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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/8/2021 through 6/10/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/8/21 through 6/10/21. Three complaints (VA00051575- substantiated with deficiency, VA00051666- unsubstantiated, VA00050771- unsubstantiated) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 169 certified bed facility was 135 at the time of the survey. The survey sample consisted of 45 current resident reviews and 7 closed record reviews.	F 000		
F 656 SS=E	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	F 656		6/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/24/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY** **MECHANICSVILLE, VA 23116**

(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 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR 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 and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for four of 52 residents in the survey sample, Residents #107, #86, #12 and #61. The findings include: 1.a. The facility staff failed to implement Resident #107's comprehensive care plan for pain	F 656	F656 Comprehensive Care Plan 1. Comprehensive care plan and prn pain administration orders were reviewed for resident #107 and revisions made to reflect resident's current status. Comprehensive care plan and oxygen administration orders were reviewed for resident #61 and revisions made to reflect resident's current status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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 2
medication administration.

Resident #107 was admitted to the facility on 10/13/20. Resident #107's diagnoses included but were not limited to heart disease, high blood pressure and a history of a hip fracture. Resident #107's significant change in status minimum data set assessment with an assessment reference date of 5/17/21, coded the resident's cognition as severely impaired.

Review of Resident #107's clinical record revealed the following physician's orders:
-5/10/21- oxycodone 5 mg (milligrams) - Give 0.5 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain 1-5.
-5/10/21- oxycodone 5 mg - Give 1 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain scale 6-10.

Resident #107's comprehensive care plan revised on 5/11/21 documented, "At risk for pain r/t (related to) DJD (degenerative joint disease) right hip incision. Interventions: meds (medications) as ordered..."

Review of Resident #107's May 2021 eMAR (electronic medication administration record) revealed Resident #107 was administered 0.5 tablet (instead of one tablet) on 5/14/21 for a pain rating of seven.

The nurse who administered prn [as needed] oxycodone to Resident #107 on 5/14/21 was not available for interview during the survey.

On 6/9/21 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of a care plan is to let

F 656

Comprehensive care plan and oxygen administration orders were reviewed for resident #86 and reflects resident's current status.

Comprehensive care plan and oxygen administration orders were reviewed for resident #12 and reflects resident's current status.

2. Current residents who reside in Autumn Care of Mechanicsville and receive prn pain medicine and oxygen have the potential to be affected by this deficient practice.
Quality review of current residents with PRN orders was completed by DON or designee to ensure prn pain medication is administered per physicians' orders.
Quality review of current residents with PRN orders was completed by DON or designee to ensure non-pharmacological interventions are offered prior to administration of PRN medications.
Quality review of current residents with an oxygen was completed by DON or designee to ensure oxygen is administered per physicians' orders.
Quality review through walking rounds was conducted to ensure all residents on oxygen had oxygen on per physician order rate and tubing stored properly.

3. Nurses were educated by Director of Nursing or designee to policy entitled "Care Plan"; "Pain Management and Pain Protocol" and "Oxygen Administration" (all routes) to ensure care plan is being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 3

the nursing staff know what is going on with the resident. LPN #2 stated the nursing staff has a book containing residents' care plans that can be reviewed at the nurses' station.

On 6/9/21 at 1:53 p.m., an interview was conducted with LPN #1. LPN #1 was shown Resident #107's as needed oxycodone physician's orders and shown Resident #107's May 2021 eMAR that documented the resident was administered 0.5 mg of oxycodone for a pain rating of seven on 5/14/21. LPN #1 stated, "He should have gotten a whole tablet." LPN #1 was asked why it was important to follow Resident #7's as needed oxycodone physician's orders. LPN #1 stated, "LPNs are not allowed to assess so we have to follow physician's orders. It really takes the guess work out of what you should give."

On 6/9/21 at 4:10 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, "Comprehensive Care Planning" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

No further information was presented prior to exit.

Reference:
(1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html

1.b. The facility staff failed to implement Resident

F 656

followed regarding PRN medication administration, non-pharmacological and oxygen administration.
AC of Mechanicsville licensed and agency nurse staff were educated on administering PRN pain medication per patient centered care plan.
AC of Mechanicsville licensed and agency nurse staff were educated on offering non-pharmacological interventions prior to administration of PRN oxycodone per patient center care plan.
Nursing staff was educated on proper way to read oxygen flow meter and proper way to store oxygen tubing when not in use.

