 10/03/2018

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 758	Continued From page 34	F 758		

non-pharmacological interventions were attempted prior to the administration of the above Ativan.

Review of Resident #103's psychotropic drug use, care plan dated 2/5/18, did not address an intervention to attempt non-pharmacological interventions prior to the administration of prn anti-anxiety medications.

On 11/3/18 at 11:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows prior to administering prn anti-anxiety medication, LPN #1 stated that nurses should first try other interventions such as redirecting the resident. LPN #1 stated there was usually a behavior grid on the MAR that was used to document the resident's behavior and the intervention that was attempted. LPN #1 showed this surveyor Resident #103's behavior grid for 10/1/18. On 7-3 shift, it was documented that Resident #103 did not have behaviors and therefore did not need non-pharmacological interventions for anxiety. LPN #1 stated that this grid was filled out per shift and the resident may have not had behaviors when the nurse signed the MAR. LPN #1 confirmed that there was no evidence that non-pharmacological interventions were attempted prior to administering Ativan on 10/1/18 at 09:31 a.m. LPN #1 stated, "If it was not documented, then it wasn't done."

The nurse who administered the Ativan on 10/1/18 could not be reached for an interview.

On 10/3/18 at 1:55 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware

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 _____	R-C 10/03/2018

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 758	Continued From page 35 of the above concerns. The facility policy titled, "Behavior Management," did not address offering non-pharmacological interventions prior to the administration of as needed anti-anxiety medication. No further information was presented prior to exit. (1) Ativan is a central nervous system depressant that is used to treat anxiety disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812	F 812 Food Safety requirements-procurement, storage, preparation and serving 1. The individual that served food in an unsanitary manner received and 1:1 education to include how the hairnet is to be placed. 2. Current residents have the potential to be affected by the deficient practice.	

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 _____	R-C 10/03/2018

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 812	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to serve food in a sanitary manner in the main dining room. The dietary staff member serving the food off the steam table failed to have a properly fitting hair net. The findings include: Observation was made of the lunch meal being served in the main dining room on 10/2/18 at 12:32 p.m. Other staff member (OSM) #5 was serving the food from the steam table and handing it to the nursing staff in the dining room to serve to residents. OSM #5's hair net was not properly covering her hair. The bottom of the hair net was at the level, equal around her head, to the top of her ears. None of the hair below the level of the top of her ears was covered. An interview was conducted with OSM #4, the cook, on 10/3/18 at 8:30 a.m. When asked how a hair net should be worn, OSM #4 stated, "It should cover all of your hair." When asked if it is acceptable to wear your hairnet at the level, equal to the top of your ears with all of the hair below that uncovered, OSM #4 stated, "No, Ma'am." A request was for the policy on hairnets was made to OSM #3, the dietary manager on 10//3/18 at 8:33 a.m. OSM #3 provided the copy of the hair restraint policy on 10/3/18 at 8:40 a.m.	F 812	3. Dietary Manager/designee will educate staff on serving food in a sanitary manner. 4. The Dietary Manager/designee will observe 5 meals a week for 12 weeks to ensure proper sanitary measures are in place. Findings will be brought to QAPI for 3 months to ensure compliance. 5. 10/15/18	

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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 812	Continued From page 37 The facility policy, "Employee Sanitary Practices" documented in part, "1. Wear hair restraints and clean clothes." Administrative staff member (ASM) #1, the administrator, was made aware of the above concern on 10/3/18 at 8:45 a.m. No further information was provided prior to exit.	F 812	F 880 Infection controlled 1. The Licensed Nurse had 1:1 education regarding infection control during the medication pass. 2. Current residents have the potential to be affected by the deficient practice. DON/Designee will perform medication observations on licensed staff to ensure that infection control practices are being followed. 3. The DON/designee will educate nurses on infection control practices during the medication pass. 4. The DON/designee will observe two nurses a week for 12 weeks to ensure infection control practices are being followed. The findings will be brought to QAPI for three months to ensure compliance. 5. 10/15/18	
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	{F 880}		

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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 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 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	{F 880}		

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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 880)	Continued From page 39	(F 880)		

Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow infection control practices for one of two residents (Resident #111) during a medication administration observation.

