STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 8/28/18 through 8/30/18. Ten complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 92 certified bed facility was 80 at the time of the survey. The survey sample consisted of 18 current resident reviews (Residents #1 through #9 and #14 through #22) and four closed record reviews (Residents #10 through #13).	F 000	***580 Notification of Changes*** 1. Residents # 7 and # 11, are not currently residents of the building. 2. Any resident receiving medications has the potential to be effected by this deficient practice. The Director of Nursing (DON)/ Designee will review Medication Administration Records for the past 30 days to ensure no other residents were affected by deficient practice. 3. The DON/Designee will educate the licensed nurses on medication administration and medication availability including notifying MD of medications not given. 4. The DON/Designee will audit residents' Medication Administration Records five (5) times a week for four (4) weeks, then weekly for 12 weeks for medication not administered and MD notification. Results of audits will be taken to QAPI committee monthly X 3 for review and revisions as needed. 5. 9/30/18	
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). (ii) When making notification under paragraph (g)	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Johnna Bromley, NHA — 9/21/18 — (X6) DATE

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

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F 580	Continued From page 1 (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, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for two of 22 residents in the survey sample, Residents #7 and #11. 1. The facility staff failed to notify Resident #7's physician when thiamine (vitamin B1) was not administered to the resident on 8/16/18 and 8/17/18.	F 580		

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F 580	Continued From page 2 2. The facility staff failed to notify Resident #11's physician when multiple medications were not administered to the resident on 5/30/18. The findings include: 1. The facility staff failed to notify Resident #7's physician when thiamine (vitamin B1) (1) was not administered to the resident on 8/16/18 and 8/17/18. Resident #7 was admitted to the facility on 8/3/18 and readmitted on 8/14/18. Resident #7's diagnoses included but were not limited to pneumonia, difficulty swallowing and quadriplegia (paralysis of all four limbs). Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/22/18, coded the resident as being cognitively intact. Review of Resident #7's clinical record revealed a physician's order dated 8/15/18 for thiamine (vitamin B1) powder- 50 mg (milligrams) via PEG (percutaneous endoscopic gastrostomy) (2) two times a day. Resident #7's August 2018 MAR (medications administration record) documented a physician's order dated 8/15/18 for thiamine powder-50 mg via PEG two times a day scheduled at 8:00 a.m. and 4:00 p.m. On 8/16/18 at 4:00 p.m., the nurse documented the code, "19= Other/See Nurse Notes." On 8/17/18 at 8:00 a.m., the nurse documented the code, "19= Other/See Nurse Notes." On 8/21/18 at 8:00 a.m., the nurse documented the code, "16=Hold/See Nurse Notes." A nurse's note dated 8/16/18 at 4:41 p.m.	F 580		

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F 580	Continued From page 3	F 580		

documented thiamine was on order. A nurse's note dated 8/17/18 at 12:22 p.m. documented thiamine was on order. A nurse's note dated 8/21/18 at 7:57 a.m. documented thiamine administration was pending pharmacy clarification and the physician and responsible party was aware.

On 8/29/18 at 3:35 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the above 8/16/18 and 8/17/18 nurses' notes). LPN #3 was asked the facility process for ensuring medications are available for administration. LPN #3 stated she sends a refill request to the pharmacy whenever a certain amount of medication remains. LPN #3 stated she calls the pharmacy if the medication has not arrived in a few days. When asked if she notifies the physician when a medication is not available, LPN #3 stated she notifies the physician and documents the notification. LPN #3 confirmed she did not administer thiamine to Resident #7 on 8/16/18 or 8/17/18 because the medication was on order from the pharmacy and had not arrived. When asked if she notified the physician, LPN #3 stated she was not positive but she thought she documented this information in the physician communication book. Review of the physician communication book failed to reveal documentation that the physician was notified of Resident #7's missed doses of thiamine.

On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/30/18 at 2:50 p.m., ASM #1 stated she could not locate a specific policy regarding

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F 580	Continued From page 4 physician notification. No further information was presented prior to exit. (1) "Thiamine is a vitamin used by the body to break down sugars in the diet. The medication helps correct nerve and heart problems that occur when a person's diet does not contain enough thiamine." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682586.html (2) "PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus." This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-peg 2. The facility staff failed to notify Resident #11's physician when multiple medications were not administered to the resident on 5/30/18. Resident #11 was admitted to the facility on 5/23/18. Resident #11's diagnoses included but were not limited to diabetes, chronic kidney disease, status post kidney transplant and high blood pressure. Resident #11's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/20/18, coded the resident as being cognitively intact. On 7/25/18, the Office of Licensure and Certification received a complaint that	F 580		

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F 580	Continued From page 5 documented Resident #11's medications were not given at various times. Review of Resident #11's clinical record revealed physician's orders that included but were not limited to: 5/24/18- clopidogrel bisulfate (1) 75 mg (milligrams) by mouth in the evening. 5/23/18- Lantus (2) 18 units subcutaneously in the evening. 5/30/18- potassium chloride (3) 20 meq (milliequivalents) - one tablet by mouth in the afternoon. 5/24/18- santyl (4) ointment 250 units per gram- apply to right lower leg wound topically in the evening. 5/25/18 tacrolimus (5) 1 mg- two capsules by mouth every 12 hours. Review of Resident #11's May 2018 MAR (medication administration record) failed to reveal clopidogrel bisulfate, Lantus, potassium chloride, santyl and the 9:00 p.m. dose of tacrolimus was administered to Resident #11 on 5/30/18 (as evidenced by a blank space on the MAR with no check mark or nurse's initials). Review of nurses' notes dated 5/30/18 failed to reveal the medications were administered. Further review of Resident #11's clinical record (including the May 2018 MAR and 5/30/18 nurses' notes) failed to reveal Resident #11's physician was notified when the above medications were not administered to the resident on 5/30/18. Resident #11's care plan dated initiated on 5/23/18 documented, "Focus: CARDIAC: Resident has cardiac symptoms r/t (related to): CAD (coronary artery disease), PVD (peripheral vascular disease), Requires Cardiac med	F 580		

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F 580	Continued From page 6 [medication]...Interventions: Medication as ordered..."Focus: DIABETES: Resident is at risk for hypo/hyperglycemia (low or high blood sugar) episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)...Interventions: medication as ordered...Focus: KIDNEY TRANSPLANT: At risk for complications r/t (related to): kidney transplant...Interventions: Meds (Medications) as ordered...Focus: SKIN INTEGRITY/PRESSURE ULCER...Resident admitted w/ (with) multiple ulcers: R (Right) lower leg ulcer...Interventions: Administer treatments as ordered..." An attempt to contact the nurse responsible for administering the above medications to Resident #11 on 5/30/18 was made and the nurse was not available for interview. On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked how nurses evidence medication administration. LPN #7 stated, "By signing off on the MAR." When asked what is meant if the MAR is not signed off, LPN #7 stated, "You assume it wasn't given." When asked if there was any other way to evidence medication administration, LPN #7 stated, "If not on the MAR, you can call the nurse." LPN #7 was shown Resident #11's May 2018 MAR and asked how one would know if the resident's medications were given on 5/30/18. LPN #7 stated, "You can't tell. It wasn't signed." On 8/30/18 at 9:06 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if the physician should be notified when a resident misses a dose of a medication. RN #1 stated, "Yes." When asked why, RN #1	F 580		

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F 580	Continued From page 7 stated, "Because if there is any kind of reaction or if he wants us to do anything: get labs [laboratory tests], give something else." On 8/30/18 at 11:07 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Clopidogrel is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html (2) "Insulin glargine (Lantus) is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html (3) "Potassium is one of the body's electrolytes, which are minerals that carry an electric charge when dissolved in body fluids such as blood. Most of the body's potassium is located inside the cells. Potassium is necessary for the normal functioning of cells, nerves, and muscles." This	F 580		

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F 580	Continued From page 8 information was obtained from the website: https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/overview-of-potassium-s-role-in-the-body (4) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information was obtained from the website: https://www.santyl.com/ (5) "Tacrolimus is used along with other medications to prevent rejection (attack of a transplanted organ by the immune system of a person receiving the organ) in people who have received kidney, liver, or heart transplants." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601117.html	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	***F 584 Clean Homelike Environment*** 1. The showers that were affected by the deficient practice were cleaned.	

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F 584	Continued From page 9 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 22 residents in the survey sample, Resident #20, and one of two shower rooms, the south unit shower room. 1. Black and brown debris (resembling dirt) was observed on the bottom floor of the shower/bathtub in Resident #20's room. 2. Pink substances were observed on a shower chair and pink, green and black substances were	F 584	2. Current residents have the potential to be effected by this deficient practice. The shower rooms were audited throughout the facility for cleanliness and any areas found, corrected. 3. The housekeeping manager/designee will educate the housekeeping staff regarding cleaning and disinfecting the shower rooms and showers inside the resident rooms. 4. The housekeeping supervisor/designee will audit shower rooms and showers within resident rooms to ensure cleanliness 5 times a week for 4 weeks then weekly for 2 months. Findings will be brought the QAPI for review and revisions as needed X 3 months. 5. DOC: 9/30/18	

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F 584	Continued From page 10 observed in two shower stalls in the south unit, shower room. The findings include: 1. Black and brown debris (resembling dirt) was observed on the bottom floor of the shower/bathtub in Resident #20's room. Resident #20 was admitted to the facility on 8/10/18. Resident #20's diagnoses included but were not limited to urinary tract infection, muscle weakness and difficulty swallowing. Resident #20's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/20/18, coded the resident as being cognitively intact. Section G coded Resident #20 as requiring one-person physical assistance with bathing. On 8/28/18 at 10:30 a.m. and 8/29/18 at 8:32 a.m., observation of the shower/bathtub in Resident #20's room was conducted. Black and brown debris (resembling dirt) was observed on the bottom floor of the bathtub. On 8/29/18 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #2 (the CNA caring for Resident #20). CNA #2 stated she had used the shower/bathtub to bathe Resident #20 one day within the past week. When asked who was responsible for cleaning the shower/bathtubs in resident rooms, CNA #2 stated she immediately cleans any bodily fluids but the housekeeping department is responsible for the routine cleaning. On 8/29/18 at 2:03 p.m., an interview was conducted with OSM (other staff member) #6 (the	F 584		

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F 584	Continued From page 11 housekeeping supervisor). OSM #6 stated the showers/bathtubs in resident rooms are cleaned daily. OSM #6 was shown the shower/bathtub in Resident #20's room. OSM #6 confirmed the shower/bathtub should be cleaned and stated she would in-service her staff. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/30/18 at 2:50 p.m., ASM #1 stated the facility did not have specific policies regarding a clean, comfortable, homelike environment or the cleaning of showers/bathtubs. No further information was presented prior to exit. 2. Pink substances were observed on a shower chair and pink, green and black substances were observed in two shower stalls in the south unit, shower room. On 8/28/18 at 3:35 p.m. and 8/29/18 at 8:28 a.m., observation of the south unit shower room was conducted. The following was observed: - The plastic/vinyl trim was removed from the first shower stall on the side where the faucet was located. Black, green and pink substances were observed on the wall. Pink substances were observed on the bottom of the shower chair near the wheels. -The plastic/vinyl trim was peeled away from the second shower stall on the side where the faucet was located. Black and pink substances were observed on the wall. On 8/29/18 at 1:39 p.m., an interview was	F 584		

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

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F 584	Continued From page 12 conducted with CNA (certified nursing assistant) #2. When asked who was responsible for cleaning shower rooms, CNA #2 stated she immediately cleans any bodily fluids but the housekeeping department is responsible for the routine cleaning. On 8/29/18 at 2:03 p.m., an interview was conducted with OSM (other staff member) #6 (the housekeeping supervisor). OSM #6 stated the housekeeping staff cleans the shower stalls in the shower rooms around 7:15 a.m. each morning. OSM #6 stated she thought CNAs were responsible for cleaning the shower chairs. OSM #6 was shown the shower stalls in the south unit shower room and asked what the black, pink and green substances were. OSM #6 stated the black substance looked like mold and would require bleach. OSM #6 stated the pink substance was soap residue. OSM #6 stated she would take care of cleaning the shower stalls. On 8/29/18 at 2:20 p.m., an interview was conducted with CNA #3. CNA #3 was asked who was responsible for cleaning the shower chairs. CNA #3 stated the night shift CNAs cleaned wheelchairs but she was not sure if they cleaned, the shower chairs or if the housekeeping department cleans the shower chairs. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/30/18 at 2:50 p.m., ASM #1 stated the facility did not have specific policies regarding a clean, comfortable, homelike environment or the cleaning of shower rooms.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 584	Continued From page 13 No further information was presented prior to exit.	F 584		
F 607 SS=D	COMPLAINT DEFICIENCY Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for two of 22 residents in the survey sample, Residents #21, and Resident #19. 1. The facility staff failed to implement the abuse policy for reporting and investigating an allegation that a male resident touched Resident #21's breast on 10/2/17. 2. The facility staff failed to implement the abuse policy for an allegation of sexual contact between Resident #1 and Resident #19. The findings include:	F 607	***F 607*** ***Develop, implement, report, and investigate abuse*** 1. Since the time of the original incidents, Residents #21, #19, and #1 have had incidents reported and investigated. Residents #21, #19, and #1 had no signs or symptoms of abuse. 2. Current residents have the potential to be affected by this deficient practice. The Administrator/Designee will review the grievances for the last three months to ensure all possible abuse	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 14 1. The facility staff failed to implement the abuse policy for reporting and investigating an allegation that a male resident touched Resident #21's breast on 10/2/17. Resident #21 was admitted to the facility on 10/27/11. Resident #21's diagnoses included but were not limited to severe intellectual disabilities, pain and low blood pressure. Resident #21's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #21 as requiring extensive assistance of two staff with bed mobility and extensive assistance of one staff with dressing, eating and personal hygiene. Review of Resident #21's clinical record revealed a nurse's note dated 10/2/17 that documented, "Was reported to this writer by another resident whom is alert and oriented that this resident whom is unable to speak for self was being touched in (sic) breast by a male resident. N/P (Nurse Practitioner) Called and notified." Further review of Resident #21's clinical record revealed the resident was assessed and interventions were implemented to protect the resident but failed to reveal an investigation or documentation that the state agency and other officials were notified. Review of a FRI (facility reported incident) submitted to the state agency on 10/24/17 revealed documentation that a male resident touched Resident #21's breast on that same day (10/24/17 [a separate incident from 10/2/17). The 10/24/17 incident was reported to the state agency/other officials and was investigated.	F 607	situations were reviewed, reported and investigated. Any possible abuse issues found will be reviewed, reported and investigated. 3. Administrator/designee will educate the staff on the policy on abuse prevention to include reporting expectations and investigation protocol. 4. The Administrator/designee will audit 24 hour report, concern logs, incident/accidents for potential abuse and neglect concerns five times a week for four weeks then 3 times a week for two months. Findings will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 15 On 8/30/18 at 12:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1 and LPN #2. LPN #1 and LPN #2 were asked about the facility process regarding a resident-to-resident sexual altercation. LPN #2 stated she removes the resident from the area and notifies LPN #1 (the unit manager) or somebody in management. LPN #1 was asked what occurs after she is notified. LPN #1 stated interventions are put in place to prevent future occurrences and either the director of nursing or the weekend on-call nurse notifies the state agency. When asked if the incident should be investigated, LPN #1 stated, "Yes. It would be investigated." When asked to describe what the investigation should include, LPN #1 stated nurses' notes would be reviewed and the nurse would be interviewed. When asked if a resident who reported the incident would be interviewed, LPN #1 stated, "Yeah. Talk to that resident." On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator who was not employed at the facility on 10/2/17). ASM #1 was asked about the facility process regarding a resident-to-resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. When asked when the incident should be reported, ASM #1 stated the incident should be reported within one to two hours if harm has occurred and within 24 hours in harm has not occurred. ASM #1 was asked to describe what the investigation should include. ASM #1 stated she would interview the resident named in	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 16	F 607		

the allegation if the resident is able to be interviewed, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. ASM #1 was made aware the FRI concerning the incident involving Resident #21 on 10/24/17 yielded no concerns but there was concern that the incident that occurred on 10/2/17 was not investigated or reported to the state agency. ASM #1 was asked to provide any evidence that the 10/2/17 incident was investigated and/or reported.

On 8/30/18 at 2:06 p.m., ASM #1 stated she had no further information.

The facility policy titled, "Virginia Resident Abuse Policy" documented, "6. Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made. b. Regional Director of Clinical Services (RDCS) and the Regional Vice President of Operations will be notified of the allegation, by the Administrator or DON...7. Investigate- Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The investigation must be completed within five (5) working days from the alleged occurrence. b. Investigation protocol. The person investigating the incident should generally take the following actions: i. Interview the resident, the accused,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 17 and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. ii. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift...iii. Obtain written statements from the resident, if possible, the accused, and each witness. iv. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the resident's records...c. Evidence of the investigation should be documented...9. Final Reports- Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged (sic) the alleged occurrence..." No further information was presented prior to exit. 2. The facility staff failed to implement the abuse policy for an allegation of sexual contact between Resident #1 and Resident #19. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 18 eating which the resident could perform independently. Resident #19 was admitted to the facility on 3/8/18 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and high cholesterol. The most recent MDS, a quarterly assessment, with an ARD of 6/16/17 coded the resident as having a BIMS of 3 out of 15 indicating the resident was severely impaired cognitively. The resident was coded as being independent in all activities of daily living except for showering which required the assistance of staff. An interview was conducted on 8/29/18 at 8:35 a.m. with Resident #1. Resident #1 stated, "They accused me of having sex with another resident. They came back later and apologized. He (name of Resident #19) came by this morning and knocked on the door and the staff told him he couldn't come in here. We're just friends." Review of the facility reported incidents did not include a report regarding the alleged sexual relationship between the residents. Review of the nurse's note dated 8/6/18 documented that the nursing supervisor had spoken to the Resident #1 regarding being friends with other residents. An interview was conducted on 8/29/18 at 11:35 a.m. with OSM (other staff member) #10, the social worker and OSM #11, the social worker. When asked about the process staff follow for allegations of sexual relations between residents, OSM #11 stated, "We have a weekly meeting, we discuss behaviors, and we discuss those daily as	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 19	F 607		

well in the 9:00 o'clock standup." When asked about an allegation regarding Resident #1 having sexual contact with another resident, OSM #11 stated, "The concern was brought to me by the DON (director of nursing). She said the residents had said they had consummated their relationship." When asked who the other resident was OSM #11 stated, "(Name of Resident #19). He is not cognitively intact so we had the physician do a cognitive assessment on him. The physician determined he was not able to make those decisions. We called the resident's responsible party and she did not want him to have a sexual relationship with (Resident#1)." When asked if there had been an investigation regarding the residents' statements of consummating their relationship, OSM #11 stated, "I don't know."

An interview was conducted on 8/29/18 at 11:55 a.m. with RN (registered nurse) #1, the nursing supervisor who spoke with Resident #1 on 8/6/18. When asked about the allegation that Resident #1 and Resident #19 had consummated their relationship, RN #1 stated, "I do know a nurse told me there was something about consummating the relationship. We talked to Resident #1 and resident #19 and they denied it." When asked if staff had been interviewed, RN #1 stated they had not. When asked if this had been documented, RN #1 stated, "I was told I didn't have to write anything because nothing happened." When asked if any interventions had been put into place, RN #1 stated the residents were not allowed to be together in their room with the door closed.

An interview was conducted on 8/29/18 at 12:45 a.m. with ASM (administrative staff member) #2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 20	F 607		

the director of nursing. ASM #2 was asked who was notified about the alleged sexual relationship between Resident #1 and Resident #19. ASM #2 stated, "Our administrator." [Note: the administrator referred to was no longer at the facility.] When asked when the residents said they had consummated their relationship, ASM #2 stated it was on 8/5/18. When asked when the investigation of the allegation was started, ASM #2 stated it was on 8/6/18. When asked if this was reported to any agency, ASM #2 stated, "After we investigated it and found out it was not true we did not report it."

On 8/29/18 at 1:00 p.m., a request for the investigation was made of ASM #1, the administrator. On 8/29/18 at approximately 3:00 p.m., ASM #2 stated there was no investigation documented.

An interview was conducted on 8/29/18 at 1:05 p.m. with CNA (certified nursing assistant) #4. When asked about the incident, CNA #4 stated, "I found out about it the day after. When I came in the nurse told me. I called the DON (director of nursing) and told her what I was told and told her I would be looking into it." When asked if the DON was aware of the situation at that time, CNA #4 stated she was not. I talked to Resident #19 and asked him if he had had sexual relations with Resident #1, he said, 'no, no, no.'"