4. The Director of Nursing or designee will conduct quality monitoring audits on 10 resident to ensure ongoing compliance with PRN pain medication administration, correct oxygen flow rate and proper oxygen tube storage. These audits will be accomplished weekly x 12 weeks and PRN as indicated to ensure ongoing compliance.
Audit results will be presented monthly the Quality Assurance Performance Improvement committee for review and recommendation.

Date of Compliance: June 28, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 4	F 656		

#107's comprehensive care plan for non-pharmacological interventions related to pain.

Review of Resident #107's clinical record revealed a physician's order dated 5/10/21 for oxycodone 5 mg (milligrams) - Give 0.5 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain 1-5.

Resident #107's comprehensive care plan revised on 5/11/21 documented, "At risk r/t (related to) DJD (degenerative joint disease)... right hip incision. Interventions: Provide distractions prn such as television, or activities, interaction with others, reading material as able..."

Review of Resident #107's May 2021 eMAR (electronic medication administration record) revealed the resident was administered 0.5 mg of oxycodone on 5/12/21 for a pain rating of three. Further review of Resident #107's clinical record (including the May 2021 eMAR and nurses' notes dated 5/12/21) failed to reveal staff attempted/ offered non-pharmacological interventions prior to the administration of prn oxycodone to Resident #107 on 5/12/21.

On 6/9/21 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who administered prn oxycodone to Resident #107 on 5/12/21). LPN #2 stated the purpose of a care plan is to let the nursing staff know what is going on the resident. LPN #2 stated the nursing staff has a book containing residents' care plans that can be reviewed at the nurses' station. LPN #2 was asked what should be done prior to administering as needed pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 5	F 656		

medication. LPN #2 stated nurses should ask the resident his or her pain level, ask the resident why they need the pain medication and document. LPN #2 stated she did not recall offering non-pharmacological interventions to Resident #107 prior to administering prn oxycodone on 5/12/21.

On 6/9/21 at 1:53 p.m., an interview was conducted with LPN #2. LPN #2 stated a non-pharmacological intervention should be attempted prior to administering prn pain medication because nurses have to attempt to maintain residents' comfort without always pushing a pill in their face.

On 6/9/21 at 4:10 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.

Reference:
(1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html

2. The facility staff failed to implement Resident #86's comprehensive care plan for the administration of oxygen as ordered.

Resident #86 was admitted to the facility on 1/27/21 with the diagnoses of but not limited to neuropathic bladder, diabetes, depression, high blood pressure, and quadriplegia. The most recent MDS (Minimum Data Set) assessment a quarterly assessment with an ARD (Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 6	F 656		

Reference Date) of 5/6/21, coded Resident #86 as moderately impaired in ability to make daily life decisions. Resident #86 was coded as requiring total care for all areas of activities of daily living.

A review of the comprehensive care plan for Resident #86 revealed one dated 1/28/21 for "Due to COVID-19 outbreak, the resident is at risk for infection r/t (related to) potential virus exposure and resident's current health status." Interventions included one dated 1/28/21 for "Oxygen as ordered...."

A review of the clinical record revealed a physician's order dated 6/2/21 for "OXYGEN @ (at) 2 LPM (liters per minute) VIA NASAL CANNULA."

On 6/8/21 at 12:12 PM observation of Resident #86 revealed the resident with oxygen on via a nasal cannula connected to an oxygen concentrator. Observation of the residents oxygen concentrator revealed the flow meter was set at 2.5 liters per minute as evidenced by the ball in the flow meter sitting half way between the 2.0 liter and 3.0 liter marks, with the line for 2.5 liters crossing through the center of the ball.

On 6/9/21 at 8:15 AM and 2:37 PM additional observations of Resident #86 and the resident's oxygen concentrator flow rate were made. During each observation the oxygen rate on the oxygen flow meter was at 2.75 liters as evidenced by the flow meter ball sitting between the 2.5 liter and 3.0 liter marks.

On 6/9/21 at approximately 3:00 PM in an interview with RN #2 (Registered Nurse), she stated the oxygen should be set at 2 liters per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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 7	F 656		

minute. At this time she checked Resident # 86's oxygen concentrator and stated that it was not set at the right rate, as the ball was between the 2.5 and 3 liter marks.