For Resident #111, facility staff failed to ensure the rim and inside of the medication cup was free from the nurse's bare fingers; and failed to ensure gloved hands were free from the nurse's scrub pockets prior to administering eardrops.

The findings include:

Resident #111 was admitted to the facility on 9/10/18 and readmitted on 9/20/18 with diagnoses that included but were not limited to muscle weakness, fracture of the left femur, and cellulitis (infection of skin and deep underlying tissues) (1) of the right ear. Resident #111's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 9/27/18. Resident #111 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

On 10/3/18 at 8:15 a.m., medication administration observation was conducted with LPN (licensed practical nurse) #2. LPN #2 was observed preparing the following medications:

1) Cymbalta 60 mg 1 tablet; [indicated for the treatment of major depressive disorder (MDD). (2)]
2) Nexium 40 mg 1 tablet; [used to treat too much acid in the stomach. (3)]

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 _____	R-C 10/03/2018

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AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

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{F 880}	Continued From page 40	{F 880}		

3) Calcium 600/Vitamin D 400 1 tablet; [supplement used to prevent osteoporosis. (4)]
4) Colace 100 mg 1 capsule; [stool softener. (5)]
5) Ofloxacin OTC Sol. 0.3 percent ear gtt (drop) for right ear cellulitis; [anti-infective for ear use. (6)]
6) Oxycodone 5 mg 1 tablet; [opioid pain reliever used to treat moderate to severe pain. (7)]
7) Cipro 250 mg 1 tablet for right ear cellulitis; [antibiotic. (8)]
8) Gabapentin 300 mg, 1 tablet. [Helps relieve pain from certain nerve disorders and controls seizures. (9)]

While LPN #2 was preparing the above medications, she popped each pill into the same medication cup. Her bare fingers were on the rim of the cup while she was popping each pill into the cup. LPN #2 then grabbed the eardrop container, placed it in her scrub pocket and carried the medication cup to Resident #111's room. LPN #2 had her right index finger on the inside of the medication cup as she was placing the cup on top of Resident #111's over bed table. LPN #2 then put on clean gloves and placed her hands in both pockets to find the eardrop container. LPN #2 pulled the eardrop container from her left scrub pocket and administered the eardrop to Resident #111's right ear with the same gloves that she had placed in her pockets. LPN #2 then removed her gloves and handed Resident #111's medication cup to the resident. Resident #111 placed her lips on the rim of the cup to take her medications. LPN #2 then washed her hands.

On 10/3/18 at 10:57 a.m., an interview was conducted with LPN #2. When asked how to maintain infection control during medication pass,

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	495244	A. BUILDING _____ B. WING _____	R-C 10/03/2018

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 880}	Continued From page 41	{F 880}		

LPN #2 stated that she would wash hands after each medication is given and use the sanitizer before preparing medications. LPN #2 stated that she would also put on gloves if she had to touch a pill. When asked how medication cups should be held while popping out medications and transporting the medication to the residents' room, LPN #2 stated that her hands should be on the bottom of the medication cup. When asked why she should hold the cup from the bottom, LPN #2 stated, "To keep fingers from being on the top where the resident's mouth is going to go." When asked if gloved hands should ever go inside her scrub pocket prior to administering medications, LPN #2 stated that she should not have done that. LPN #2 stated it was an infection control issue.

On 10/3/18 at 1:55 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "General Dose Preparation and Medication Administration," did not address the above concerns. No further information was presented prior to exit.

(1) This information was obtained from The National Institutes of Health. https://medlineplus.gov/cellulitis.html.
(2) This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=81a06b90-50d3-40c1-98ca-0e344c76b2c4.
(3) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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(F 880)	Continued From page 42 T0010169/. (4) This information was obtained from The National Institutes of Health. https://www.bones.nih.gov/health-info/bone/bone-health/nutrition/calcium-and-vitamin-d-important-every-age. (5) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010877/. (6) This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8db221b1-32f3-f6ca-e404-71f56a860d08. (7) This information was obtained from The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/oxycodone#section=Top. (8) This information was obtained from The National Institutes of Health. https://aidsinfo.nih.gov/drugs/458/ciprofloxacin/0/patient. (9) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010419/?report=details.	(F 880)		