An interview was conducted on 8/29/18 at 2:30 p.m. with LPN (licensed practical nurse) #6, a nurse familiar with Resident #1. When asked about the allegation of sexual conduct, LPN #6 stated, "(Resident #1) said, 'Guess what? (Resident #19) likes me. He needs a friend now. Did you know he is gay? I went to his room and

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 21 we consummated our relationship last night.' I was worried because (Resident #19) had a stroke and he needs to be protected" When asked what she did then, LPN #6 stated, "I passed it on in report. And we did 15 minute checks to make sure they weren't together." When asked the process staff follow in these situations, LPN #6 stated, "Well you should report it to the supervisor or whoever was on call." When asked if she had reported this to Resident #1's nurse, LPN #6 stated, "No. I told the supervisor." An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, the unit manager for Resident #19. LPN # 1 was asked what she knew about the relationship between Resident #1 and Resident #19. LPN #1 stated, "Different ones (staff) were saying there's a relationship starting. I don't know if it's true because I never saw it." When asked what she did then, LPN #1 stated, "I didn't do anything then because I didn't know until Monday. They didn't tell me to do anything. I was going to tell (ASM #1, the administrator) and (ASM #2, the director of nursing) but they already knew. We're supposed to keep them separated." On 8/29/18 at 7:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 8/30/18 at 12:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1 and LPN #2. LPN #1 and LPN #2 were asked the facility process regarding a resident to resident sexual altercation. LPN #2 stated she removes the resident from the area and notifies LPN #1 (the unit manager) or somebody in management. LPN #1 was asked what occurs after she is notified. LPN #1 stated interventions are put in	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 22	F 607		

place to prevent future occurrences and either the director of nursing or the weekend on-call nurse notifies the state agency. When asked if the incident should be investigated, LPN #1 stated, "Yes. It would be investigated." When asked to describe an investigation, LPN #1 stated nurses' notes would be reviewed and the nurse would be interviewed. When asked if a resident who reported the incident would be interviewed, LPN #1 stated, "Yeah. Talk to that resident."

On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 was asked the facility process regarding a resident to resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. When asked when the incident should be reported, ASM #1 stated the incident should be reported within one to two hours if harm has occurred and within 24 hours if harm has not occurred. ASM #1 was asked to describe what the investigation should include. ASM #1 stated she would interview the resident named in the allegation if the resident is interviewable, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them.

Review of the facility's policy titled, "Virginia Resident Abuse Policy" documented, "POLICY: It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation or residents, misappropriated of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 607	Continued From page 23 Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. PROCEDURE: 7) Investigate. Once the Administrator and DOH (department of health) are notified, an investigation of the allegation or suspicion will be conducted." No further information was provided prior to exit. (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609	***F 609*** ***Develop, implement, report, and investigate abuse*** 1. Since the time of the original incidents, Residents #21, #19, and #1 have had incidents reported and investigated. Residents #21, #19, and #1 had no signs or symptoms of abuse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 609	Continued From page 24 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an allegation of abuse for three of 22 residents in the survey sample, Residents #21, #19 and #1. 1. The facility staff failed to notify the state agency and other officials in accordance with state law when a male resident allegedly touched Resident #21's breast on 10/2/17. 2. The facility staff failed to report an allegation of sexual contact to the appropriate reporting agencies for Resident #1 and Resident #19. The findings include:	F 609	2. Current residents have the potential to be affected by this deficient practice. The Administrator/Designee will review the grievances for the last three months to ensure all possible abuse situations were reviewed, reported and investigated. Any possible abuse issues found will be reviewed, reported and investigated. 3. Administrator/designee will educate the staff on the policy on abuse prevention to include reporting expectations and investigation protocol. 4. The Administrator/designee will audit 24 hour report, concern logs,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 609	Continued From page 25 1. The facility staff failed to notify the state agency and other officials in accordance with state law when a male resident allegedly touched Resident #21's breast on 10/2/17. Resident #21 was admitted to the facility on 10/27/11. Resident #21's diagnoses included but were not limited to severe intellectual disabilities, pain and low blood pressure. Resident #21's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #21 as requiring extensive assistance of two staff with bed mobility and extensive assistance of one staff with dressing, eating and personal hygiene. Review of Resident #21's clinical record revealed a nurse's note dated 10/2/17 that documented, "Was reported to this writer by another resident whom is alert and oriented that this resident whom is unable to speak for self was being touched in (sic) breast by a male resident. N/P (Nurse Practitioner) Called and notified." Further review of Resident #21's clinical record revealed the resident was assessed and interventions were implemented to protect the resident but failed to reveal the incident was reported to the state agency and other officials. Review of a FRI (facility reported incident) submitted to the state agency on 10/24/17 revealed documentation that a male resident touched Resident #21's breast on that same day (10/24/17 [a separate incident from 10/2/17). The 10/24/17 incident was reported to the state agency and other officials.	F 609	incident/accidents for potential abuse and neglect concerns five times a week for four weeks then 3 times a week for two months. Findings will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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F 609	Continued From page 26 On 8/30/18 at 12:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1 and LPN #2. LPN #1 and LPN #2 were asked about the facility process regarding a resident-to-resident sexual altercation. LPN #2 stated she removes the resident from the area and notifies LPN #1 (the unit manager) or somebody in management. LPN #1 was asked what occurs after she is notified. LPN #1 stated interventions are put in place to prevent future occurrences and either the director of nursing or the weekend on-call nurse notifies the state agency. On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator who was not employed at the facility on 10/2/17). ASM #1 was asked about the facility process regarding a resident-to-resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. When asked when the incident should be reported, ASM #1 stated the incident should be reported within one to two hours if harm has occurred and within 24 hours in harm has not occurred. ASM #1 was made aware the FRI concerning the incident involving Resident #21 on 10/24/17 yielded no concerns but there was concern that the incident that occurred on 10/2/17 was not reported to the state agency. ASM #1 was asked to provide any evidence that the 10/2/17 incident was reported. On 8/30/18 at 2:06 p.m., ASM #1 stated she had no further information.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 609	Continued From page 27 The facility policy titled, "Virginia Resident Abuse Policy" documented, "6. Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made...9. Final Reports- Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged (sic) the alleged occurrence..." No further information was presented prior to exit. 2. The facility staff failed to report an allegation of sexual contact to the appropriate reporting agencies for Resident #1 and Resident #19. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to high blood pressure, irregular heartbeat, post-traumatic stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently. Resident #19 was admitted to the facility on	F 609		

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F 609	Continued From page 28 3/8/18 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and high cholesterol. The most recent MDS, a quarterly assessment, with an ARD of 6/16/17 coded the resident as having a BIMS of 3 out of 15 indicating the resident was severely impaired cognitively. The resident was coded as being independent in all activities of daily living except for showering which required the assistance of staff. An interview was conducted on 8/29/18 at 8:35 a.m. with Resident #1. Resident #1 stated, "They accused me of having sex with another resident. They came back later and apologized. He (name of Resident #19) came by this morning and knocked on the door and the staff told him he couldn't come in here. We're just friends." An interview was conducted on 8/29/18 at 11:35 a.m. with OSM (other staff member) #10, the social worker and OSM #11, the social worker. When asked about the process staff follow for allegations of sexual relations between residents, OSM #11 stated, "We have a weekly meeting, we discuss behaviors, and we discuss those daily as well in the 9:00 o'clock standup." When asked about an allegation regarding Resident #1 having sexual contact with another resident, OSM #11 stated, "The concern was brought to me by the DON (director of nursing). She said the residents had said they had consummated their relationship." When asked who the other resident was OSM #11 stated, "(Name of Resident #19). He is not cognitively intact so we had the physician do a cognitive assessment on him. The physician determined he was not able to make those decisions. We called the resident's responsible party and she did not want him to	F 609		

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F 609	Continued From page 29 have a sexual relationship with (Resident#1)." When asked if there had been an investigation regarding the residents' statements of consummating their relationship, OSM #11 stated, "I don't know." An interview was conducted on 8/29/18 at 11:55 a.m. with RN (registered nurse) #1, the nursing supervisor who spoke with Resident #1 on 8/6/18. When asked about the allegation that Resident #1 and Resident #19 had consummated their relationship, RN #1 stated, "I do know a nurse told me there was something about consummating the relationship. We talked to Resident #1 and resident #19 and they denied it." When asked if staff had been interviewed, RN #1 stated they had not. When asked if this had been documented, RN #1 stated, "I was told I didn't have to write anything because nothing happened." When asked if any interventions had been put into place, RN #1 stated the residents were not allowed to be together in their room with the door closed. Review of the facility reported incidents did not include a report regarding the alleged sexual relationship between the residents. Review of the nurse's note dated 8/6/18 documented that the nursing supervisor had spoken to the Resident #1 regarding being friends with other residents. An interview was conducted on 8/29/18 at 12:45 a.m. with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked who was notified about the alleged sexual relationship between Resident #1 and Resident #19. ASM #2 stated, "Our administrator." When asked when the residents said they had consummated their	F 609		

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F 609	Continued From page 30 relationship, ASM #2 stated it was on 8/5/18. When asked when the investigation started, ASM #2 stated it was on 8/6/18. When asked if this was reported to any agency, ASM #2 stated, "After we investigated it and found out it was not true we did not report it." On 8/29/18 at 1:00 p.m., a request for the investigation was made of ASM #1, the administrator. On 8/29/18 at approximately 3:00 p.m., ASM #2 stated there was no investigation documented. On 8/29/18 at 7:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 was asked the facility process regarding a resident to resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. When asked when the incident should be reported, ASM #1 stated the incident should be reported within one to two hours if harm has occurred and within 24 hours if harm has not occurred. ASM #1 was asked to describe what the investigation should include. ASM #1 stated she would interview the resident named in the allegation if the resident is interviewable, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. Review of the facility's policy titled, "Virginia Resident Abuse Policy" documented, "POLICY: It	F 609		

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F 609	Continued From page 31 is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation or residents, misappropriated of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. PROCEDURE: 6) Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (department of health) immediately, but not later than 2 hours after the allegation is made." No further information was provided prior to exit. (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from:	F 609		

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F 609	Continued From page 32 https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1	F 609	**F 610**	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate an allegation of abuse for three of 22 residents in the survey sample, Residents #21, #19 and #1. 1. The facility staff failed to investigate an allegation that a male resident touched Resident #21's breast on 10/2/17. 2. The facility staff failed to investigate an allegation of sexual contact for Resident #1 and Resident #19.	F 610	**Develop, implement, report, and investigate abuse** 1. Since the time of the original incidents, Residents #21, #19, and #1 have had incidents reported and investigated. Residents #21, #19, and #1 had no signs or symptoms of abuse. 2. Current residents have the potential to be affected by this deficient practice. The Administrator/Designee will review the grievances for the last three months to ensure all possible abuse situations were reviewed, reported and investigated. Any possible abuse issues found will be reviewed,	

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

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F 610	Continued From page 33 The findings include: 1. The facility staff failed to investigate an allegation that a male resident touched Resident #21's breast on 10/2/17. Resident #21 was admitted to the facility on 10/27/11. Resident #21's diagnoses included but were not limited to severe intellectual disabilities, pain and low blood pressure. Resident #21's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #21 as requiring extensive assistance of two staff with bed mobility and extensive assistance of one staff with dressing, eating and personal hygiene. Review of Resident #21's clinical record revealed a nurse's note dated 10/2/17 that documented, "Was reported to this writer by another resident whom is alert and oriented that this resident whom is unable to speak for self was being touched in (sic) breast by a male resident. N/P (Nurse Practitioner) Called and notified." Further review of Resident #21's clinical record revealed the resident was assessed and interventions were implemented to protect the resident but failed to reveal an investigation. Review of a FRI (facility reported incident) submitted to the state agency on 10/24/17 revealed documentation that a male resident touched Resident #21's breast on that same day (10/24/17 [a separate incident from 10/2/17). The 10/24/17 incident was investigated.	F 610	reported and investigated. 3. Administrator/ designee will educate the staff on the policy on abuse prevention to include reporting expectations and investigation protocol. 4. The Administrator/designee will audit 24 hour report, concern logs, incident/accidents for potential abuse and neglect concerns five times a week for four weeks then 3 times a week for two months. Findings will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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F 610	Continued From page 34 On 8/30/18 at 12:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1 and LPN #2. LPN #1 and LPN #2 were asked about the facility process regarding a resident-to-resident sexual altercation. LPN #2 stated she removes the resident from the area and notifies LPN #1 (the unit manager) or somebody in management. LPN #1 was asked what occurs after she is notified. LPN #1 stated interventions are put in place to prevent future occurrences and either the director of nursing or the weekend on-call nurse notifies the state agency. When asked if the incident should be investigated, LPN #1 stated, "Yes. It would be investigated." When asked to describe what the investigation should include, LPN #1 stated nurses' notes would be reviewed and the nurse would be interviewed. When asked if a resident who reported the incident would be interviewed, LPN #1 stated, "Yeah. Talk to that resident." On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator who was not employed at the facility on 10/2/17). ASM #1 was asked about the facility process regarding a resident-to-resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. ASM #1 was asked to describe what the investigation should include. ASM #1 stated she would interview the resident named in the allegation if the resident is able to be interviewed, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. ASM #1 was made aware the FRI concerning the incident involving	F 610		

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F 610	Continued From page 35 Resident #21 on 10/24/17 yielded no concerns but there was concern that the incident that occurred on 10/2/17 was not investigated. ASM #1 was asked to provide any evidence that the 10/2/17 incident was investigated. On 8/30/18 at 2:06 p.m., ASM #1 stated she had no further information. The facility policy titled, "Virginia Resident Abuse Policy" documented, "7. Investigate- Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted. a. Time frame for investigation. The investigation must be completed within five (5) working days from the alleged occurrence. b. Investigation protocol. The person investigating the incident should generally take the following actions: i. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. ii. If there are no direct witnesses, then the interviews may be expanded. For example, to cover all employees on the unit, or, as appropriate, the shift...iii. Obtain written statements from the resident, if possible, the accused, and each witness. iv. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the resident's records...c. Evidence of the investigation should be documented..." No further information was presented prior to exit.	F 610		

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

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F 610	Continued From page 36 2. The facility staff failed to investigate an allegation of sexual contact between Resident #1 and Resident #19. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently. Resident #19 was admitted to the facility on 3/8/18 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and high cholesterol. The most recent MDS, a quarterly assessment, with an ARD of 6/16/17 coded the resident as having a BIMS of 3 out of 15 indicating the resident was severely impaired cognitively. The resident was coded as being independent in all activities of daily living except for showering which required the assistance of staff. An interview was conducted on 8/29/18 at 8:35 a.m. with Resident #1. Resident #1 stated, "They accused me of having sex with another resident. They came back later and apologized. He (name of Resident #19) came by this morning and knocked on the door and the staff told him he couldn't come in here. We're just friends."	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 610	Continued From page 37 Review of the facility reported incidents did not include a report regarding the alleged sexual relationship between the residents. Review of the nurse's note dated 8/6/18 documented that the nursing supervisor had spoken to the Resident #1 regarding being friends with other residents. An interview was conducted on 8/29/18 at 11:35 a.m. with OSM (other staff member) #10, the social worker and OSM #11, the social worker. When asked the process staff follow for allegations of sexual relations between residents, OSM #11 stated, "We have a weekly meeting, we discuss behaviors, and we discuss those daily as well in the 9:00 o'clock standup." When asked about an allegation regarding Resident #1 having sexual contact with another resident, OSM #11 stated, "The concern was brought to me by the DON (director of nursing). She said the residents had said they had consummated their relationship." When asked who the other resident was OSM #11 stated, "(Name of Resident #19). He is not cognitively intact so we had the physician do a cognitive assessment on him. The physician determined he was not able to make those decisions. We called the resident's responsible party and she did not want him to have a sexual relationship with (Resident#1)." When asked if there had been an investigation regarding the residents' statements of consummating their relationship, OSM #11 stated, "I don't know." An interview was conducted on 8/29/18 at 11:55 a.m. with RN (registered nurse) #1, the nursing supervisor who spoke with Resident #1 on 8/6/18. When asked about the allegation that Resident	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 610	Continued From page 38 #1 and Resident #19 had consummated their relationship, RN #1 stated, "I do know a nurse told me there was something about consummating the relationship. We talked to Resident #1 and resident #19 and they denied it." When asked if staff had been interviewed, RN #1 stated they had not. When asked if this had been documented, RN #1 stated, "I was told I didn't have to write anything because nothing happened." When asked if any interventions had been put into place, RN #1 stated the residents were not allowed to be in together in their room with the door closed. An interview was conducted on 8/29/18 at 12:45 a.m., with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked who was notified about the alleged sexual relationship between Resident #1 and Resident #19. ASM #2 stated, "Our administrator." When asked when the residents said they had consummated their relationship, ASM #2 stated it was on 8/5/18. When asked when the investigation started, ASM #2 stated it was on 8/6/18. When asked if this was reported to any agency, ASM #2 stated, "After we investigated it and found out it was not true we did not report it." On 8/29/18 at 1:00 p.m., a request for the investigation was made of ASM #1, the administrator. On 8/29/18 at approximately 3:00 p.m., ASM #2 stated there was no investigation documented. An interview was conducted on 8/29/18 at 1:05 p.m. with CNA (certified nursing assistant) #4. When asked about the incident, CNA #4 stated, "I found out about it the day after. When I came in the nurse told me. I called the DON (director of	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 610	Continued From page 39	F 610		

nursing) and told her what I was told and told her I would be looking into it." When asked if the DON was aware of the situation at that time, CNA #4 stated she was not. I talked to Resident #19 and asked him if he had had sexual relations with Resident #1, he said, 'no, no, no.'"

An interview was conducted on 8/29/18 at 2:30 p.m. with LPN (licensed practical nurse) #6, a nurse familiar with Resident #1. When asked about the allegation of sexual conduct, LPN #6 stated, "(Resident#1) said, 'Guess what? (Resident #19) likes me. He needs a friend now. Did you know he is gay? I went to his room and we consummated our relationship last night.'" When asked what she did then, LPN #6 stated, "I passed it on in report." When asked the process staff follow in these situations, LPN #6 stated, "Well you should report it to the supervisor or whoever was on call." When asked if she had reported this to Resident #1's nurse, LPN #6 stated, "No. I told the supervisor."

An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, the unit manager for Resident #19, regarding what she knew about the relationship between Resident #1 and Resident #19. LPN #1 stated, "Different ones (staff) were saying there's a relationship starting. I don't know if it's true because I never saw it." When asked what she did then, LPN #1 stated, "I didn't do anything then because I didn't know until Monday. They didn't tell me to do anything. I was going to tell (ASM #1, the administrator) and (ASM #2, the director of nursing) but they already knew. We're supposed to keep them separated."

On 8/29/18 at 7:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 610	Continued From page 40 were made aware of the findings. On 8/30/18 at 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 was asked the facility process regarding a resident to resident sexual altercation. ASM #1 stated staff should make sure the resident is safe, assess the resident and report the incident to administration. ASM #1 stated administration investigates the incident and reports the incident to the state. When asked when the incident should be reported, ASM #1 stated the incident should be reported within one to two hours if harm has occurred and within 24 hours if harm has not occurred. ASM #1 was asked to describe what the investigation should include. ASM #1 stated she would interview the resident named in the allegation if the resident is interviewable, interview the resident who reported the allegation, and interview other residents to see if anything has happened to them. Review of the facility's policy titled, "Virginia Resident Abuse Policy" documented, "POLICY: It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation or residents, misappropriated of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. PROCEDURE: 7) Investigate. Once the Administrator and DOH (sic) are notified, an investigation of the allegation or suspicion will be conducted."	F 610		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 610	Continued From page 41 No further information was provided prior to exit. (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1	F 610		
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	F 656	***F 656 Develop and Implement Care Plans*** 1. The facility will administer doxycycline for Resident #1 separately from other medications. Resident #16's CP was reviewed and revised to accurately reflect oxygen administration. Resident #11 is no longer a resident of the facility.	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 42 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 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 observation, staff interview, facility document review clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the comprehensive care plan for three of 22 residents in the survey sample, Resident #1, Resident #16 and Resident #11. 1. The facility staff failed to implement the comprehensive care plan and follow the physician's order to administer doxycycline separately from other medications for Resident #1.	F 656	2. Current residents have the potential to be affected by this deficient practice. The MDS Coordinator/Designee will review the care plans that were developed in the last 30 days to ensure care plans were developed and implemented for residents throughout the facility. 3. The Director of Nursing/Designee will educate the IDT on generating Comprehensive Care Plans. The Director of Nursing/designee will educate the licensed nurses on implementing the care plan. 4. The DON/designee will audit 5 comprehensive care plans weekly prior	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 43 2. The facility staff failed to implement the comprehensive care plan and physician's order to administer continuous oxygen for Resident #16. 3. The facility staff failed to implement Resident #11's comprehensive care plan for medication administration on 5/30/18. The findings include: 1. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently. Review of the resident's comprehensive care plan initiated on 6/14/18 and revised on 8/29/18 documented, "Focus INFECTION: Resident has infection R/T (related to) Obstructive Pyleonephritis (2). Interventions medications/flushes as ordered. Review of the August 2018 physician's orders documented, "Doxycycline Hyclate (3) Capsule 100 MG (milligrams). Give 1 capsule by mouth in the afternoon for ureteral stones 1 caps (sic) in afternoon before dinner and separate from other meds (medications). Metoprolol Tartrate (4)	F 656	the MDS submission for 12 weeks to ensure completion and implementation Results will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

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 44 Tablet 50 MG Give 1 tablet by mouth two times a day." Review of the August 2018 medication administration record documented, "Doxycycline Hyclate (3) Capsule 100 MG (milligrams). Give 1 capsule by mouth in the afternoon for ureteral stones 1 caps (sic) in afternoon before dinner and separate from other meds (medications). Metoprolol Tartrate (4) Tablet 50 MG Give 1 tablet by mouth two times a day." The medications were documented as being given each day at 4:00 p.m. A medication administration observation was conducted on 8/28/18 at 4:48 p.m. with LPN (licensed practical nurse) #10. LPN #10 put the doxycycline and metoprolol into a medicine cup and took the medication to Resident #1. The resident took the medications. An interview was conducted on 8/29/18 at 2:10 p.m. with LPN #10. LPN #10 was asked to review the doxycycline and metoprolol orders. When asked if she had given the medication together LPN #10 stated she had. When asked if that was correct, LPN #10 stated, "No. we should notify the pharmacy and have them separate them out." An interview was conducted on 8/29/18 at 3:35 p.m. with LPN #7. When asked why residents had care plans, LPN #7 stated, "Make a goal, a specific plan of care." When asked who used the care plan, LPN #7 stated everyone did. When asked if staff were expected to follow the care plan, LPN #7 stated they were. An interview was conducted on 8/29/18 at 3:58 p.m. with LPN #3, the resident's nurse. When	F 656		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 45	F 656		

asked who entered the time medications were to be given into the computer, LPN #3 stated, "Whoever puts in the order." When asked if she had administered medication to Resident #1, LPN #3 stated she had. LPN #3 was asked to review the doxycycline and metoprolol orders for Resident #1. LPN #3 stated, "I never saw the bottom part of that (the instructions for the doxycycline)." When asked if she had given the metoprolol with the doxycycline, LPN #3 stated she had.

An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, a unit manager. When asked why residents had care plans, LPN #1 stated, "Basically it gives you the information concerning their care." When asked who used the care plan, LPN #1 stated, "Everyone except the CNAs (certified nursing assistants). They have a kardex." When asked if staff were to follow the care plan, LPN #1 stated they were.

On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director or nursing were made aware of the findings.

Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. PROCEDURE: D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented.

No further information was provided prior to exit.

(1) Wilson disease -- Wilson disease is a genetic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 46	F 656		

disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1

(2) Obstructive Pyleonephritis -- Because obstructive pyelonephritis secondary to ureteral stones can easily cause sepsis and concomitant disseminated intravascular coagulation (DIC), it is a potentially lethal disease. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/26419073

(3) Doxycycline Hyclate -- To reduce the development of drug-resistant bacteria and maintain the effectiveness of doxycycline hyclate delayed-release tablets and other antibacterial drugs, Doxycycline hyclate delayed-release tablets should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd2ab9b8-9619-4199-8a5d-83377b3274d1

(4) Metoprolol -- Metoprolol is a cardioselective beta-blocker that is widely used in the treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 47 of hypertension and angina pectoris. This information was obtained from: https://livertox.nih.gov/Metoprolol.htm 2. The facility staff failed to implement the comprehensive care plan and physician's order to administer continuous oxygen for Resident #16. Resident #16 was admitted to the facility on 3/1/16 and readmitted on 8/1/18 with diagnoses that included but were not limited to: heart failure, irregular heartbeat, dementia, diabetes and depression. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 8/8/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. The resident was coded as receiving oxygen. Review of the resident's comprehensive care plan documented, "Focus RESPIRATORY/OXYGEN NEEDS Resident requires oxygen R/T (related to) CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), chronic respiratory failure: pneumonia. Interventions Administer oxygen as ordered." Review of the August 2018 physician's orders documented, "OXYGEN @ (at) 2 LPM (liters per minute) VIA NASAL CANNULA (soft prongs that fit into the nose to deliver oxygen) every shift..." Review of the August 2018 treatment	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 48 administration record documented, "OXYGEN @ 2 LPM (liters per minute) VIA NASAL CANNULA (soft prongs that fit into the nose to deliver oxygen) every shift..."The oxygen was documented as being administered every day. An observation was made on 8/28/18 at 5:00 p.m. of Resident #16. The resident was in the dining room. There was an oxygen tank on the back of the wheelchair and the resident was wearing the nasal cannula. The oxygen tank was empty as evidenced by the arrow in the red colored area marked "empty". An observation was made on 8/29/18 at 11:55 a.m. of Resident #16. The resident was in the dining room. The resident was wearing the nasal cannula that was connected to the oxygen tank. The oxygen tank was turned off. On 8/29/18 at 1:25 p.m., an observation was made of Resident #16 with LPN #11, the resident's nurse. LPN #11 was asked to check the resident's oxygen tank, LPN #11 stated, "It's supposed to be at two (liters)." LPN #11 was asked to obtain an oxygen saturation on the resident. The oxygen saturation (1) was 90%. LPN #11 then turned on the oxygen tank. Review of the August 2018 oxygen saturation summary sheet documented the resident's oxygen saturation levels ranged from 95 % to 97 %. An interview was conducted on 8/29/18 at 3:35 p.m. with LPN #7. When asked why residents had care plans, LPN #7 stated, "Make a goal, a specific plan of care." When asked who used the care plan, LPN #7 stated everyone did. When	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 49 asked if staff were expected to follow the care plan, LPN #7 stated they were. An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, a unit manager. When asked why resident's had care plans, LPN #1 stated, "Basically it gives you the information concerning their care." When asked who used the care plan, LPN #1 stated, "Everyone except the CNAs (certified nursing assistants). They have a kardex." When asked if staff were to follow the care plan, LPN #1 stated they were. On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director or nursing were made aware of the findings. No further information was provided prior to exit. (1) Oxygen saturation -- 1 the fraction of the hemoglobin molecules in a blood sample that are saturated with oxygen at a given partial pressure of oxygen. Normal saturation is 95% to 100%. This information was obtained from: https://medical-dictionary.thefreedictionary.com/Oxygen+saturation 3. The facility staff failed to implement Resident #11's care plan for medication administration on 5/30/18. Resident #11 was admitted to the facility on 5/23/18. Resident #11's diagnoses included but were not limited to diabetes, chronic kidney disease, status post kidney transplant and high blood pressure. Resident #11's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/20/18, coded the resident as being	F 656		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 656	Continued From page 50 cognitively intact. On 7/25/18, the Office of Licensure and Certification received a complaint that documented Resident #11's medications were not given at various times. Review of Resident #11's clinical record revealed physician's orders that included but are not limited to the following: 5/24/18- clopidogrel bisulfate (1) 75 mg (milligrams) by mouth in the evening. 5/23/18- Lantus (2) 18 units subcutaneously in the evening. 5/24/18- santyl (3) ointment 250 units per gram- apply to right lower leg wound topically in the evening. 5/25/18 tacrolimus (4) 1 mg- two capsules by mouth every 12 hours. Review of Resident #11's May 2018 MAR (medication administration record) failed to reveal clopidogrel bisulfate, Lantus, santyl and the 9:00 p.m. dose of tacrolimus was administered to Resident #11 on 5/30/18 (as evidenced by a blank space on the MAR with no check mark or nurse's initials). Review of nurses' notes dated 5/30/18 failed to reveal the medications were administered. Resident #11's care plan dated initiated on 5/23/18 documented, "Focus: CARDIAC: Resident has cardiac symptoms r/t (related to): CAD (coronary artery disease), PVD (peripheral vascular disease), Requires Cardiac med...Interventions: Medication as ordered..."Focus: DIABETES: Resident is at risk for hypo/hyperglycemia (low or high blood sugar) episodes R/T (related to): IDDM (insulin	F 656		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 656	Continued From page 51 dependent diabetes mellitus)...Interventions: medication as ordered...Focus: KIDNEY TRANSPLANT: At risk for complications r/t (related to): kidney transplant...Interventions: Meds (Medications) as ordered...Focus: SKIN INTEGRITY/PRESSURE ULCER...Resident admitted w/ (with) multiple ulcers: R (Right) lower leg ulcer...Interventions: Administer treatments as ordered..." An attempt to contact the nurse responsible for administering the above medications to Resident #11 on 5/30/18 was made and the nurse was not available for interview. On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked to explain the purpose of a care plan. LPN #7 stated, "To make a goal and to meet it. I guess a specific target plan of care." When asked how staff ensures residents' care plans are followed, LPN #7 stated, "They have the care plans." LPN #7 was asked how nurses evidence medication administration. LPN #7 stated, "By signing off on the MAR (medication administration record)." When asked what is meant if the MAR is not signed off, LPN #7 stated, "You assume it wasn't given." When asked if there was any other way to evidence medication administration, LPN #7 stated, "If not on the MAR, you can call the nurse." LPN #7 was shown Resident #11's May 2018 MAR and asked how one would know if the resident's medications were given on 5/30/18. LPN #7 stated, "You can't tell. It wasn't signed." On 8/30/18 at 11:07 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 656		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 656	Continued From page 52 above concern. No further information was presented prior to exit. (1) "Clopidogrel is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html (2) "Insulin glargine (Lantus) is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html (3) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information was obtained from the website: https://www.santyl.com/ (4) "Tacrolimus is used along with other medications to prevent rejection (attack of a transplanted organ by the immune system of a person receiving the organ) in people who have received kidney, liver, or heart transplants." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601117.html	F 656		

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F 656	Continued From page 53 COMPLAINT DEFICIENCY F 657 Care Plan Timing and Revision SS=E CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined, that the facility staff failed to review and revise the care plan for	F 656 F 657	***F 657 Care Plan timing and revision*** 1. Resident #1's CP was revised to include interventions regarding the allegation of sexual conduct. Resident #19's CP was revised to included interventions regarding the allegation of sexual conduct. Resident #3's CP was reviewed and is current. Resident #7 is no longer a resident at the facility. Resident #14's CP was revised and the Nicotine Patch was removed from the CP. 2. Current residents have the potential to be affected by this deficient practice. The DON/designee will review MD orders and Change of Condition for the past 30 days to	

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

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F 657	Continued From page 54 five of 22 residents in the survey sample, Residents #1, #19, #3, #7 and #14. 1. The facility staff failed to revise Resident #1's comprehensive care plan to address an allegation of sexual conduct. 2. The facility staff failed to revise the comprehensive care plan following an allegation of sexual conduct for Resident #19. 3. The facility staff failed to revise the comprehensive care plan to include offering pain medication to Resident #3 upon waking. 4. The facility staff failed to revise Resident #7's comprehensive care plan to address isolation precautions that were being implemented. 5. The facility staff failed to review and revise the comprehensive care plan after the Nicotine patches for Resident #14, were discontinued. The findings include: 1. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently.	F 657	ensure accuracy of the Care plan. 3. The DON/Designee will educate the IDT and licensed nurses on care plan policy to include review and revision for change of condition and new/discontinued orders. 4. The DON/designee will review 10 care plans a week for 12 weeks with MD orders and change of condition to ensure accuracy. Results will be taken to QAPI meeting for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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F 657	Continued From page 55 Review of the comprehensive care plan did not evidence documentation regarding an 8/5/18 allegation of sexual conduct between Resident #1 and another resident. An interview was conducted on 8/29/18 at 11:35 a.m. with OSM (other staff member) #10, the social worker and OSM #11, the social worker. When asked the process staff follow for allegations of sexual relations between residents, OSM #11 stated, "We have a weekly meeting, we discuss behaviors, and we discuss those daily as well in the 9:00 o'clock standup." When asked about an allegation regarding Resident #1 having sexual contact with another resident, OSM #11 stated, "The concern was brought to me by the DON (director of nursing). She said the residents had said they had consummated their relationship." When asked who the other resident was OSM #11 stated, "(Name of Resident #19). Resident #19 is not cognitively intact so we had the physician do a cognitive assessment on him. The physician determined he was not able to make those decisions. We called the resident's responsible party and she did not want him to have a sexual relationship with (Resident#1)." When asked if Resident #1's care plan had been revised to reflect this situation, OSM #11 stated, "No." When asked why residents had care plans, OSM #11 stated, "So we know what their problems are, their needs, and their goals." When asked who updated the care plan, OSM #11 stated, "Everybody on the IDT (interdisciplinary team) updates the care plan." When asked how staff would be aware of the allegation/situation between Resident #1 and (Resident #19), OSM #11 stated, "The unit manager relayed this to the CNAs (certified nursing assistants)." When asked	F 657		

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F 657	Continued From page 56 how other staff would be made aware, OSM #11 did not have an answer. An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, the unit manager. When asked why residents had care plans, LPN #1 stated, "Basically it gives you information concerning their care." When asked what was put on the care plan, LPN #1 stated, "everything." When asked when a care plan was revised, LPN #1 stated, "Any time there's a change." When asked if Resident #1's care plan should have been updated following the concern about sexual conduct, LPN #1 stated, "Yes, you should. Absolutely." On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements an done on a as need bases. PROCEDURE: V) The MDS Coordinator is to review the 24- Hour Report daily for significant changes or changes in resident's ADL (activities of daily living). The Care Planning coordinator will add minor changes in resident's status to the exiting Car Plan on daily basis." No further information was provided prior to exit. (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too	F 657		

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F 657	Continued From page 57 much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1 2. The facility staff failed to revise the comprehensive care plan following an allegation of sexual contact for Resident #19. Resident #19 was admitted to the facility on 3/8/18 with diagnoses that included but were not limited to: stroke, depression, high blood pressure and high cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/16/17 coded the resident as having a BIMS (brief interview for mental status) of 3 out of 15 indicating the resident was severely impaired cognitively. The resident was coded as being independent in all activities of daily living except for showering which required the assistance of staff. Review of the care plan did not evidence documentation regarding an 8/5/18 allegation of sexual conduct between Resident #19 and another resident. An interview was conducted on 8/29/18 at 11:35 a.m. with OSM (other staff member) #10, the social worker and OSM #11, the social worker.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 657	Continued From page 58 When asked the process staff follow for allegations of sexual relations between residents, OSM #11 stated, "We have a weekly meeting, we discuss behaviors, and we discuss those daily as well in the 9:00 o'clock standup." When asked about an allegation regarding Resident #19 having sexual contact with another resident, OSM #11 stated, "The concern was brought to me by the DON (director of nursing). She said the residents had said they had consummated their relationship." When asked who the other resident was OSM #11 stated, "(Name of Resident #1). Resident #19 is not cognitively intact so we had the physician do a cognitive assessment on him. The physician determined he was not able to make those decisions. We called the resident's responsible party and she did not want him to have a sexual relationship with (Resident#1)." When asked if the care plan had been revised to reflect this situation, OSM #11 stated, "No." When asked why residents had care plans, OSM #11 stated, "So we know what their problems are, their needs, their goals." When asked who updated the care plan, OSM #11 stated, "Everybody on the IDT (interdisciplinary team) updates the care plan." When asked how staff would be aware of the allegation and situation between Resident #19 and Resident #1, OSM #11 stated, "The unit manager relayed this to the CNAs (certified nursing assistants)." When asked how other staff would be made aware, OSM #11 did not have an answer. An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, the unit manager. When asked why residents had care plans, LPN #1 stated, "Basically it gives you information concerning their care." When asked what was put on the care plan, LPN #1 stated, "everything." When asked	F 657		

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F 657	Continued From page 59 when a care plan was revised, LPN #1 stated, "Any time there's a change." When asked if Resident #19's care plan should have been updated following the concern about sexual conduct, LPN #1 stated, "Yes, you should. Absolutely." On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 3. The facility staff failed to revise the care plan to include offering pain medication to Resident #3 upon waking. Resident #3 was admitted to the facility on 9/24/17 and readmitted on 6/30/18 with diagnoses that included but were not limited to: Parkinson's Disease (1), weakness, chronic pain, high blood pressure and irregular heartbeat. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 713/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the resident's care plan did not evidence documentation regarding the resident requesting pain medication upon waking. Review of the July 2018 physician's orders documented, "Tramadol HCL (hydrochloride) (2)	F 657		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 657	Continued From page 60 Tablet 50 MG (milligrams) Give 2 tablet by mouth every 4 hours as needed for pain." The medication administration record documented, "Tramadol HCL (2) Tablet 50 MG (milligrams) Give 2 tablet (sic) by mouth every 4 hours as needed for pain." On 8/2/18 at 6:02 a.m., 8/4/18 at 6:00 a.m., 8/6/18 at 5:31 a.m. and 8/24/18 at 6:30 a.m. the medication had been administered to the resident. The resident's pain level was documented as being zero indicating the resident did not have pain when the medication was given. On 8/30/18 at 4:15 p.m. ASM (administrative staff member), #1 and ASM #2, the director of nursing were made aware of the concern that the resident received pain medication when she did not have any pain. A telephone interview was conducted on 8/30/18 at 4:25 p.m. with LPN (licensed practical nurse) #12, the nurse who administered the Tramadol. LPN #12 was asked about the process she follows when giving pain medication. LPN #12 stated, "I would ask them where they're hurting and how bad is the pain on a scale from one to ten." When asked if the pain level would be documented, LPN #12 stated, "Yeah, I would put that in (name of software)." When asked when would she give an as needed pain medication to a resident who did not have pain, LPN #12 stated, "Well, some people take it to keep from having pain." When asked if she had a resident who she gave pain medication when they did not have pain, LPN #12 stated, "There's (name of Resident #3). They used to have it scheduled around the clock but they want her to decrease the amount of pain medication she takes so they changed it	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 61 so she would have to ask for her pain medication." She and I have an agreement that I give her a pain pill when she wakes up so she doesn't get pain." When asked if this request should be added to the care plan, LPN #12 stated, "I'm kinda new so yeah it should be. I don't really know how to do it." An interview was conducted on 8/29/18 at 4:20 p.m. with LPN #1, the unit manager. When asked why residents had care plans, LPN #1 stated, "Basically it gives you information concerning their care." When asked what was put on the care plan, LPN #1 stated, "Basically everything. Have to have everything." When asked when a care plan was revised, LPN #1 stated, "Any time there's a change." No further information was provided prior to exit. (1) Parkinson's disease -- Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantia nigra. That controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease (2) Tramadol -- Tramadol is an opioid analgesic used for the therapy of mild-to-moderate pain. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Tramadol#section=Top 4. The facility staff failed to revise Resident #7's comprehensive care plan to address isolation precautions that were being implemented.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 62 Resident #7 was admitted to the facility on 8/3/18 and readmitted on 8/14/18. Resident #7's diagnoses included but were not limited to pneumonia, difficulty swallowing and quadriplegia (paralysis of all four limbs). Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/22/18, coded the resident as being cognitively intact. Review of Resident #7's clinical record revealed a hospital progress noted dated 8/13/18 that documented, "Sputum positive for Pseudomonas (1), but likely represents colonization..." A hospital general medicine discharge summary dated 8/14/18 documented, "VRE (vancomycin-resistant enterococci) (2) surveillance swab positive..." but failed to document information regarding isolation precautions. Review of Resident #7's physician orders from 8/14/18 to 8/28/18 failed to reveal documentation of isolation precautions. Resident #7's care plan initiated on 8/13/18 failed to document information regarding isolation precautions. On 8/28/18 at 11:10 a.m., a yellow bag containing gowns, gloves and masks was observed hanging on Resident #7's door. A CNA (certified nursing assistant) was observed in the resident's room pushing an over bed table next to the bed. The CNA was wearing gloves but no gown or mask. On 8/28/18 at 11:11 a.m., a housekeeper entered Resident #7's room with a mop and began washing the floor. The housekeeper was not wearing a gown, gloves or a mask.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 63 On 8/29/18 at 9:35 a.m., an interview was conducted with RN (registered nurse) #1. When asked if Resident #7 was on isolation, RN #1 stated, "Yes." When asked why, RN #1 stated, "We are on the phone trying to clarify." When asked what type of isolation precautions should be followed in Resident #7's room, RN #1 stated the resident was on contact precautions, a gown, mask and gloves should be worn by staff when in the resident's room. When asked about the facility process for clarifying isolation precautions, RN #1 stated the nurses receive a report from hospital staff when a resident is admitted and the nurses have to call the physician to review all admission orders. RN #1 stated the physician may discontinue isolation if the infection is colonized. RN #1 was asked how staff is supposed to know what precautions to follow if the staff is unsure of why the resident is on isolation. RN #1 stated, "Correct." RN #1 was made aware this surveyor wanted to go into Resident #7's room and asked what protective equipment should be worn. RN #1 stated a mask, gown and gloves should be worn. On 8/29/18 at 9:55 a.m., an interview was conducted with Resident #7 while the resident was lying in bed. The resident stated he did not know why he was on isolation. When asked if staff always wears a gown and gloves when near him or touching items in his room, Resident #7 stated they did not. On 8/29/18 at 10:06 a.m., RN #1 stated she called the infectious disease department at the hospital and the staff there was unsure why Resident #7 was on isolation. RN #1 stated the staff at the hospital saw documentation that Resident #7 had a positive VRE rectal swab and	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 64	F 657		

three negative swabs were needed to clear the infection so this is probably why Resident #7 was on isolation. RN #1 stated the hospital case manager was supposed to call her back.

On 8/29/18 at 11:07 a.m., an interview was conducted with OSM (other staff member) #7 (the activities director). OSM #7 was asked why Resident #7 was on isolation and what protective equipment should be worn in the resident's room. OSM #7 stated she did not know why the resident was on isolation but she wears a gown, gloves and a mask when she goes into the resident's room.

On 8/29/18 at 2:03 p.m., an interview was conducted with OSM #6 (the housekeeping manager). OSM #6 was asked how the housekeeping staff is made aware of residents who are on isolation precautions. OSM #6 stated she is notified in the morning meetings and isolation rooms have yellow bags containing gowns, gloves and masks hanging on the doors. OSM #6 stated housekeepers are supposed to wear a gown and gloves every time they go in an isolation room. OSM #6 was made aware a housekeeper was observed without a gown or gloves in Resident #7's room. OSM #6 stated she was aware of this and in-serviced the housekeeper.

On 8/29/18 at 2:34 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how she is made aware of what type of protective equipment she should wear in an isolation room. CNA #1 stated she usually asks the nurse.

On 8/29/18 at 4:50 p.m., an interview 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 _____	C 08/30/2018

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 657	Continued From page 65	F 657		

conducted with LPN (licensed practical nurse) #4 and LPN #5 (both MDS nurses). LPN #4 stated if a resident is discharged to the hospital and their return is anticipated within 30 days, then the original care plan is re-opened and updates are added when the resident returns. LPN #4 was made aware Resident #7's care plan failed to document information regarding isolation precautions. LPN #4 stated there was never a physician's order for isolation precautions so isolation precautions were not added to Resident #7's care plan. LPN #4 was asked if isolation precautions should be documented on the care plan if staff are expected to follow them, regardless of there not being a physician's order. LPN #4 stated she checks orders and if there is an order, she adds the precautions to the care plan. When asked to clarify that if there is not an order then she does not care plan isolation precautions, LPN #4 stated, "Yes." LPN #5 stated, "We bring it to the attention of the nurse that there is no order." LPN #4 was asked if isolation precautions should be on a resident's care plan. LPN #4 stated the staff has to determine if the resident really should be on isolation. LPN #4 stated she did not know why Resident #7 was on isolation and never received an order for isolation. When asked how staff would know the resident was supposed to be on isolation, LPN #4 stated there was a yellow bag hanging on the resident's door.

On 8/29/18 at 5:29 p.m., RN #1 stated she had talked to five different people at the hospital. RN #1 stated Resident #7 tested positive for VRE on 4/17/18. RN #1 stated the case manager stated Resident #7 would have probably been deemed colonized but a third VRE test was supposed to have been done. RN #1 presented a progress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 66 note signed by an infection prevention nurse at the hospital and dated 8/6/18. The note documented, "Lab Data: Date: 4/17/18. Specimen: Perirectal. Organism: Vancomycin Resistant Enterococcus (VRE). Isolation/Precaution Required (in addition to Standard Precautions): Contact Precautions-Private room, gown, gloves. A follow up test for colonization has been ordered..." RN #1 stated this document was not provided to facility staff when Resident #7 was admitted but there was a document provided that mentioned VRE. RN #1 stated she made Resident #7's physician aware of this and Resident #7's physician ordered a VRE peri-rectal swab to be obtained on the next day. When asked why Resident #7 was initially placed on isolation if the nurses were unaware why isolation was needed, RN #1 stated, "the admissions department asks the hospital staff about isolation precautions and would have told the facility nurses to follow isolation precautions, and the hospital nurse is supposed to inform the facility staff during the phone report." When asked to explain the professional standard for action to be taken if an admitted resident is suspected of needing isolation precautions, RN #1 stated, the facility staff should find out what organism the resident is infected with and obtain clarification of what precautions and protective equipment should be used. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/30/18 at 10:26 a.m., an interview was conducted with LPN #1. LPN #1 was asked the facility process for admitting a resident suspected	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 67 of having an infection that requires isolation. LPN #1 stated usually the nurse from the hospital will call and inform facility staff and the information should be on discharge instructions. When asked what information should be obtained and clarified, LPN #1 stated, "What are they on isolation for? MRSA (3)? VRE? Where at? Treatment? Precautions to follow? When asked if isolation precautions should be documented on a resident's care plan, LPN #1 stated, "Yes Ma'am." No further information was presented prior to exit. (1) "What is a Pseudomonas infection? Pseudomonas infection is caused by strains of bacteria found widely in the environment; the most common type causing infections in humans is called Pseudomonas aeruginosa. What types of infections does Pseudomonas aeruginosa cause? Serious Pseudomonas infections usually occur in people in the hospital and/or with weakened immune systems. Infections of the blood, pneumonia, and infections following surgery can lead to severe illness and death in these people." This information was obtained from the website: https://www.cdc.gov/hai/organisms/pseudomonas.html (2) "Vancomycin-resistant Enterococci are specific types of antimicrobial-resistant bacteria that are resistant to vancomycin, the drug often used to treat infections caused by enterococci. Enteroccocci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Most vancomycin-resistant	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 68 Enterococci infections occur in hospitals. [Vancomycin-resistant Enterococci is also called VRE]...What is the treatment for VRE? People with colonized VRE (bacteria are present, but have no symptoms of an infection) do not need treatment. Most VRE infections can be treated with antibiotics other than vancomycin. Laboratory testing of the VRE can determine which antibiotics will work. For people who get VRE infections in their bladder and have urinary catheters, removal of the catheter when it is no longer needed can also help get rid of the infection. How is VRE spread? VRE is often passed from person to person by the contaminated hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not spread through the air by coughing or sneezing." This information was obtained from the website: https://www.cdc.gov/HAI/organisms/vre/vre.html The CDC (Centers for Disease Control) further documented, "Multidrug-resistant organisms (MDROs), infection or colonization (e.g., VRE...) Type of Precaution: Contact + Standard MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infectioncontrol/guidelines/	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 69 mdro/ accessed May 2016) [870]. Contact state health department for guidance regarding new or emerging MDRO." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf (3) "MRSA is methicillin-resistant Staphylococcus aureus, a type of staph bacteria that is resistant to several antibiotics. In the general community, MRSA most often causes skin infections. In some cases, it causes pneumonia (lung infection) and other issues. If left untreated, MRSA infections can become severe and cause sepsis - a life-threatening reaction to severe infection in the body." This information was obtained from the website: https://www.cdc.gov/mrsa/community/ 5. The facility staff failed to review and revise the comprehensive care plan after the Nicotine patches for Resident #14, were discontinued. Resident #14 was admitted to the facility on 10/18/17 with diagnoses that included but were not limited: peripheral vascular disease (any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart) (1), diabetes, high blood pressure, right leg above the knee amputation, and COPD (chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/29/18, coded the resident as scoring a 15 on the BIMS (brief	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 70	F 657		

interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided.

The comprehensive care plan dated, 12/29/17 and revised on 4/20/18, documented in part, "Focus: Smoking: Resident smokes during family/friend visits outside of facility. Resident is a smoker and resident is a supervised smoker due to: safety, with scheduled times in room, @ (at) station. 3/18 (2018) New order for Nicotine Patch." The "Interventions" documented in part, "3/3/18 - Nicotine patch as directed.

During the entrance conference, on 8/28/18 at approximately 10:30 a.m., a list of the current smokers in the building was requested. Resident #14 was documented as being a current smoker.

The review of the current physician orders for August 2018, failed to evidence documentation of the physician order for the Nicotine patch.

Review of the August 2018 MAR (medication administration record) for Resident #14, failed to evidence documentation of the order for the Nicotine patch.

A physician order dated, 3/5/18, documented, "Nicotine Patch 24 14 MG/24HR (milligrams per 24 hours) transdermally (application of a medicine or drug through the skin) in the morning for nicotine dependence for 14 days. Discontinue if pt (patient) demands to go outside to smoke and remove per schedule."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 657	Continued From page 71 The March 2018 MAR documented the above order. The Nicotine patch was documented as being applied on 3/5/18, 3/6/18 and 3/7/18. The order was discontinued on 3/7/18. An interview was conducted with LPN (licensed practical nurse) #7 on 8/29/18 at 3:25 p.m. When asked the purpose of the care plan, LPN #7 stated, "To make a goal for the resident to meet. It's the specific plan of care so the resident can recover quicker." When asked who updates the care plan, LPN #7 stated, "(Name of MDS nurse - LPN # 4) and we do if there's a fall." An interview was conducted with LPN #4, the MDS (minimum data set) nurse, on 8/29/18 at 3:52 p.m. When asked who updates the care plans, LPN #4 stated, "MDS nurses, everybody is supposed to." The care plan documented above was reviewed with LPN #4. When asked if the care plan have been reviewed and revised since there was a quarterly assessment, with an ARD of 6/29/18, completed after the Nicotine patches were discontinued, LPN #4 stated, "Yes, Ma'am." The administrator and director of nursing were made aware of the above finding on 8/29/18 at 7:00 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 447. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 F 658 SS=D	Continued From page 72 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, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to follow professional standards of practice for three of 22 residents in the survey sample, Residents #6, #7, and #1. 1. a. The facility staff failed to clarify medication orders with the physician for Resident #6. 1. b. The facility staff borrowed medication from another resident to administer to Resident #6. 2. The facility staff failed to clarify the reason Resident #7 was on isolation precautions and what type of precautions that staff were required to follow. 3. The facility staff failed to document accurately that the Minipress medication had not been given to Resident #1. The findings include: 1. a. The facility staff failed to clarify medication orders with the physician for Resident #6.	F 658 F 658	***F 658 Professional Standards*** 1. The facility clarified #6's orders to include the dose of the medication. Nurse was counceled regarding borrowing medications. Resident #7 is no longer a resident of the facility. Physician was notified of the incorrect documentation of the Minipress for Resident #1. 2. Current residents have the potential to be affected by this deficient practice. DON/Designee will review other residents with isolation to ensure proper orders and reason known. DON/designee will review current medication orders for current residents to ensure medications are given per specific times.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 73 Resident #6 was admitted to the facility on 8/23/18 with diagnoses that included but were not limited to: high blood pressure, diabetes, gout (a disease in which a defect in uric acid metabolism causes the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints) (1) and stroke. A MDS (minimum data set) assessment had not yet been completed at the time of survey. The "Admission Evaluation" dated, 8/23/18 documented in part, "Resident is alert and verbal, able to make needs known. Oriented X (times) 3 (person, place and time)." The "Pain Evaluation" documented the resident had no pain at the time of the assessment. The physician orders dated, 8/23/18 documented, "Acetaminophen Tablet (Tylenol) (used to treat fever and minor aches and pain) (2); Give 2 tablet by mouth every 4 hours as needed for pain related to GOUT." There was no dose of Acetaminophen documented. The physician orders dated, 8/23/18 documented, "Melatonin Tablet; Give 1 tablet by mouth at bedtime related to other symbolic dysfunction." There was no dose of Melatonin documented. The August 2018 MAR (medication administration record) documented the above medication orders. The Acetaminophen had not been administered. The Melatonin had been administered on 8/23/18, 8/24/18, 8/25/18, 8/26/18 and 8/27/18. The nurse's note dated, 8/23/18 at 4:18 p.m. documented in part, "Resident meds (mediations) verified with MD (medical doctor) and faxed to	F 658	3. DON/designee will educate the nurses on medication administration policy to include timing of medication, documentation of med administration and not borrowing medications. 4. DON/designee will educate the licensed nurses and admissions team to ensure reason for isolation is known by facility staffDON/designee will audit admissions and new MD orders 5 times a week for any new documentation of need for isolation and reason. DON/designee will audit 2 nurses a week during medication pass to ensure no deficient practice. Findings will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

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

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F 658	Continued From page 74 pharmacy." The nurse practitioner's note dated, 8/24/18 at 12:59 p.m. documented in part, "Insomnia, estab (established) - no acute complaints; cont (continue) melatonin as ordered and will monitor." The physician's note dated, 8/28/18 at 2:16 p.m. documented in part, "Insomnia, estab- no acute complaints; cont melatonin as ordered and will monitor." The care plan dated, 8/24/18, documented in part, "Focus: The resident has potential for pain r/t (related to) HTN (high blood pressure), DMII (diabetes type two), Gout." The "Interventions" dated, 8/24/18, documented in part, "Assess and record pain per routine and prn (as needed). Assess/ record/report to nurse resident complaints of pain or requests for pain treatment." The stock medication list documented, "Melatonin 3 mg (milligrams) - pkg (package) size - 60 tablets." An interview was conducted with LPN (licensed practical nurse) #7 on 8/28/18 at 4:30 p.m. LPN #7 was documented as having administered the Melatonin on 8/8/27/18. When asked where she obtained the melatonin she gave on 8/27/18, LPN #7 pulled the medication card for another resident who was also receiving the same medication. When asked what dose of Melatonin Resident #6 was to receive, LPN #7 stated, "The standard dose is 3 mg." When asked if this dose was included in the physician order, LPN #7 stated, "It needs to be clarified with the doctor." When asked if the facility stocks Melatonin in the bulk	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 658	Continued From page 75 supply of over the counter medications, LPN #7 stated, "Yes, they are in the medication room." LPN #7 and this writer went to the medication room. A bottle of Melatonin 3 mg was located on the shelf. The Acetaminophen order was reviewed with LPN #7. When asked what dose she would give if the resident complained of pain, LPN #7 stated, "I would need to know what dose; either 650 mg or 1000 mg. Clarification is needed for that order too." The facility policy, "General Dose Preparation and Medication Administration" documented in part, "Facility staff should verify that the medication name and dose are correct." According to Lippincott's "Fundamentals of Nursing, 5th edition, page 553 documents the following statement, "Always clarify with the prescriber any medication order that is unclear or seems in appropriate." The administrator, ASM (administrative staff member) #1, and ASM #2, the director of nursing were made aware of the above finding on 8/29/18 at 7:00 p.m. When asked what standard the facility used, ASM #2 stated Lippincott or the facility policies and procedures. 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 252. (2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 76 gXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7. 1. b. The facility staff borrowed medication from another resident to administer to Resident #6. Resident #6's physician orders dated, 8/23/18 documented, "Melatonin Tablet; Give 1 tablet by mouth at bedtime related to other symbolic dysfunction." There was no dose of Melatonin documented in the order. An interview was conducted with LPN (licensed practical nurse) #7 on 8/28/18 at 4:30 p.m. LPN #7 was documented as having administered the Melatonin on 8/8/27/18. When asked where she obtained the melatonin she gave on 8/27/18, LPN #7 pulled the medication card for another resident who was also receiving the same medication. When asked if she is supposed to borrow medications from another resident, LPN #7 stated, "I didn't want him to go without his medication." The facility policy, "General Dose Preparation and Medication Administration" documented in part, "The facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct rate, at the correct time, and for the correct resident." The phrase, "Neither a borrower nor a lender be," originated from Shakespeare's famous play, Hamlet (1603), during which Lord Polonius gives this advice to his son who is heading back to school. Because our world is different today, you may believe this advice is outdated and irrelevant. But when it comes to medication safety,	F 658		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 77 Shakespeare's advice is timeless; medications should never be borrowed from or lent to others. His advice is simple enough to follow, but practitioners can be tempted to borrow a "missing medication" (a dose that should have been available) or the first dose of a new medication from another patient's cassette, a discharged patient's unused medications, or another patient care unit. Borrowing medications as a workaround to speed the process of administering medications due to inherent or excessive wait times associated with the pharmacy dispensing process increases the risk of an error.(1) The administrator and director of nursing were made aware of the above finding on 8/29/18 at 7:00 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: http://www.ismp.org/resources/shakespeare-was-target-dont-be-borrower-or-lender 2. The facility staff failed to clarify the reason Resident #7 was on isolation precautions and what type of precautions were required to be followed. On 7/25/18, the Office of Licensure and Certification received a complaint regarding a resident who no longer resided at the facility during the survey. The complaint documented the facility staff failed to practice infection control and failed to wear isolation attire. Resident #7 was admitted to the facility on 8/3/18	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 78	F 658		

and readmitted on 8/14/18. Resident #7's diagnoses included but were not limited to pneumonia, difficulty swallowing and quadriplegia (paralysis of all four limbs). Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/22/18, coded the resident as being cognitively intact.

Review of Resident #7's clinical record revealed a hospital progress noted dated 8/13/18 that documented, "Sputum positive for Pseudomonas (1), but likely represents colonization..." A hospital general medicine discharge summary dated 8/14/18 documented, "VRE (vancomycin-resistant enterococci) (2) surveillance swab positive..." but failed to document information regarding isolation precautions.

Review of Resident #7's physician orders from 8/14/18 to 8/28/18 failed to reveal documentation of isolation precautions. Resident #7's care plan initiated on 8/13/18 failed to document information regarding isolation precautions.

On 8/28/18 at 11:10 a.m., a yellow bag containing gowns, gloves and masks was observed hanging on Resident #7's door. A CNA (certified nursing assistant) was observed in the resident's room pushing an over bed table next to the bed. The CNA was wearing gloves but no gown or mask.

On 8/28/18 at 11:11 a.m., a housekeeper entered Resident #7's room with a mop and began washing the floor. The housekeeper was not wearing a gown, gloves or a mask.

On 8/29/18 at 9:35 a.m., an interview 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 _____	C 08/30/2018

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F 658	Continued From page 79 conducted with RN (registered nurse) #1. When asked if Resident #7 was on isolation, RN #1 stated, "Yes." When asked why, RN #1 stated, "We are on the phone trying to clarify." When asked what type of isolation precautions should be followed in Resident #7's room, RN #1 stated the resident was on contact precautions, a gown, mask and gloves should be worn by staff when in the resident's room. When asked about the facility process for clarifying isolation precautions, RN #1 stated the nurses receive a report from hospital staff when a resident is admitted and the nurses have to call the physician to review all admission orders. RN #1 stated the physician may discontinue isolation if the infection is colonized. RN #1 was asked how staff is supposed to know what precautions to follow if the staff is unsure of why the resident is on isolation. RN #1 stated, "Correct." RN #1 was made aware this surveyor wanted to go into Resident #7's room and asked what protective equipment should be worn. RN #1 stated a mask, gown and gloves should be worn. On 8/29/18 at 9:55 a.m., an interview was conducted with Resident #7 while the resident was lying in bed. The resident stated he did not know why he was on isolation. When asked if staff always wears a gown and gloves when near him or touching items in his room, Resident #7 stated they did not. On 8/29/18 at 10:06 a.m., RN #1 stated she called the infectious disease department at the hospital and the staff there was unsure why Resident #7 was on isolation. RN #1 stated the staff at the hospital saw documentation that Resident #7 had a positive VRE rectal swab and three negative swabs were needed to clear the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 658	Continued From page 80	F 658		

infection so this is probably why Resident #7 was on isolation. RN #1 stated the hospital case manager was supposed to call her back.

On 8/29/18 at 11:07 a.m., an interview was conducted with OSM (other staff member) #7 (the activities director). OSM #7 was asked why Resident #7 was on isolation and what protective equipment should be worn in the resident's room. OSM #7 stated she did not know why the resident was on isolation but she wears a gown, gloves and a mask when she goes into the resident's room.

On 8/29/18 at 2:03 p.m., an interview was conducted with OSM #6 (the housekeeping manager). OSM #6 was asked how the housekeeping staff is made aware of residents who are on isolation precautions. OSM #6 stated she is notified in the morning meetings and isolation rooms have yellow bags containing gowns, gloves and masks hanging on the doors. OSM #6 stated housekeepers are supposed to wear a gown and gloves every time they go in an isolation room. OSM #6 was made aware a housekeeper was observed without a gown or gloves in Resident #7's room. OSM #6 stated she was aware of this and in-serviced the housekeeper.

On 8/29/18 at 2:34 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how she is made aware of what type of protective equipment she should wear in an isolation room. CNA #1 stated she usually asks the nurse.

On 8/29/18 at 5:29 p.m., RN #1 stated she had talked to five different people at the hospital. RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 81 #1 stated Resident #7 tested positive for VRE on 4/17/18. RN #1 stated the case manager stated Resident #7 would have probably been deemed colonized but a third VRE test was supposed to have been done. RN #1 presented a progress note signed by an infection prevention nurse at the hospital and dated 8/6/18. The note documented, "Lab Data: Date: 4/17/18. Specimen: Perirectal. Organism: Vancomycin Resistant Enterococcus (VRE). Isolation/Precaution Required (in addition to Standard Precautions): Contact Precautions-Private room, gown, gloves. A follow up test for colonization has been ordered..." RN #1 stated this document was not provided to facility staff when Resident #7 was admitted but there was a document provided that mentioned VRE. RN #1 stated she made Resident #7's physician aware of this and Resident #7's physician ordered a VRE peri-rectal swab to be obtained on the next day. When asked why Resident #7 was initially placed on isolation if the nurses were unaware why isolation was needed, RN #1 stated, "the admissions department asks the hospital staff about isolation precautions and would have told the facility nurses to follow isolation precautions, and the hospital nurse is supposed to inform the facility staff during the phone report." When asked to explain the professional standard for action to be taken if an admitted resident is suspected of needing isolation precautions, RN #1 stated, the facility staff should find out what organism the resident is infected with and obtain clarification of what precautions and protective equipment should be used. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 82 above concern. On 8/30/18 at 10:26 a.m., an interview was conducted with LPN #1. LPN #1 was asked the facility process for admitting a resident suspected of having an infection that requires isolation. LPN #1 stated usually the nurse from the hospital will call and inform facility staff and the information should be on discharge instructions. When asked what information should be obtained and clarified, LPN #1 stated, "What are they on isolation for? MRSA (3)? VRE? Where at? Treatment? Precautions to follow? When asked how she would obtain this information if it were not provided by hospital staff, LPN #1 stated, "I'm going to call the hospital as soon as they get here and if it's not in the information, ask them to fax it." When asked what precautions should be followed for a resident with VRE, LPN #1 stated, "Contact. Gown, gloves, probably a mask and probably goggles." When asked if the facility staff obtains a physician's order for isolation precautions, LPN #1 stated, "We obtain an order. If there is not an order then I wouldn't know unless I saw the items hanging on the door." When asked if it is a professional standard to clarify a resident's isolation status upon admission, LPN #1 stated, "Yes." The facility policy titled, "INFECTION CONTROL-TRANSMISSION BASED PRECAUTIONS" documented, "PROCEDURE: A) There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions... (Refer to Appendix A 'Type and duration of Precautions Recommend (sic) for Selected Infections and conditions'). Transmission based Precautions are always used in addition to Standard Precautions. 1. Contact	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 83 Precautions- intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment recommended: a. Gloves- whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. b. Gowns- whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident..." Appendix A documented, "MDROs (multidrug-resistant organisms) (including VRE) judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings..." No further information was presented prior to exit. (1) "What is a Pseudomonas infection? Pseudomonas infection is caused by strains of bacteria found widely in the environment; the most common type causing infections in humans is called Pseudomonas aeruginosa. What types of infections does Pseudomonas aeruginosa cause? Serious Pseudomonas infections usually occur in people in the hospital and/or with weakened immune systems. Infections of the blood, pneumonia, and infections following	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 658	Continued From page 84	F 658		

surgery can lead to severe illness and death in these people." This information was obtained from the website: https://www.cdc.gov/hai/organisms/pseudomonas.html

(2) "Vancomycin-resistant Enterococci are specific types of antimicrobial-resistant bacteria that are resistant to vancomycin, the drug often used to treat infections caused by enterococci. Enteroccocci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Most vancomycin-resistant Enterococci infections occur in hospitals. [Vancomycin-resistant Enterococci is also called VRE]...What is the treatment for VRE? People with colonized VRE (bacteria are present, but have no symptoms of an infection) do not need treatment. Most VRE infections can be treated with antibiotics other than vancomycin. Laboratory testing of the VRE can determine which antibiotics will work. For people who get VRE infections in their bladder and have urinary catheters, removal of the catheter when it is no longer needed can also help get rid of the infection. How is VRE spread? VRE is often passed from person to person by the contaminated hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not spread through the air by coughing or sneezing." This information was obtained from the website: https://www.cdc.gov/HAI/organisms/vre/vre.html The CDC (Centers for Disease Control) further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 85 documented, "Multidrug-resistant organisms (MDROs), infection or colonization (e.g., VRE...) Type of Precaution: Contact + Standard MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infectioncontrol/guidelines/mdro/ accessed May 2016) [870]. Contact state health department for guidance regarding new or emerging MDRO." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf (3) "MRSA is methicillin-resistant Staphylococcus aureus, a type of staph bacteria that is resistant to several antibiotics. In the general community, MRSA most often causes skin infections. In some cases, it causes pneumonia (lung infection) and other issues. If left untreated, MRSA infections can become severe and cause sepsis - a life-threatening reaction to severe infection in the body." This information was obtained from the website: https://www.cdc.gov/mrsa/community/ COMPLAINT DEFICIENCY 3. The facility staff failed to document accurately that the medication Minipress had not been given to Resident #1.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 86 Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic stress disorder (PTSD) and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. An interview was conducted on 8/29/18 at 8:35 a.m. with Resident #1. Resident #1 stated, "They came in here last night and said 'We're out of Minipress. How does that happen? I need that medication to help with my PTSD they don't understand that. I didn't get to sleep until 5:30 this morning." A review of the August 2018 physician's orders documented, "Minipress Capsule 5 MG (milligrams) Give 2 capsule (sic) by mouth at bedtime." Review of the August 2018 medication administration guide documented, "Minipress Capsule 5 MG (milligrams) Give 2 capsule (sic) by mouth at bedtime." The medication was documented as being given on 8/28/18. An interview was conducted on 8/29/18 at 2:10 p.m. with LPN (licensed practical nurse) #10; the nurse who documented the Minipress was given on 8/28/18. When asked if they had run out of Minipress the night before, LPN #10 stated, "Yes. I ordered it from the pharmacy." When asked if	F 658		

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F 658	Continued From page 87 she gave the Minipress, LPN #10 stated, "No. It wasn't here before I went home. The night nurse was to give it." When asked to review the medication administration guide for the Minipress, LPN #10 stated, "That was a mistake, I didn't give it." When asked if accurate document was important, LPN #10 stated it was. An interview was conducted on 8/29/18 at 2:20 p.m. with LPN #11, the resident's nurse. LPN #11 was asked to show this writer Resident #1's Minipress. The medication card of Minipress was observed to contain ten capsules, and had not been opened. LPN #11 stated, "Yeah the 11:00 (p.m.) to 7:00 (a.m.) nurse told me it came in last night. She didn't give it because it was signed off." On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 reads "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes ...this includes accurate documentation and explanation ..." (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is	F 658		

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F 658	Continued From page 88 a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1 (2) Minipress -- Patients with post-traumatic stress disorder (PTSD) are frequently symptomatic despite being on medications currently approved by the US Food and Drug Administration for PTSD. There is evidence to support the notion that prazosin is effective for PTSD nightmares. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3896131/	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to ensure two of 22 residents in the survey sample, Residents #8, and #10, were provided the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677	***F 677 ADL Care*** 1. Facility staff offered and documented oral care for Resident #8. Resident # 10 is no longer a resident of the facility. 2. Current residents have the potential to be effected by this deficient practices. DON/designee will review current resident ADL Sheets for oral, for the last 30 days to ensure proper oral care was given.	

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F 677	Continued From page 89 1. Resident #8, who was coded as requiring extensive assistance of one staff with personal hygiene, was not provided adequate oral care by facility staff on multiple occasions from June through August 2018. 2. Resident #10, who was coded as requiring extensive assistance of one staff with personal hygiene on, was not provided adequate oral care by facility staff on 12/29/17 and 12/31/17. The findings include: 1. Resident #8, who was coded as requiring extensive assistance of one staff with personal hygiene, was not provided adequate oral care by facility staff on multiple occasions from June through August 2018. Resident #8 was admitted to the facility on 11/21/16. Resident #8's diagnoses included but were not limited to diabetes, anxiety disorder and difficulty swallowing. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/7/18, coded the resident as being cognitively intact. Section G coded Resident #8 as requiring extensive assistance of one staff with personal hygiene. Review of Resident #8's June 2018, July 2018 and August 2018 ADL (activities of daily living) records revealed the resident received oral care only once on the following dates: 6/16/18 6/17/18 6/30/18	F 677	3. The DON/designee will educate the CNAs regarding appropriate ADL care for the residents and documentation. 4. The Social Service Director/Designee will interview 5 residents a week for 12 weeks to ensure residents are receiving appropriate ADL care. The DON/designee will audit 5 residents' charts a week for 12 weeks to ensure documentation of ADL care is provided. Findings will be brought to QAPI for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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

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F 677	Continued From page 90 7/1/18 7/2/18 7/13/18 7/14/18 8/4/18 8/15/18 Review of nurses' notes for the above dates failed to reveal any further documentation regarding oral care (including refusal) on the above dates. Resident #8's care plan initiated on 3/30/18 documented, "DENTAL NEEDS: The resident has potential for continued oral health problems r/t (related to) having several teeth extracted. Requires extensive assistance from staff with oral/dental care...Interventions: oral care per routine and prn with extensive assistance from staff..." On 8/28/18 at 3:25 p.m., an interview was conducted with Resident #8. When asked if the staff assist her with oral care each day, Resident #8 stated the staff do not. On 8/29/18 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #2 regarding oral care. CNA #2 stated the CNAs are responsible for providing oral care in the morning and again at night. CNA #2 stated oral care is documented in the ADL system. When asked how a CNA could evidence oral care was done if it was not documented in the ADL system, CNA #2 stated it is the responsibility of the CNAs to document. When asked how this surveyor would know if oral care was provided if it was not documented in the ADL system, CNA #2 stated, "You don't." On 8/29/18 at 3:22 p.m., an interview was	F 677		

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

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F 677	Continued From page 91 conducted with LPN (licensed practical nurse) #7 regarding oral care. LPN #7 stated CNAs are responsible for providing oral care unless a resident has special protocols. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Oral Hygiene" documented, "Nursing staff personnel will provide oral hygiene in order to cleanse the mouth and lessen the occurrence of mouth infections." No further information was presented prior to exit. "Oral Hygiene (mouth care) does the following: Keeps the mouth and teeth clean. Prevents mouth odors and infections. Increases comfort. Makes food taste better. Reduces risk for cavities (dental caries) and periodontal disease (gum disease, pyorrhea). Illness, disease and some drugs often cause a bad taste in the mouth. They may cause a whitish coating in the mouth and on the tongue. Others cause redness and swelling in the mouth and on the tongue. Dry mouth is common from oxygen, smoking, decreased fluid intake and anxiety. Some drugs cause dry mouth." This information was obtained from: Mosby's Essentials for Nursing Assistants 3rd edition, Sorrentino and Gorek, page 205. "Promoting Safety and Comfort: Assist with oral hygiene on awakening, after meals and at bedtime. Many people practice oral hygiene before meals. Some persons need mouth care every 2 hours or more often. Always follow the care plan." This information was obtained from:	F 677		

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

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F 677	Continued From page 92 Mosby's Essentials for Nursing Assistants 3rd edition, Sorrentino and Gorek, page 205. 2. Resident #10, who was coded as requiring extensive assistance of one staff with personal hygiene on, was not provided adequate oral care by facility staff on 12/29/17 and 12/31/17. Resident #10 was admitted to the facility on 12/28/17. Resident #10's diagnoses included but were not limited to paralysis following stroke, difficulty swallowing and muscle weakness. Resident #10's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 1/1/18, coded as being cognitively intact. Section G coded Resident #10 as requiring extensive assistance of one staff with personal hygiene. Resident #10 discharged from the facility on 1/1/18. Review of Resident #10's December 2017 ADL (activities of daily living) records revealed the resident received oral care (documented as mouth care) only once on 12/29/17 and none on 12/31/17. Further review of Resident #10's clinical record (including nurses' notes and speech therapy notes) failed to reveal any further documentation regarding oral care (including refusal) on 12/29/17 and 12/31/17. Resident #10's care plan dated 12/28/17 documented, "PERSONAL HYGIENE/ORAL CARE: The resident requires 1 staff extensive participation with personal hygiene and oral care..." On 8/29/18 at 1:39 p.m., an interview was conducted with CNA (certified nursing assistant) #2 regarding oral care. CNA #2 stated the CNAs are responsible for providing oral care in the	F 677		

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F 677	Continued From page 93 morning and again at night. CNA #2 stated oral care is documented in the ADL system. When asked how a CNA could evidence oral care was done if it was not documented in the ADL system, CNA #2 stated it is the responsibility of the CNAs to document. When asked how this surveyor would know if oral care was provided if it was not documented in the ADL system, CNA #2 stated, "You don't." On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7 regarding oral care. LPN #7 stated CNAs are responsible for providing oral care unless a resident has special protocols. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. The American Dental Association Mouth Healthy website documented, "Brushing and flossing your teeth is just as important for you as it is for your grandchildren. Even though it may have been years since you've had a cavity, your risk of cavities increases with age. One of the reasons is dry mouth-a common side effect of many prescription medications. Brush your teeth twice a day with fluoride toothpaste..." This information was obtained from the website: https://www.mouthhealthy.org/en/adults-over-60/healthy-habits	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 94 § 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 observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to provide treatments and care in accordance with professional standards of practice and the comprehensive person-centered care plan for three of 22 residents in the survey sample, Resident #1, Resident #3, Resident #11. 1. The facility staff failed to administer the doxycycline as ordered by the physician for Resident #1. 2. The facility staff failed to administer the Tramadol as ordered by the physician for Resident #3. 3. The facility staff failed to administer medications (available in the facility STAT box) to Resident #11 on 5/30/18. The findings include: 1. Resident #1 was admitted to the facility on 5/25/18 and readmitted on 8/3/18 with diagnoses that included but were not limited to: high blood pressure, irregular heartbeat, post-traumatic	F 684	***F 684-Following Physician's Orders*** 1. The facility will administer Resident #1's doxycycline as ordered. The facility will administer Resident's Tramadol as ordered. Resident # 11 is no longer a resident of the facility. 2. Current residents have the potential to be affected by this deficient practice. 3. The DON/Designee will educate the licensed nurses on following physician's orders. DON/designee will educate the nurses on proper procedures for medication pass to include timing of medication, documentation of med administration.	

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F 684	Continued From page 95 stress disorder and Wilson disease (1). The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/22/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently. Review of the resident's comprehensive care plan initiated on 6/14/18 and revised on 8/29/18 documented, "Focus INFECTION: Resident has infection R/T (related to) Obstructive Pyleonephritis (2). Interventions medications/flushes as ordered. Review of the August 2018 physician's orders documented, "Doxycycline Hyclate (3) Capsule 100 MG (milligrams). Give 1 capsule by mouth in the afternoon for ureteral stones 1 caps (sic) in afternoon before dinner and separate from other meds (medications). Metoprolol Tartrate (4) Tablet 50 MG Give 1 tablet by mouth two times a day." Review of the August 2018 medication administration record documented, "Doxycycline Hyclate (3) Capsule 100 MG (milligrams). Give 1 capsule by mouth in the afternoon for ureteral stones 1 caps (sic) in afternoon before dinner and separate from other meds (medications). Metoprolol Tartrate (4) Tablet 50 MG Give 1 tablet by mouth two times a day." The medications were documented as being given each day at 4:00 p.m.	F 684	4. The DON/Designee will audit 5 residents a week for 12 weeks to ensure physician's orders are being followed. DON/designee will audit 2 nurses a week during medication pass to ensure no deficient practice. Findings will be brought to QAPI for 3 months for review and revision as needed to monitor compliance. 5. DOC: 9/30/18	

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F 684	Continued From page 96 A medication administration observation was conducted on 8/28/18 at 4:48 p.m. with LPN (licensed practical nurse) #10. LPN #10 put the doxycycline and metoprolol into a medicine cup and took the medication to Resident #1. The resident took the medications. An interview was conducted on 8/29/18 at 2:10 p.m. with LPN #10. LPN #10 was asked to review the doxycycline and metoprolol orders. When asked if she had given the medications together, LPN #10 stated she had. When asked if that was correct, LPN #10 stated, "No, we should notify the pharmacy and have them separate them out." When asked if she had followed the physician's order, LPN #10 stated, "No." An interview was conducted on 8/29/18 at 3:58 p.m. with LPN #3, the resident's nurse. When asked who entered the time medications were to be given into the computer, LPN #3 stated, "Whoever puts in the order." When asked if she had administered medication to Resident #1, LPN #3 stated she had. LPN #3 was asked to review the doxycycline and metoprolol orders for Resident #1. LPN #3 stated, "I never saw the bottom part of that (the instructions for the doxycycline)." When asked if she had given the metoprolol with the doxycycline, LPN #3 stated she had. When asked if she had followed the physician's order, LPN #3 stated she had not. On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director or nursing were made aware of the findings. Review of the facility's policy titled, "Physician's Orders" did not evidence documentation	F 684		

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F 684	Continued From page 97 regarding following a physician's order. No further information was obtained prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." (1) Wilson disease -- Wilson disease is a genetic disease that prevents the body from removing extra copper. The body needs a small amount of copper from food to stay healthy; however, too much copper is poisonous. Normally, the liver filters extra copper and releases it into bile. Bile is a fluid made by the liver that carries toxins and wastes out of the body through the gastrointestinal tract. In Wilson disease, the liver does not filter copper correctly and copper builds up in the liver, brain, eyes, and other organs. Over time, high copper levels can cause life-threatening organ damage. This information was obtained from: https://www.niddk.nih.gov/health-information/liver-disease/wilson-disease#sec1 (2) Obstructive Pyleonephritis -- Because obstructive pyelonephritis secondary to ureteral stones can easily cause sepsis and concomitant disseminated intravascular coagulation (DIC), it is a potentially lethal disease. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/26419073 (3) Doxycycline Hyclate -- To reduce the development of drug-resistant bacteria and	F 684		

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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 98 maintain the effectiveness of doxycycline hyclate delayed-release tablets and other antibacterial drugs, Doxycycline hyclate delayed-release tablets should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cd2ab9b8-9619-4199-8a5d-83377b3274d1 (4) Metoprolol -- Metoprolol is a cardioselective beta-blocker that is widely used in the treatment of hypertension and angina pectoris. This information was obtained from: https://livertox.nih.gov/Metoprolol.htm 2. The facility staff failed to administer the Tramadol as ordered by the physician for Resident #3. Resident #3 was admitted to the facility on 9/24/17 and readmitted on 6/30/18 with diagnoses that included but were not limited to: Parkinson's Disease (1), weakness, chronic pain, high blood pressure and irregular heartbeat. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/18, coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Review of the resident's care plan initiated on 7/4/18 and revised on 7/16/18 documented, "Focus PAIN Interventions Administer analgesic/medications per orders."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 99	F 684		

Review of the July 2018 physician's orders documented, "Tramadol HCL (2) Tablet 50 MG (milligrams) Give 2 tablet by mouth every 4 hours as needed for pain."

The August 2018 medication administration record documented, "Tramadol HCL Tablet 50 MG (milligrams) Give 2 tablet (sic) by mouth every 4 hours as needed for pain." On 8/2/18 at 6:02 a.m., 8/4/18 at 6:00 a.m., 8/6/18 at 5:31 a.m. and 8/24/18 at 6:30 a.m. the medication had been administered to the resident. The resident's pain level was documented as being zero indicating the resident did not have pain when the medication was given.

On 8/30/18 at 4:15 p.m. ASM (administrative staff member), #1 and ASM #2, the director of nursing were made aware of the concern that the resident received pain medication when she did not have any pain.

A telephone interview was conducted on 8/30/18 at 4:25 p.m. with LPN (licensed practical nurse) #12, the nurse who administered the Tramadol. LPN #12 was asked about the process she follows when giving pain medication. LPN #12 stated, "I would ask them where they're hurting and how bad is the pain on a scale from one to ten." When asked if the pain level would be documented, LPN #12 stated, "Yeah, I would put that in (name of software)." When asked when would she give an as needed pain medication to a resident who did not have pain, LPN #12 stated, "Well, some people take it to keep from having pain." When asked if she had a resident who she gave pain medication when they did not have pain, LPN #12 stated, "There's (name of Resident #3). They used to have it scheduled around the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 100	F 684		

clock but they want her to decrease the amount of pain medication she takes so they changed it so she would have to ask for her pain medication." She and I have an agreement that I give her a pain pill when she wakes up so she doesn't get pain." When asked if it was appropriate to give pain medication to a resident who did not have pain, LPN #12 stated, "Well no." When asked if she had followed the physician's order, LPN #12 stated, "No."

No further information was provided prior to exit.

(1) Parkinson's disease -- Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantia nigra that controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease

(2) Tramadol -- Tramadol is an opioid analgesic used for the therapy of mild-to-moderate pain. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Tramadol#section=Top

3. The facility staff failed to administer medications (available in the facility STAT [immediate] box) to Resident #11 on 5/30/18.

Resident #11 was admitted to the facility on 5/23/18. Resident #11's diagnoses included but were not limited to diabetes, chronic kidney disease, status post kidney transplant and high blood pressure. Resident #11's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/20/18, coded the resident as being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 101 cognitively intact. On 7/25/18, the Office of Licensure and Certification received a complaint that documented Resident #11's medications were not given at various times. Review of Resident #11's clinical record revealed physician's orders that included but were not limited to: 5/24/18- clopidogrel bisulfate (1) 75 mg (milligrams) by mouth in the evening. 5/30/18- potassium chloride (2) 20 meq (milliequivalents) - one tablet by mouth in the afternoon. Review of Resident #11's May 2018 MAR (medication administration record) failed to reveal clopidogrel bisulfate and potassium chloride was administered to Resident #11 on 5/30/18 (as evidenced by a blank space on the MAR with no check mark or nurse's initials). Review of nurses' notes dated 5/30/18 failed to reveal the medications were administered. Resident #11's care plan initiated on 5/23/18 documented, "CARDIAC: Resident has cardiac symptoms r/t (related to): CAD (coronary artery disease), PVD (peripheral vascular disease), Requires Cardiac med [medication]...Interventions: Medication as ordered..." Review of the facility STAT medication box list (a box containing various medications that can be accessed to obtain medications for residents) revealed five tablets of clopidogrel bisulfate 75mg and five tablets of potassium chloride 10 meq were available. An attempt to contact the nurse responsible for	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 102 administering clopidogrel bisulfate and potassium chloride to Resident #11 on 5/30/18 was made and the nurse was not available for interview. On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked how nurses evidence medication administration. LPN #7 stated, "By signing off on the MAR." When asked what is meant if the MAR is not signed off, LPN #7 stated, "You assume it wasn't given." When asked if there was any other way to evidence medication administration, LPN #7 stated, "If not on the MAR, you can call the nurse." LPN #7 was shown Resident #11's May 2018 MAR and asked how one would know if the resident's medications were given on 5/30/18. LPN #7 stated, "You can't tell. It wasn't signed." On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "Procedure: 1. Facility staff should comply with facility policy, applicable law and the State Operations Manual when administering medications...6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given..." No further information was presented prior to exit.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 103 (1) "Clopidogrel is used alone or with aspirin to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601040.html (2) "Potassium is one of the body's electrolytes, which are minerals that carry an electric charge when dissolved in body fluids such as blood. Most of the body's potassium is located inside the cells. Potassium is necessary for the normal functioning of cells, nerves, and muscles." This information was obtained from the website: https://www.merckmanuals.com/home/hormonal-and-metabolic-disorders/electrolyte-balance/overview-of-potassium-s-role-in-the-body	F 684		
F 686 SS=G	COMPLAINT DEFICIENCY Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686	***F686-Pressure Ulcer*** 1. Resident #18's pressure ulcer was found on 8/27/18 with treatment was ordered. 2. Current residents have the potential to be affected by this deficient practice. The DON/Designee completed a skin sweep on current residents to ensure no other pressure ulcer were in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 104 by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to provide care and services for the prevention and treatment of a pressure injury for one of 22 residents in the survey sample, Resident #18. The facility staff failed to identify a pressure injury on Resident #18's fourth left toe until it was at an advanced stage. The pressure sore was found on 8/26/18, and was assessed and staged by staff on 8/27/18, as a Stage III wound, measuring 1.0 (centimeters) by 0.8 cm (centimeters) with a depth of 0.2 cm., with yellow tissue in the wound bed and a scant amount of purulent drainage, resulting in harm. The facility staff also failed to ensure complete skin assessments including measurements, descriptions of the area on Resident #18's fourth left toe, prior to the staff identifying the stage III Pressure sore. The findings include: Resident #18 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)) (1), anxiety disorder, atrial fibrillation (2) high blood pressure, history of a heart attack, insomnia, depression and dementia. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 8/14/18, coded the resident as scoring a "15" on the BIMS (brief	F 686	3. The DON/Designee will educate the nursing staff on wound management to include reporting skin issues and documenting on Shower sheets and bi-weekly skin checks. 4. The DON/Designee will audit 10 resident's weekly skin checks a week for 12 weeks to ensure proper documentation has occurred. The DON/Designee will observe 10 resident's skin to ensure all skin is properly reviewed and treatments are in place as necessary. Findings will be brought to QAPI for three months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

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 686	Continued From page 105	F 686		

interview for mental status) score, indicating she was capable of making her own daily cognitive decisions. The resident was coded as requiring limited to extensive assistance for most of her activities of daily living except eating as she only required supervision. In Section M - Skin Conditions, the resident was coded as being at risk for developing pressure ulcers but as not having any current unhealed ulcers.

During the entrance conference, a list of residents with pressure injuries was requested from the administrator (administrative staff member- ASM #1). Resident #18 was listed as having a pressure injury that was facility acquired on 8/26/18. The pressure injury was documented as being located on the left foot 4th digit (toe). The pressure injury was staged as a Stage III pressure injury.

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (3).

Stage 3 Pressure Injury: Full-thickness skin loss: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 106 wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (4) The Admission Evaluation dated, 8/7/18, documented in part, "Braden Score - 21." A total score of 12 or less indicates a high risk for developing pressure injuries. A score of 19 or above indicates a low risk of developing pressure injuries. (5) The "Bi-Weekly Skin Check" sheet dated 8/7/18, documented in part, "Does the resident have current Skin Issues." A mark was made next to "Yes." The "Description" documented, "left 4th toe cellulitis." The nurse's note dated, 8/7/18 at 2:20 p.m. documented in part, "While doing skin assessment noted resident to have on her left foot fourth toe there was a sore that was swollen red and warm to touch doctor here on rounds new order received." (Sic. Sentence typed as is written in the clinical record). The nurse's note dated, 8/8/18 at 12:06 a.m. documented in part, "Resident is currently on antibiotic therapy. Currently taking Doxycycline (antibiotic) cellulitis to 4th toe. Resident is having no adverse effects from antibiotic." The nurse practitioner note dated, 8/8/18 at 4:10 p.m. documented in part, "Skin: warm, dry...Assessment/plan: 8. Cellulitis, acute - doxycycline as ordered."	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 107 The nurse's note dated, 8/9/18 at 12:06 a.m. documented in part, "Resident is currently on antibiotic therapy. currently (Sic.) taking Doxycycline (antibiotic) cellulitis to 4th toe. Resident is having no adverse effects from antibiotic." The nurse's note dated, 8/10/18 at 12:06 a.m. documented in part, "Resident is currently on antibiotic therapy. currently (Sic.) taking Doxycycline (antibiotic) cellulitis to 4th toe. Resident is having no adverse effects from antibiotic." The nurse's note dated, 8/10/18 at 12:06 p.m. documented in part, "Resident continues to receive Doxycycline for cellulitis. No s/s (signs or symptoms) adverse reactions noted." The "Bi-Weekly Skin Check" dated, 8/10/18 at 8:06 p.m. documented in part, "Does the resident have current Skin Issues." A mark was made next to "Yes." The "Description" documented, "L (left) 4th toe cellulitis. ABTX (antibiotic treatment) continues." The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/10/18, documented the resident "didn't want shower, wanted to get washed up in her room." The form documented the resident had no rashes, bruises, or redness and the skin was intact. The "Bi-Weekly Skin Check" dated, 8/13/18 at 8:06 p.m. documented in part, "Does the resident have current Skin Issues." A mark was made next to "Yes." The "Description" documented, "4th toe red and swelling (cellulitis)."	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 108 The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/13/18, documented the resident had no rashes or bruises. The resident was documented as having redness on her 4th toe and the skin was intact. The physician note dated, 8/14/18 at 1:57 p.m. documented in part, "Skin: warm, dry...Assessment/Plan: Cellulitis, acute - doxycycline as ordered." The "Bi-Weekly Skin Check" dated, 8/16/18 at 8:06 p.m. documented in part, "Does the resident have current Skin Issues." A mark was made next to "Yes." The "Description" documented, "4th toe." The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/17/18, documented the resident had no rashes or bruises and the skin was intact. The resident was documented as having redness but nothing was documented as to where the redness was. The "Bi-Weekly Skin Check" dated, 8/19/18 at 8:06 p.m. documented in part, "Does the resident have current Skin Issues." A mark was made next to "Yes." The "Description" documented, "fourth toe." The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/20/18 documented the resident had no rashes, bruises or redness and the skin was intact. The "Bi-Weekly Skin Check" dated, 8/22/18 at	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 109 8:06 p.m. documented in part, "Does the resident have current Skin Issues." A mark was made next to "No." The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/24/18 documented the resident had no rashes, bruises, redness and the skin was intact. The nurse practitioner note dated, 8/24/18 at 2:56 p.m. failed to evidence documentation related to the resident's left fourth toe. There were no further nurse's notes documenting anything related to the toe until 8/27/18. The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/27/18 documented the resident refused her shower. There was no documentation related to the skin assessment by the CNA. The "Weekly Wound Assessment" dated 8/27/18 documented, "Wound type: Pressure. Stage - 3. Wound location: left foot 4th digit. Length - 1.0 (centimeters). Width - 0.8 cm (centimeters). Depth - 0.2 cm. Location where wound was acquired: In house. Date wound identified: 8/26/18. Drainage - Purulent. Drainage amount - scant. Wound bed appearance - Yellow. Odor - none. Periwound appearance - macerated. Wound status - new wound. Comments: ...Resident informed not to wear shoe at this time." The "Bi-Weekly Skin Check" dated, 8/28/18 at 8:06 p.m. documented in part, "Does the resident	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 110 have current Skin Issues." A mark was made next to "Yes." The "Description" documented,"4th digit." The "Shower/Tub bath/ Bed Bath Sheet" completed by the CNA (certified nursing assistant), dated, 8/10/18, documented the resident "didn't want shower, wanted to get washed up in her room." The form documented the resident had no rashes, bruises, or redness and the skin was intact. The comprehensive care plan dated, 8/7/18 documented, "Focus: SKIN INTEGRITY/PRESSURE ULCER RISK: The resident has potential for pressure ulcer development r/t (related to) dementia, depression, osteoarthritis, anxiety and requires assistance from staff to remind and assist with positioning." The revision on 8/27/18, documented, "Stage 3 t left foot 4th digit." The "Interventions" documented, "8/7/18 - Assess. Document/report to MD (medical doctor) PRN (as needed) changes in skin status. Inform the resident/family/ and/or caregivers of any new area of skin breakdown as needed. Monitor nutritional status. Serve diet as ordered, monitor intake and record." On 8/27/18, the care plan was revised to include, "Pressure reducing mattress to bed. Supplement therapy for wound, no shoe till (Sic.) heals. TX (treatment) as directed." Observation was made of Resident #18's wound, on 8/30/18 at 9:06 a.m. accompanied by LPN (licensed practical nurse) #2. The resident was observed with slip on tennis like shoes on. The resident's foot was observed with multiple deformities in bone structure. The wound was measured by LPN #2 as follows: width 1 cm,	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 111	F 686		

length 1.2 cm, depth 0.2 cm." When LPN #2 was asked about the stage of the wound, LPN #2 stated it was a stage 2 pressure injury. In the middle of the wound, yellow slough was observed. The edges appeared macerated. LPN #2 further stated, "She came in with a black scab on her toe. The toe was warm to touch. They treated it for cellulitis. This was caused by the shoes she wore."

An interview was conducted with the nurse practitioner, administrative staff member (ASM) #3, on 8/30/18 at 9:50 a.m. When asked her knowledge of the resident's cellulitis on admission, ASM #3 stated that it had resolved. ASM #3 stated the nurse manager had notified her this week of a pressure ulcer on the same toe. When asked if she had observed the pressure ulcer, ASM #3 stated that she had not seen it. When asked if upon admission the area on the fourth toe had an open area on it, ASM #3 stated, that it did not. ASM #3 stated if she doesn't have, it (open wound) documented then it's a no. ASM #3 stated, "It wasn't a pressure ulcer on admission, it was a cellulitis, (LPN # 1) felt it was from her shoes." When asked if she has assessed the wound since her first assessment of the cellulitis, ASM #3 stated she did not take the resident's shoes off for her second visit (8/24/18 *see note above) with the resident.

An interview was conducted with LPN #1, the unit manager, on 8/30/18 at 10:12 a.m. When asked to describe Resident #18's fourth toe on admission, LPN #1 stated, "There was a scab on the toe, it was red and inflamed on the outside. It looked like it had a sore and it scabbed over." (Name of Medical Doctor) was in the house, so I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 112	F 686		

had him look at it. He felt it was cellulitis." When asked the next time the 4th toe was observed after the doxycycline was finished, LPN #1 stated, "The CNAs (certified nursing assistants) look at the resident during their showers." When asked how often a nurse checks the skin, LPN #1 stated, twice a week." The above Biweekly skin sheets were reviewed with LPN #1. LPN #1 stated, "They don't tell you anything." When asked how she was notified the resident needed to be seen, LPN #1 stated, "I was told by the evening supervisor from the weekend. I went in to assess it [pressure sore on the 4th left toe] on Monday." When asked what the facility policy says about completing the Bi-Weekly skin checks, LPN #1 stated, "They should have a description other than 4th toe. They failed to do a thorough weekly assessment." When asked why it is important to do a thorough assessment of the area, LPN #1 stated, "It has to be a complete assessment so we can evaluate the wound." When asked if she was certified in wound care, LPN #1 stated she was not a trained wound nurse but I have been doing it for many years of my nursing and worked closely with several wound doctors." When asked why there would be concerns about Resident #18's wound, LPN #1 stated, "We didn't follow our policies and have more of a description of her wound prior to finding it at the stage 3."

The nurse practitioner, ASM #3, returned on 8/30/18 at 10:38 a.m. and stated the wound was a stage III pressure area with yellow slough around the edge, like a crescent moon, from the 3 o'clock position to the 7 o'clock position. There was no necrosis and the rest of the wound bed was pink. ASM #3 stated, "She is at high risk for pressure injury development due to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 113 deformities of her feet." On 8/30/18 at 10:50 a.m. the administrator and the director of nursing, (administrative staff member - ASM) #2, were made aware of the concern for harm. When asked if the staff should do a full assessment and include a full description of the area, for a skin concern, ASM #2, the director of nursing stated, "Yes." When asked about the process staff follows for new skin areas identified, ASM #2 stated, "The unit manager goes in the next day and assesses the wound. She contacts the doctor or nurse practitioner and gets orders to treat." When asked why it is important to document a description of the area on the wound assessments and skin assessments, ASM #2 stated, "It's so we can assure we are treating it properly." An interview was conducted with LPN #3 on 8/30/18 at 12:50 p.m. When asked about the process staff follows for completing skin assessments, LPN #3 stated, "It (skin assessment) pops up weekly or sometimes more often on the computer. I look at the whole entire body. If there are old issues I answer a yes." When asked if she was describing an area would she document, "left fourth toe," LPN #3 stated, "We should describe what we see. I was told today that I should but I wasn't doing it that was before today." The facility policy, "Wound Management" documented in part, "Policy: It is the policy of (Name of Corporation) based on the comprehensive assessment of a resident; the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 114 develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing ....Monitoring - 3. Twice weekly, on bath/shower days, the nursing assistant will look at the resident's skin and place the identified area on the shower sheet. The nursing assistant will report any reddened and/or areas of concern to the licensed nurse. 4. The licensed nurse will complete a head to toe body review twice a week as well. This head to toe body review is inn additions to the nursing assistant's skin review." The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 686	Continued From page 115 2014. 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 522. (2) Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. This information was obtained from: 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: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (5) This information was obtained from the following website: https://www.in.gov/isdh/files/Braden_Scale.pdf	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 116 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and treatment for respiratory services for three of 22 residents in the survey sample. Resident #5, Resident #9 and Resident #16. 1. The facility staff failed to store the continuous positive airway pressure (CPAP) mask in a sanitary manner for Resident #5. 2. The facility staff failed to store the continuous positive airway pressure mask in a sanitary manner for Resident #9. 3. The facility staff failed to administer oxygen per the physician's order for Resident #16. The findings include: 1. Resident #5 was admitted to the facility on 10/11/17 and readmitted on 8/7/18 with diagnoses that included but were not limited to: morbid obesity, lymphedema (1), depression, diabetes, high blood pressure, arthritis and kidney disease. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/18 coded the resident as having a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The	F 695	***695 Respiratory Services*** 1. Resident's # 9 tubing was changed and Residents # 5 and 16 CPAP masks were cleaned and bagged. 2. Residents receiving oxygen and CPAP treatments have the potential to be affected by this deficient practice. The DON/Designee will audit residents that have respiratory services to ensure proper storage and cleaning of tubing. 3. The DON/designee will educate the nursing staff on proper storage of respiratory equipment.	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 117 resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform independently. Review of the comprehensive care plan initiated on 8/7/18 documented, "Focus CARDIAC/RESPIRATORY: USE OF C-PAP Interventions Cleanse mask after use as ordered." Review of the August 2018 physician orders documented, "CPAP (2) at bedtime every evening shift." Review of the August 2018 treatment administration record documented, "cpap bedtime every evening shift." The CPAP was documented as being applied every day except for 8/29/18 when the resident refused it. An observation was made on 8/28/18 at 10:45 a.m. of Resident #5. The resident was sitting up in the chair. The CPAP mask was lying face down on the bedside stand. An observation was made on 8/29/18 at 10:30 a.m. of Resident #5. The resident was sitting up in the wheelchair. The CPAP mask was lying face down on the bedside stand. An interview was conducted on 8/19/18 at 2:00 p.m. with LPN (licensed practical nurse) #9, the resident's nurse. When asked how the CPAP mask was to be stored when not in use, LPN #9 stated, "They're supposed to be in a plastic bag and I need to go get plastic bags for all three of mine." When asked which residents were hers, LPN #9 named Resident #5. When asked why	F 695	4. The unit manager/designees will audit 5 residents per week for 12 weeks to ensure respiratory equipment is cleaned and stored appropriately. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

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 695	Continued From page 118 they were stored in plastic bags, LPN #9 stated, "To keep the germs and dust off." On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1 and ASM #2 the director of nursing were made aware of the findings. Review of the facility's policy titled, "CPAP/BIPAP Support Policy" did not document how the mask was to be stored when not in use. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." (1) Lymphedema is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs. This information was obtained from: https://medlineplus.gov/lymphedema.html (2) CPAP -- It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/cpap 2. The facility staff failed to store the continuous positive airway pressure mask in a sanitary	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 119 manner for Resident #9. Resident #9 was admitted to the facility on 3/23/17 and readmitted on 8/1/17 with diagnoses that included but were not limited to: dementia, respiratory failure, depression and urinary tract infections. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 8/4/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview fro mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating, which the resident could perform independently. Review of the resident's comprehensive care plan initiated on 7/31/17 and revised on 5/14/18 documented, "Focus OXYGEN USE: Resident requires oxygen R/T (related to) COPD (chronic obstructive pulmonary disease); use of C-PAP at HS (hour of sleep)." There were no interventions relating to mask care and storage. Review of the August 2017 physician's orders documented, "CPAP on at bedtime." Review of the August 2017 medication administration record documented, "CPAP on at bedtime." It was documented as being on every day. An observation was made on 8/28/18 at 10:30 a.m. of Resident #9. The resident was up in the wheelchair. The CPAP mask was lying face down on the bedside table.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 120 An observation was made on 8/29/18 at 8:25 a.m. of Resident #9. The resident was sitting up in a chair. The CPAP mask was lying face down on the bedside table. An observation was made on 8/29/18 at 10:55 a.m. of Resident #9. The resident was sitting up in a wheelchair. The CPAP mask was lying face down on the bedside table. An interview was conducted on 8/19/18 at 2:00 p.m. with LPN (licensed practical nurse) #9, the resident's nurse. When asked how the CPAP mask was to be stored when not in use, LPN #9 stated, "They're supposed to be in a plastic bag and I need to go get plastic bags for all three of mine." When asked which residents were hers, LPN #9 named Resident #9. When asked why they were stored in plastic bags, LPN #9 stated, "To keep the germs and dust off." On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1 and ASM #2 the director of nursing were made aware of the findings. 3. The facility staff failed to administer oxygen per the physician's order for Resident #16. Resident #16 was admitted to the facility on 3/1/16 and readmitted on 8/1/18 with diagnoses that included but were not limited to: heart failure, irregular heartbeat, dementia, diabetes and depression. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 8/8/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 121 from mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living. The resident was coded as receiving oxygen. Review of the resident's care plan documented, "Focus RESPIRATORY/OXYGEN NEEDS Resident requires oxygen R/T (related to) CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), chronic respiratory failure: pneumonia. Interventions Administer oxygen as ordered." Review of the August 2018 physician's orders documented, "OXYGEN @ (at) 2 LPM (liters per minute) VIA NASAL CANNULA (soft prongs that fit into the nose to deliver oxygen) every shift..." Review of the August 2018 treatment administration record documented, "OXYGEN @ 2 LPM (liters per minute) VIA NASAL CANNULA (soft prongs that fit into the nose to deliver oxygen) every shift..." The oxygen was documented as being administered every day. An observation was made on 8/28/18 at 5:00 p.m., of Resident #16. The resident was in the dining room. There was an oxygen tank on the back of the wheelchair and the resident was wearing the nasal cannula. The oxygen tank was empty as evidenced by the control arrow pointing in the red zone with the notation of "empty". An observation was made on 8/29/18 at 11:55 a.m. of Resident #16. The resident was in the dining room. The resident was wearing the nasal cannula that was connected to the oxygen tank. The oxygen tank was turned off.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 695	Continued From page 122 On 8/29/18 at 1:25 p.m., an observation was made of Resident #16 with LPN #11, the resident's nurse. LPN #11 was asked to check the resident's oxygen tank, LPN #11 stated, "It's supposed to be at two (liters)." LPN #11 was asked to obtain an oxygen saturation on the resident. The oxygen saturation (1) was 90%. LPN #11 then turned on the oxygen tank. When asked if the physician's orders were being followed, LPN #11 stated they were not. Review of the August 2018 oxygen saturation summary sheet documented the resident's oxygen saturation levels ranged from 95 % to 97 %. On 8/29/18 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director or nursing were made aware of the findings. No further information was provided prior to exit. (1) Oxygen saturation -- 1 the fraction of the hemoglobin molecules in a blood sample that are saturated with oxygen at a given partial pressure of oxygen. Normal saturation is 95% to 100%. This information was obtained from: https://medical-dictionary.thefreedictionary.com/Oxygen+saturation	F 695		
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,	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 _____	C 08/30/2018

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 123 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 that the facility staff failed to offer non-pharmacological interventions prior to administering pain medication for one of 22 residents in the survey sample, Resident #3. The facility staff failed to offer non-pharmacological interventions prior to administering the narcotic pain medication to Resident #3. The findings include: Resident #3 was admitted to the facility on 9/24/17 and readmitted on 6/30/18 with diagnoses that included but were not limited to: Parkinson's Disease (1), weakness, chronic pain, high blood pressure and irregular heart beat. The most recent MDS, a quarterly assessment, with an ARD of 7/13/18 coded the resident as having scored 15 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the resident's care plan initiated on 7/4/18 and revised on 7/16/18 documented, "Focus PAIN Interventions assess/document for probable cause of each pain episode. Remove/limit causes where possible." Review of the July 2018 physician's orders	F 697	***F 697 Pain Management*** 1. Resident # 3 care plan was reviewed to ensure nonpharmacological interventions were in place. 2. Current residents receiving pain medications have the potential to be affected by this deficient practice. The DON/Designee will audit care plans of residents with PRN pain management to ensure non pharmacological interventions are in place. 3. The DON/Designee will educate licensed nurses on using non pharmacological interventions before giving pain medication as part of pain management.	

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F 697	Continued From page 124 documented, "Tramadol HCL (hydrochloride) (2) Tablet 50 MG (milligrams) Give 2 tablet by mouth every 4 hours as needed for pain." The August 2018 medication administration record documented, "Tramadol HCL Tablet 50 MG (milligrams) Give 2 tablet (sic) by mouth every 4 hours as needed for pain." The medication was documented as being administered each day for one to four times each day. Review of the August 2018 nurse's notes did not evidence that non-pharmacological interventions had been attempted prior to administering the Tramadol. An interview was conducted on 8/30/18 at 11:45 a.m. with RN (registered nurse) #1. When asked about the process staff follows when a resident complains of pain, RN #1 stated, "They would ask them what their pain level is and they would check to see what they have ordered. I've always been taught to use mild, moderate and severe (for patients to rate their pain)." When asked if there was anything else, staff do, RN #1 stated, "They could re-position them. Maybe laying down." When asked if that would be documented, RN #1 stated, "Yes it should be." An interview was conducted on 3/30/18 at 1:35 p.m. with Resident #3. When asked if the staff offered anything other than the pain medication when she had pain, Resident #3 stated they did not. Resident #3 stated, "I wish I could use a heating pad for my neck. That really helps. They used to let me sit at the nurse's station, they would put it on me, and I would watch the clock. They don't do that anymore." The resident stated	F 697	4. The DON/Designee will audit 5 residents a week for 12 weeks to ensure non pharmacological interventions are being used before administering pain medications. Findings will be brought to QAPI for 3 months for review and revisions as needed to ensure compliance. 5. DOC: 9/30/18	

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F 697	Continued From page 125 the only time she got warm heat on her neck was if she went to the therapy department and that the department was only open so many hours per day. A telephone interview was conducted on 8/30/18 at 4:55 p.m. with LPN #12. When asked about the process staff follows when a resident complains of pain, LPN #12 stated, "I would ask them where they're hurting and how bad the pain was from one to ten." When asked if she did anything else, LPN #12 stated that she gave Resident #3 her pain medication every morning and pulled the last pain level over into the medication administration record. When asked what that meant, LPN #12 stated that she and the resident had an agreement that she would give the resident pain medication first thing in the morning. LPN #12 stated she would take the last reported pain level and she would use that pain level as the resident's current pain level even though she had not asked the resident what her pain level was. When asked if she did anything else, LPN #12 stated no. Review of the facility's policy titled, "Pain Management and Pain Protocol" documented, "POLICY: It is the policy of this facility to ensure any resident that is admitted to the facility is assessed for pain and/or the potential for pain in order for the resident to obtain or maintain his/her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. PROCEDURE: 3. Non-pharmacological intervention will be attempted prior to the administration of PRN (as needed) pain medications."	F 697		

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F 697	Continued From page 126 No further information was provided prior to exit. (1) Parkinson's disease -- Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantial nigra, that controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease (2) Tramadol -- Tramadol is an opioid analgesic used for the therapy of mild-to-moderate pain. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Tramadol#section=Top	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide medically related social services for one of 22 residents in the survey sample, Resident #2. The facility staff failed to ensure Resident #2, who was admitted without any teeth, was assisted and educated, regarding his health care options, specifically dental services.	F 745	***F 745 Medically Related SS*** 1. Resident #2 was interviewed by Social Services and voiced that he does not want dentures and does not want to talk about it anymore. 2. Current residents without dentures or edentulous have the potential to be affected by this deficient practice. Social Services/designee will interview residents without real teeth or dentures to see if they would like information on obtaining dentures.	

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F 745	Continued From page 127 The findings include: Resident #2 was admitted to the facility on 1/13/15. Resident #2's diagnoses included but were not limited to pneumonia, difficulty swallowing and heart failure. Resident #2's current payer source was Medicaid. Resident #2's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 6/29/18, coded the resident's cognition as moderately impaired. Section L coded Resident #2 as having no natural teeth. Resident #2's comprehensive care plan dated 6/27/18 documented, "DENTAL NEEDS: The resident has potential for oral health problems r/t (related to) edentulous (no teeth) without use of dentures..." On 7/24/18, the Office of Licensure and Certification received a complaint that documented the facility failed to provide dental care. Review of Resident #2's clinical record failed to reveal any dental consults. On 8/28/18 at 3:35 p.m., an interview was conducted with Resident #2. The resident was observed to have no teeth. Resident #2 stated he did not have dentures. When asked if any facility staff had talked to him about dental services and/or obtaining dentures, Resident #2 stated no one had. On 8/29/18 at 11:38 a.m., another interview was conducted with Resident #2. Resident #2 was asked if he was interested in obtaining dentures. The resident stated he had thought about it but could not afford them. When asked if any facility staff had spoken to him regarding the financial options available for	F 745	3. Administrator/designee will education IDT regarding offering education to residents to obtain dentures. 4. Social Services/designee will audit 5 residents a week for 12 weeks to ensure they are getting the services and items that they need. Findings will be brought to QAPI for 3 months to ensure compliance. 5. DOC: 9/30/18	

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F 745	Continued From page 128 obtaining dentures, Resident #2 stated no one had. On 8/29/18 at 5:23 p.m., an interview was conducted with OSM (other staff member) #1 (the director of social services). OSM #1 was asked if the facility provides dental services for residents. OSM #1 stated the facility has a contract with a local dentist who accepts residents who receive Medicaid. OSM #1 stated the nursing department is responsible for obtaining physician orders for dental consults and arranging appointments. When asked about the facility staff's role in assisting Medicaid residents with obtaining dentures, OSM #1 stated the business office manager could complete a map adjustment. When asked to explain a map adjustment, OSM #1 stated the business office sends a form to the department of social services and obtains approval to decrease the amount of money a resident pays the facility to offset the cost for dentures. When asked if this process is explained to residents who have no teeth and no dentures, OSM #1 stated no residents, family members or nursing employees had come to her with any concerns and she would not know to explain this process to someone unless a concern is verbalized to her. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/30/18 at 7:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (Resident #2's unit manager) and LPN #2 (a nurse who routinely cares for Resident #2). LPN #1 and LPN #2 stated they were not aware of	F 745		

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F 745	Continued From page 129 Resident #2 or the resident's family wanting dentures to be obtained for the resident. LPN #2 stated she could arrange for a dental consult if Resident #2 was interested in dentures. LPN #2 stated she would have obtained a dental consult for Resident #2 but the resident did not have any teeth or dentures when she first became employed at the facility (approximately five years ago) so she did not do anything. When asked if she had initiated conversation or asked if Resident #2 was interested in dental services and/or dentures, LPN #2 stated she had not. LPN #1 stated, "I don't think we normally ask. We ask if they have teeth. If they have a few then we look at them and if they have no teeth then we ask if they have dentures. If they don't (have dentures), normally we don't ask if they are interested." When asked if a dentist had seen Resident #2 since his admission to the facility, LPN #2 stated she did not remember. LPN #2 stated the nurses do not offer assistance with obtaining dentures until a resident or family member asks. LPN #2 stated many residents have had dentures in the past. When asked if Resident #2 had previously had dentures, LPN #2 stated she did not know. The facility policy titled, "Dental Services Policy" documented, "1. Dental services are available to meet the resident's needs...9. The Director of Nursing Services, his /her designee, or any clinical staff member is responsible for notifying Social Services of a resident's need for dental services. 10. Social Services personnel or designee will, if necessary or requested, assist the resident/resident representative in making dental appointments and transportation arrangements to and from the dental services location..."	F 745		

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F 745	Continued From page 130 No further information was presented prior to exit.	F 745		
F 755 SS=D	COMPLAINT DEFICIENCY Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755	***F 755 Pharmacy Services*** 1. Resident's # 7 and 11 is no longer a residents of the facility. 2. Current residents receiving medications have the potential to be affected by this deficient practice. The DON/designee will audit the MARs for the last 30 days to ensure meds were given and signed off on per physician's order. 3. The DON/designee will educate the licensed staff on documenting physician orders to include accuracy and on following MD orders to include medication administration.	

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F 755	Continued From page 131 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide pharmaceutical services to meet the needs for two of 22 residents in the survey sample, Residents #7 and #11. 1. The facility staff failed to ensure thiamine (vitamin B1) was available for administration as prescribed by the physician, for Resident #7 on 8/16/18, 8/17/18 and 8/21/18. 2. The facility staff failed to ensure multiple medications prescribed by the physician for Resident #11 were available for administration on 5/30/18. The findings include: 1. The facility staff failed to ensure thiamine (vitamin B1) was available for administration as prescribed by the physician, for Resident #7 on 8/16/18, 8/17/18 and 8/21/18. Resident #7 was admitted to the facility on 8/3/18 and readmitted on 8/14/18. Resident #7's diagnoses included but were not limited to pneumonia, difficulty swallowing and quadriplegia (paralysis of all four limbs). Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/22/18, coded the resident as being cognitively intact. Review of Resident #7's clinical record revealed a physician's order dated 8/15/18 for thiamine	F 755	4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure pain medications were given properly, the medications were given and signed off per physicians orders. The findings will be brought to QAPI for three months to ensure compliance. 5. DOC: 9/30/18	

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F 755	Continued From page 132 (vitamin B1) powder- 50 mg (milligrams) via PEG (percutaneous endoscopic gastrostomy) (2) two times a day. Resident #7's August 2018 MAR (medication administration record) documented a physician's order dated 8/15/18 for thiamine powder-50 mg via PEG two times a day scheduled at 8:00 a.m. and 4:00 p.m. On 8/16/18 at 4:00 p.m., the nurse documented the code, "19= Other/See Nurse Notes." On 8/17/18 at 8:00 a.m., the nurse documented the code, "19= Other/See Nurse Notes." On 8/21/18 at 8:00 a.m., the nurse documented the code, "16=Hold/See Nurse Notes." A nurse's note dated 8/16/18 at 4:41 p.m. documented thiamine was on order. A nurse's note dated 8/17/18 at 12:22 p.m. documented thiamine was on order. A nurse's note dated 8/21/18 at 7:57 a.m. documented thiamine administration was pending pharmacy clarification and the physician and responsible party was aware. Review of the facility list of available bulk medications revealed thiamine 100 mg was available but not thiamine 50 mg. On 8/29/18 at 3:35 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented the above 8/16/18 and 8/17/18 nurses' notes). LPN #3 was asked about the facility process for ensuring medications are available for administration. LPN #3 stated she sends a refill request to the pharmacy whenever a certain amount of medication remains. LPN #3 stated she calls the pharmacy if the medication has not arrived in a few days. LPN #3 confirmed she did not administer thiamine to Resident #7 on 8/16/18 or	F 755		

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F 755	Continued From page 133 8/17/18 because the medication was on order from the pharmacy and had not arrived. When asked if she called the pharmacy regarding Resident #7's thiamine, LPN #3 stated she thought she talked to someone at the pharmacy and asked them to send the thiamine STAT (immediately) but sometimes it takes several hours to receive medications from the pharmacy. LPN #3 stated she really did not recall details about the conversation with someone from the pharmacy. Resident #7's care plan initiated on 8/13/18 failed to document specific information regarding thiamine administration. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "Procedure: 1. Facility staff should comply with facility policy, applicable law and the State Operations Manual when administering medications...6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given..." No further information was presented prior to exit. (1) "Thiamine is a vitamin used by the body to break down sugars in the diet. The medication helps correct nerve and heart problems that	F 755		

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F 755	Continued From page 134 occur when a person's diet does not contain enough thiamine." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682586.html (2) "PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus." This information was obtained from the website: https://www.asge.org/home/for-patients/patient-information/understanding-peg 2. The facility staff failed to ensure multiple medications prescribed by the physician for Resident #11 were available for administration on 5/30/18. Resident #11 was admitted to the facility on 5/23/18. Resident #11's diagnoses included but were not limited to diabetes, chronic kidney disease, status post kidney transplant, and high blood pressure. Resident #11's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/20/18, coded the resident as being cognitively intact. On 7/25/18, the Office of Licensure and Certification received a complaint that documented Resident #11's medications were not given at various times. Review of Resident #11's clinical record revealed physician's orders that included but were not	F 755		

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

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F 755	Continued From page 135 limited to the following: - 5/23/18- Lantus (1) 18 units subcutaneously in the evening. - 5/24/18- santyl (2) ointment 250 units per gram- apply to right lower leg wound topically in the evening. - 5/25/18 tacrolimus (3) 1 mg- two capsules by mouth every 12 hours. Review of Resident #11's May 2018 MAR (medication administration record) failed to reveal `Lantus, santyl and the 9:00 p.m. dose of tacrolimus was administered to Resident #11 on 5/30/18 (as evidenced by a blank space on the MAR with no check mark or nurse's initials). Review of nurses' notes dated 5/30/18 failed to reveal the medications were administered. Resident #11's care plan initiated on 5/23/18 documented, "Focus: DIABETES: Resident is at risk for hypo/hyperglycemia (low or high blood sugar) episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)...Interventions: medication as ordered... Focus: KIDNEY TRANSPLANT: At risk for complications r/t (related to): kidney transplant...Interventions: Meds (Medications) as ordered...Focus: SKIN INTEGRITY/PRESSURE ULCER...Resident admitted w/ (with) multiple ulcers: R (Right) lower leg ulcer...Interventions: Administer treatments as ordered..." Review of the facility STAT (immediate) medication box list (a box containing various medications that can be accessed to obtain medications for residents) revealed Lantus, santyl and tacrolimus were not available in the STAT box. An attempt to contact the nurse responsible for	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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F 755	Continued From page 136 administering Lantus, santyl and the 9:00 p.m. dose of tacrolimus to Resident #11 on 5/30/18 was made and the nurse was not available for interview. On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked how nurses evidence medication administration. LPN #7 stated, "By signing off on the MAR." When asked what is meant if the MAR is not signed off, LPN #7 stated, "You assume it wasn't given." When asked if there was any other way to evidence medication administration, LPN #7 stated, "If not on the MAR, you can call the nurse." LPN #7 was shown Resident #11's May 2018 MAR and asked how one would know if the resident's medications were given on 5/30/18. LPN #7 stated, "You can't tell. It wasn't signed." On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Insulin glargine (Lantus) is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html	F 755		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 755	Continued From page 137 (2) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information was obtained from the website: https://www.santyl.com/ (3) "Tacrolimus is used along with other medications to prevent rejection (attack of a transplanted organ by the immune system of a person receiving the organ) in people who have received kidney, liver, or heart transplants." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601117.html	F 755		
F 757 SS=D	COMPLAINT DEFICIENCY Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	***F 757 Unnecessary Drugs*** 1. The facility will administer Resident #3's Tramadol per physician's order. 2. Current residents receiving pain medications have the potential to be affected by this deficient practice. The DON/designee will audit last 30 days of MARs for pain medications to ensure PRNs were given with the proper pain scale.	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 757	Continued From page 138 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the medication regimen for one resident in the survey sample of 22 residents, (Resident #3) was free from unnecessary medications, as evidenced by the administration of Tramadol, an opioid analgesic, without adequate indications for its use. The facility staff failed to follow the physician's order to administer Tramadol for complaints of pain, and administered the medication to Resident #3 when the resident had no complaints of pain. The findings include: Resident #3 was admitted to the facility on 9/24/17 and readmitted on 6/30/18 with diagnoses that included but were not limited to: Parkinson's Disease (1), weakness, chronic pain, high blood pressure and irregular heart beat. The most recent MDS(minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/13/18 coded the resident as having a 15 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.	F 757	3. The DON/designee will educate the licensed staff on pain scale documentation. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure pain medications were given properly and documented pain scale matches med given. The findings will be brought to QAPI for 3 months to ensure compliance. 5. DOC: 9/30/18	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 757	Continued From page 139 Review of the resident's care plan initiated on 7/4/18 and revised on 7/16/18 documented, "Focus PAIN Interventions Administer analgesic/medications per orders." Review of the July 2018 physician's orders documented, "Tramadol HCL (hydrochloride) (2) Tablet 50 MG (milligrams) Give 2 tablet by mouth every 4 hours as needed for pain." The August 2018 medication administration record documented, "Tramadol HCL Tablet 50 MG (milligrams) Give 2 tablet (sic) by mouth every 4 hours as needed for pain." On 8/2/18 at 6:02 a.m., 8/4/18 at 6:00 a.m., 8/6/18 at 5:31 a.m., and 8/24/18 at 6:30 a.m. the medication had been administered to the resident. The resident's pain level was documented as being zero indicating the resident did not have pain when the medication was given. An interview was conducted on 3/30/18 at 1:35 p.m. with Resident #3. When asked if the staff offered anything other than the pain medication when she had pain, Resident #3 stated they did not. Resident #3 stated, "I wish I could use a heating pad for my neck. That really helps. They used to let me sit at the nurse's station, they would put it on me, and I would watch the clock. They don't do that anymore." The resident stated the only time she got warm heat on her neck was if she went to the therapy department and that the department was only open so many hours per day. An interview was conducted on 8/30/18 at 11:45 a.m. with RN (registered nurse) #1. When asked the process staff followed when a resident complained of pain, RN #1 stated, "They would	F 757		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 757	Continued From page 140	F 757		

ask them what their pain level is and they would check to see what they have ordered. I've always been taught to use mild, moderate and severe (for patients to rate their pain)." When asked when staff would give a resident pain medication when they did not have pain, RN #1 stated they would not.

On 8/30/18 at 4:15 p.m. ASM (administrative staff member), #1 and ASM #2, the director of nursing were made aware of the concern that the resident received pain medication when she did not have any pain.

A telephone interview was conducted on 8/30/18 at 4:25 p.m. with LPN (licensed practical nurse) #12, the nurse who administered the Tramadol. LPN #12 was asked about the process she follows when giving pain medication. LPN #12 stated, "I would ask them where they're hurting and how bad is the pain on a scale from one to ten." When asked if the pain level would be documented, LPN #12 stated, "Yeah, I would put that in (name of software)." When asked when would she give an as needed pain medication to a resident who did not have pain, LPN #12 stated, "Well, some people take it to keep from having pain." When asked if she had a resident who she gave pain medication when they did not have pain, LPN #12 stated, "There's (name of Resident #3). They used to have it scheduled around the clock but they want her to decrease the amount of pain medication she takes so they changed it so she would have to ask for her pain medication." She and I have an agreement that I give her a pain pill when she wakes up so she doesn't get pain." When asked if it was appropriate to give pain medication to a resident who did not have pain, LPN #12 stated, "Well no."

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 141 When asked if she had followed the physician's order, LPN #12 stated, "No." No further information was provided prior to exit. (1) Parkinson's disease -- Parkinson disease is a progressive disorder of the nervous system. The disorder affects several regions of the brain, especially an area called the substantia nigra. that controls balance and movement. This information was obtained from: https://ghr.nlm.nih.gov/condition/parkinson-disease (2) Tramadol -- Tramadol is an opioid analgesic used for the therapy of mild-to-moderate pain. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Tramadol#section=Top	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to ensure a resident was free from a significant medication error for one of 22 residents in the survey sample, Resident #11. The facility staff failed to administer Lantus insulin to Resident #11 on 5/30/18, as prescribed by the physician. The findings include:	F 760	***F 760-significant medication error*** 1. Resident #11 is no longer a resident of the facility. 2. Current Residents receiving medications have the potential to be affected by this deficient practice. The DON/designee will audit the MARs for the last 30 days to ensure no other resident was affected by the deficient practice.	

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F 760	Continued From page 142 Resident #11 was admitted to the facility on 5/23/18. Resident #11's diagnoses included but were not limited to diabetes, chronic kidney disease, status post kidney transplant and high blood pressure. Resident #11's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/20/18, coded the resident as being cognitively intact. On 7/25/18, the Office of Licensure and Certification received a complaint that documented Resident #11's medications were not given at various times. Review of Resident #11's clinical record revealed physician's orders that included but were not limited to 5/23/18- Lantus (1) 18 units subcutaneously in the evening (scheduled at 8:00 p.m.) Review of Resident #11's May 2018 MAR (medication administration record) failed to reveal Lantus was administered to Resident #11 on 5/30/18 (as evidenced by a blank space on the MAR with no check mark or nurse's initials). Review of nurses' notes dated 5/30/18, failed to reveal the medication was administered. Further review of Resident #11's May 2018 MAR revealed the resident was administered seven units of lispro (2) insulin based on a sliding scale for a blood sugar of 305 (3) on 5/31/18 at 11:30 a.m. Resident #11's care plan initiated on 5/23/18 documented, "Focus: DIABETES: Resident is at risk for hypo/hyperglycemia (low or high blood sugar) episodes R/T (related to): IDDM (insulin dependent diabetes mellitus)...Interventions:	F 760	3. The DON/designee will educate the licensed staff on medication administration and the 5 rights of med administration. 4. The DON/designee will audit 5 residents MARs a week for 12 weeks to ensure the medications were given and signed off per physicians orders and residents are free of significant medication errors. Findings will be brought to QAPI for 3 months to ensure compliance. 5. DOC: 9/30/18	

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 760	Continued From page 143 medication as ordered..." An attempt to contact the nurse responsible for administering Lantus to Resident #11 on 5/30/18 was made and the nurse was not available for interview. On 8/29/18 at 3:22 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked how nurses evidence medication administration. LPN #7 stated, "By signing off on the MAR." When asked what is meant if the MAR is not signed off, LPN #7 stated, "You assume it wasn't given." When asked if there was any other way to evidence medication administration, LPN #7 stated, "If not on the MAR, you can call the nurse." LPN #7 was shown Resident #11's May 2018 MAR and asked how one would know if the resident's medication was given on 5/30/18. LPN #7 stated, "You can't tell. It wasn't signed." On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/30/18 at 8:45 a.m., a telephone interview was conducted with OSM (other staff member) #5 (the consulting pharmacist). OSM #5 was asked the potential consequences of a missed dose of Lantus. OSM #5 stated the consequences were very dependent on how fragile of a diabetic the resident is and many factors including whether the resident is eating, whether the dose was missed or given late, and whether the resident receives other insulin. The facility pharmacy policy titled, "6.0 General	F 760		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 760	Continued From page 144 Dose Preparation and Medication Administration" documented, "Procedure: 1. Facility staff should comply with facility policy, applicable law and the State Operations Manual when administering medications...6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given..." No further information was presented prior to exit. (1) "Insulin glargine (Lantus) is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes...Insulin glargine comes as a solution (liquid) to inject subcutaneously (under the skin). It is injected once a day. You should use insulin glargine at the same time every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use insulin glargine exactly as directed. Do not use more or less of it or use it more often than prescribed by your doctor." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html (2) "Insulin lispro is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of	F 760		

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	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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

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F 760	Continued From page 145 sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. In patients with type 1 diabetes, insulin lispro is always used with another type of insulin, unless it is used in an external insulin pump. In patients with type 2 diabetes, insulin lispro may be used with another type of insulin or with oral medication(s) for diabetes. Insulin lispro is a short-acting, manmade version of human insulin. Insulin lispro works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html (3) "What are target blood sugar levels for people with diabetes? A target is something that you aim for or try to reach. Your health care team may also use the term goal. People with diabetes have blood sugar targets that they try to reach at different times of the day. These targets are: oRight before your meal: 80 to 130 oTwo hours after the start of the meal: Below 180." This information was obtained from the website: https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/know-blood-sugar-numbers COMPLAINT DEFICIENCY	F 760		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 803	Continued From page 146 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow the menu for three of five observed meals and failed to provide the correct portion to maintain nutritive value for all units and the dining room during two observed meals. 1. The facility staff failed to serve the registered	F 803	***F 803 Menus meet the needs of residents and followed*** 1. No residents names to affected by this deficient practice. 2. Current I residents had the potential to be affected by this deficient practice. 3. The Certified Dietary Manager (CDM) will educate the dietary employees on appropriate substitutions, following the menu and following the stated portion sizes to maintain the residents' nutritional status. 4. The CDM will audit menus and any substitutions along with portion sizes 5 meals a week for 12 weeks to ensure compliance with stated menus. Findings will be brought to QAPI for 3 months to ensure compliance. 5. DOC: 9/30/18	

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 _____	C 08/30/2018

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 803	Continued From page 147 dietitian planned menu for three of five observed meals. 2. The facility staff failed to serve the correct food portions as per the registered dietitian's recommendations. The findings include: 1. The facility staff failed to serve the registered dietitian planned menu for three of five observed meals. A complaint was received to the reporting agency on 7/24/18 with the allegation that the menus were not being followed. An observation was made on 8/28/18 at 12:00 noon of the lunch tray preparation in the kitchen. The residents were served beef stroganoff over noodles, green beans and ice cream. Review of the menu documented the meal was to consist of rice or noodles, dinner roll or bread and a blonde brownie. On 8/28/2018, during the lunch meal observation at approximately 12:30 p.m., when random residents were asked what they were getting at meals they would state that it was a mystery to them. An observation was made on 8/29/18 at 12:30 p.m. of the lunch service in the dining room. The residents were served pork roast with gravy, mashed potatoes, vegetable blend and angel food cake. The menu documented the meal was to consist of O'Brien potatoes and angel food cake with fruit topping.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 803	Continued From page 148 An observation was made on 8/29/18 at 5:02 p.m. of the dinner service in the dining room. The residents were served baked ziti, green and wax beans, garlic sticks and citrus banana cup. The menu documented the meal was to consist of baked penne pasta with cheese and California vegetable blend. An interview was conducted on 8/30/18 at 9:05 a.m. with OSM (other staff member) #12, the cook. When asked how they knew what the menu was supposed to be, OSM #12 stated they had pre-printed menus. When asked if they were supposed to follow the menus, OSM #12 stated they were but they frequently did not have the food needed on hand to follow the menu. When asked why the residents did not get a roll or bread at lunch on 8/28/18, OSM #12 stated, "I'm new as the head cook. I forget to put the bread on the trays." When asked why the residents did not get potatoes O'Brien at lunch on 8/29/18, OSM #12 stated, "We did not have those so I had to make mashed potatoes. Since we haven't had a dietary manager the person ordering the food wasn't familiar with what to order." When asked how often the menu wasn't followed, OSM #12 stated, "A lot since we haven't had a manager." When asked how long they were without a manager, OSM #12 stated it had been about two weeks. OSM #12 stated, "We had trouble with her too. She didn't order what we were supposed to have so we would have to pull something from another menu." When asked if it was important to follow the menus, OSM #12 stated, "Yes ma'am. They're (the residents) expecting that for that day. And if I have to pull hamburgers for a meal because I don't have the right food, I won't have any if a resident wants a hamburger."	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 803	Continued From page 149 On 8/30/18 at 4:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "MENU SUBSTITUTION" documented, "POLICY: The Federal Survey Guidelines state that menu substitutions should be of equal nutritional value. To provide a substitute when an uncontrollable situation (i.e., inventory emergency) has temporarily made the item unavailable, decisions on menu substitution will be made after discussion with the dietary manage whenever possible. PROCEDURE: 1. The dietary manager in consultation with the dietitian should be responsible for approving menu changes/substitutions." No further information was provided prior to exit. COMPLAINT DEFICIENCY 2. The facility staff failed to serve the correct portion as per the registered dietitian's recommendations. An observation was made on 8/28/18 at 12:00 p.m. with OSM (other staff member) #12, the cook of the lunch tray preparation in the kitchen. OSM #12 was observed filling a gray scoop with beef stroganoff and pouring 1/2 to 3/4 of the scoop over the noodles. An observation was made on 8/28/18 at 12:25 p.m. with OSM #13, the dietary aid. OSM #13 was serving the residents in the dining room. OSM #13 was observed filling a white scoop with beef stroganoff and pouring it over the noodles.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 803	Continued From page 150 OSM #13 was observed using a blue handled scoop to serve the pureed beef stroganoff. When asked how many ounces the white and blue scoops were, OSM #13 stated, "I have no idea. I don't usually serve this meal." An observation was made on 8/29/18 at 5:02 p.m. with OSM #14, a dietary aide. OSM #14 was serving residents in the dining room. OSM #14 was observed using a blue handled scoop to serve the pureed penne pasta. The menu documented that the beef stroganoff portion was to be six ounces and the penne portion was to be eight ounces. The residents received anywhere from two to four ounce servings of the beef stroganoff and two ounces of the pureed penne. An interview was conducted on 10/30/18 at 9:05 a.m. with OSM #12, the cook. When asked how many ounces the blue scoop was, OSM #12 stated she wasn't sure, the scoop was filled with water and then measured in a cup. The scoop held two ounces. When asked how many ounces the white scoop was, OSM #12 stated she was not sure. When shown the ounces on the handle, OSM #12 stated, "Thirty ounces? No, it's three ounces." When asked what how many ounces the gray ladle scoop was, OSM #12 checked the handle and stated it was six ounces. When asked how staff knew which scoop to use for each food item, OSM #12 stated, "I just did what the other cooks told me." When informed that she was observed only poured 1/2 to 3/4 of the gray scoop of beef stroganoff over the noodles, OSM #12 agreed that she had done that, and stated, "I just like to make sure there's enough sauce over the noodles." When asked why the menu had portion	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 803	Continued From page 151 sizes, OSM #12 stated, "So the resident gets the right portion of food." When asked if the residents had received the correct portions for the 8/28/18 lunch and dinner and the 8/29/18 dinner, OSM #12 stated they had not. On 8/301/18 at 4:15 p.m. ASM #1, the administrator and ASM #2, of the director of nursing were made aware of the findings. Review of the facility's policy titled, "PORTION CONTROL" documented, "POLICY: In order to ensure nutritional adequacy, Residents will receive the appropriate portions of food as planned on the menu. PROCEDURE: 1. Portion sizes are noted on standardized recipes, therapeutic diet spreadsheets, and production sheets. 2. Portion control utensils such as scoops, ladles, and spoodles shall be used during food preparation and service. Unmeasured serving spoons are not to be used to portion food." No further information was provided prior to exit.	F 803		
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	F 880	***F 880-Infection Control*** 1. Resident #7 is no longer a resident of the facility. 2. Current residents have the potential to be affected by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 152 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: (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	F 880	deficient practice. The DON/Designee will audit residents currently with isolation orders to ensure infection control policy is being followed. 3. The DON/designee will educate the staff on infection control policy to include the use of appropriate PPE use for residents requiring isolation. 4. The DON/designee will audit residents requiring isolation weekly for 12 weeks to ensure staff is following proper isolation procedures. Findings will be brought to QAPI for 3 months to ensure compliance. 5. DOC:9/30/18	

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 _____	C 08/30/2018

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 880	Continued From page 153 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: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to implement infection control practices for one of 22 residents in the survey sample, Resident #7. The facility staff failed to clarify the reason Resident #7 was on isolation precautions, what precautions were required to be followed, and failed to consistently wear personal protective equipment. The findings include: On 7/25/18, the Office of Licensure and Certification received a complaint regarding a resident who no longer resided at the facility during the survey. The complaint documented the facility staff failed to practice infection control and failed to wear isolation attire.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 154 Resident #7 was admitted to the facility on 8/3/18 and readmitted on 8/14/18. Resident #7's diagnoses included but were not limited to pneumonia, difficulty swallowing and quadriplegia (paralysis of all four limbs). Resident #7's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/22/18, coded the resident as being cognitively intact. Review of Resident #7's clinical record revealed a hospital progress noted dated 8/13/18 that documented, "Sputum positive for Pseudomonas (1), but likely represents colonization..." A hospital general medicine discharge summary dated 8/14/18 documented, "VRE (vancomycin-resistant enterococci) (2) surveillance swab positive..." but failed to document information regarding isolation precautions. Review of Resident #7's physician orders from 8/14/18 to 8/28/18 failed to reveal documentation of isolation precautions. Resident #7's care plan initiated on 8/13/18 failed to document information regarding isolation precautions. On 8/28/18 at 11:10 a.m., a yellow bag containing gowns, gloves and masks was observed hanging on Resident #7's door. A CNA (certified nursing assistant) was observed in the resident's room pushing an over bed table next to the bed. The CNA was wearing gloves but no gown or mask. On 8/28/18 at 11:11 a.m., a housekeeper entered Resident #7's room with a mop and began washing the floor. The housekeeper was not wearing a gown, gloves or a mask.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 155 On 8/29/18 at 9:35 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if Resident #7 was on isolation and stated, "Yes." When asked why, RN #1 stated, "We are on the phone trying to clarify." When asked what type of isolation precautions should be followed in Resident #7's room, RN #1 stated the resident was on contact precautions and a gown, mask and gloves should be worn by staff when in the resident's room. When asked the facility process for clarifying isolation precautions, RN #1 stated the nurses receive a report from hospital staff when a resident is admitted and the nurses have to call the physician to review all admission orders. RN #1 stated the physician may discontinue isolation if the infection is colonized. RN #1 was asked how staff is supposed to know what precautions to follow if the staff is unsure of why the resident is on isolation. RN #1 stated, "Correct." RN #1 was made aware this surveyor wanted to go into Resident #7's room and asked what protective equipment should be worn. RN #1 stated a mask, gown and gloves should be worn. On 8/29/18 at 9:55 a.m., an interview was conducted with Resident #7 while the resident was lying in bed. The resident stated he did not know why he was on isolation. When asked if staff always wears a gown and gloves when near him or touching items in his room, Resident #7 stated they did not. On 8/29/18 at 10:06 a.m., RN #1 stated she called the infectious disease department at the hospital and the staff there was unsure why Resident #7 was on isolation. RN #1 stated the staff at the hospital saw documentation that Resident #7 had a positive VRE rectal swab and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 156	F 880		

three negative swabs were needed to clear the infection so this is probably why Resident #7 was on isolation. RN #1 stated the hospital case manager was supposed to call her back.

On 8/29/18 at 11:07 a.m., an interview was conducted with OSM (other staff member) #7 (the activities director). OSM #7 was asked why Resident #7 was on isolation and what protective equipment should be worn in the resident's room. OSM #7 stated she did not know why the resident was on isolation but she wears a gown, gloves and a mask when she goes into the resident's room.

On 8/29/18 at 2:03 p.m., an interview was conducted with OSM #6 (the housekeeping manager). OSM #6 was asked how the housekeeping staff is made aware of residents who are on isolation precautions. OSM #6 stated she is notified in the morning meetings and isolation rooms have yellow bags containing gowns, gloves and masks hanging on the doors. OSM #6 stated housekeepers are supposed to wear a gown and gloves every time they go in an isolation room. OSM #6 was made aware a housekeeper was observed without a gown or gloves in Resident #7's room. OSM #6 stated she was aware of this and in-serviced the housekeeper.

On 8/29/18 at 2:34 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how she is made aware of what type of protective equipment she should wear in an isolation room. CNA #1 stated she usually asks the nurse.

On 8/29/18 at 5:29 p.m., RN #1 stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 157 talked to five different people at the hospital. RN #1 stated Resident #7 tested positive for VRE on 4/17/18. RN #1 stated the case manager stated Resident #7 would have probably been deemed colonized but a third VRE test was supposed to have been done. RN #1 presented a progress note signed by an infection prevention nurse at the hospital and dated 8/6/18. The note documented, "Lab Data: Date: 4/17/18. Specimen: Perirectal. Organism: Vancomycin Resistant Enterococcus (VRE). Isolation/Precaution Required (in addition to Standard Precautions): Contact Precautions-Private room, gown, gloves. A follow up test for colonization has been ordered..." RN #1 stated this document was not provided to facility staff when Resident #7 was admitted but there was a document provided that mentioned VRE. RN #1 stated she made Resident #7's physician aware of this and Resident #7's physician ordered a VRE peri-rectal swab to be obtained on the next day. When asked why Resident #7 was initially placed on isolation if the nurses were unaware why isolation was needed, RN #1 stated the admissions department asks the hospital staff about isolation precautions and would have told the facility nurses to follow isolation precautions, and the hospital nurse is supposed to inform the facility staff during the phone report. When asked to explain the professional standard for action to be taken if an admitted resident is suspected of needing isolation precautions, RN #1 stated, the facility staff should find out what organism the resident is infected with and obtain clarification of what precautions and protective equipment should be used. On 8/29/18 at 6:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 158 (the director of nursing) were made aware of the above concern. The facility policy titled, "INFECTION CONTROL-TRANSMISSION BASED PRECAUTIONS" documented, "PROCEDURE: A) There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions... (Refer to Appendix A 'Type and duration of Precautions Recommend (sic) for Selected Infections and conditions'). Transmission based Precautions are always used in addition to Standard Precautions. 1. Contact Precautions- intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment recommended: a. Gloves- whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. b. Gowns- whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident..." Appendix A documented, "MDROs (multidrug-resistant organisms) (including VRE) judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings..."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 880	Continued From page 159 No further information was presented prior to exit. (1) "What is a Pseudomonas infection? Pseudomonas infection is caused by strains of bacteria found widely in the environment; the most common type causing infections in humans is called Pseudomonas aeruginosa. What types of infections does Pseudomonas aeruginosa cause? Serious Pseudomonas infections usually occur in people in the hospital and/or with weakened immune systems. Infections of the blood, pneumonia, and infections following surgery can lead to severe illness and death in these people." This information was obtained from the website: https://www.cdc.gov/hai/organisms/pseudomonas.html (2) "Vancomycin-resistant Enterococci are specific types of antimicrobial-resistant bacteria that are resistant to vancomycin, the drug often used to treat infections caused by enterococci. Enteroccocci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Most vancomycin-resistant Enterococci infections occur in hospitals. [Vancomycin-resistant Enterococci is also called VRE]...What is the treatment for VRE? People with colonized VRE (bacteria are present, but have no symptoms of an infection) do not need treatment. Most VRE infections can be treated with antibiotics other than vancomycin. Laboratory testing of the VRE can determine which antibiotics will work. For people who get VRE infections in their bladder and have urinary catheters, removal of the catheter when it is no	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 08/30/2018

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 160 longer needed can also help get rid of the infection. How is VRE spread? VRE is often passed from person to person by the contaminated hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not spread through the air by coughing or sneezing." This information was obtained from the website: https://www.cdc.gov/HAI/organisms/vre/vre.html The CDC (Centers for Disease Control) further documented, "Multidrug-resistant organisms (MDROs), infection or colonization (e.g., VRE...) Type of Precaution: Contact + Standard MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infectioncontrol/guidelines/mdro/ accessed May 2016) [870]. Contact state health department for guidance regarding new or emerging MDRO." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf	F 880		