When asked if the care plan was implemented if the interventions documented to administer oxygen as ordered and the oxygen was set at the incorrect rate, RN #2 stated, "No."

A review of the facility policy, "Comprehensive Care Planning" documented, "....Z). All direct care staff must always know, understand and follow their resident's care plan. If unable to implement any part of the plan, notify your charge nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary."

On 6/9/21 at approximately 4:00 PM, ASM #1 and #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to implement Resident #12's comprehensive care plan for the administration of oxygen as ordered.

Resident #12 was admitted to the facility on 12/1/20 with the diagnoses of but not limited to depression, hypothyroidism, dementia, psychosis, high blood pressure, acute respiratory failure, senile degeneration of the brain and palliative care. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 3/10/21, coded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 8	F 656		

Resident #12 as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, transfers, and toileting; extensive assistance for dressing and hygiene; and supervision for eating.

A review of the comprehensive care plan revealed one dated 12/2/20 for "At risk for altered cardiac/resp (respiratory) status r/t (related to) htn (hypertension - high blood pressure), gerd (gastroesophageal reflux disease), hypothyroidism, sob (shortness of breath) related to resp failure." The interventions included one dated 12/2/20 for "02 (oxygen) as ordered."

A review of the clinical record revealed a physician's order dated 3/23/21 for "OXYGEN @ (at) 2LPM (two liters per minute) VIA NASAL CANNULA every shift for SOB (shortness of breath) related to resp failure."

Observations were made of Resident #12's oxygen concentrator as follows:

" On 6/9/21 at 8:15 AM the oxygen concentrator was observed and was noted to be set at the incorrect rate of 1 liter per minute as evidenced by the ball on the flow meter positioned so that the 1 liter mark on the flow meter passed through the center of the ball.

" On 6/9/21 at 2:16 PM, the concentrator was again observed. The flow meter was noted to still be set at the 1 liter mark. However, this time, the resident did not have the cannula on. It was in the bed next to the resident. A visitor of the resident stated that she did not have the oxygen on at the moment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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 9	F 656		

On 6/9/21 at approximately 3:00 PM in an interview with RN #2 (Registered Nurse), she stated the oxygen should be set at 2 liters per minute. At this time RN #2 checked the oxygen concentrator and stated that it was not set at the right rate, as the ball was positioned on the 1 liter mark. Observation revealed as RN #2 was adjusting the concentrator to set it on the correct rate, the flow meter demonstrated a delayed response to responding to the adjusted setting and was slow to indicate if it was on the correct rate. RN #2 stated that this concentrator may have an issue that need to be addressed by the company that services them.

On 6/9/21 at 3:37 PM in a follow up interview with RN #2, she stated that Resident #12's oxygen concentrator is supplied and maintained by her Hospice nurse, and that they (the Hospice company) were being notified of the concern for the possible faulty flow meter.

When asked if the care plan was implemented if the interventions documented to administer oxygen as ordered and the oxygen was set at the incorrect rate, RN #2 stated, "No."

A review of the facility policy, "Comprehensive Care Planning" documented, "....Z). All direct care staff must always know, understand and follow their resident's care plan. If unable to implement any part of the plan, notify your charge nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary."

On 6/9/21 at approximately 4:00 PM, ASM #1 and #2 (Administrative Staff Members - the Administrator and Director of Nursing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 10	F 656		

respectively) were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to implement Resident # 61's comprehensive care plan for physician ordered oxygen.

Resident # 61 was admitted to the facility with diagnoses that include but not limited to: asthma, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/23/2021, coded Resident # 61 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 13 for "Oxygen Therapy" while a resident.

On the following dates and time 06/08/21 at 11:40 a.m., 06/08/21 at 12:26 p.m., observations of Resident #61's room revealed an oxygen concentrator running, ands Resident # 61 lying in bed watching television. Observation of the nasal cannula connected to the oxygen concentrator revealed it was lying on the floor on Resident # 61's left side.

On 06/08/21 at 12:58 p.m., an observation of Resident # 61's room revealed CNA [certified nursing assistant] # 2 entered Resident # 61 room with a lunch tray, set it on the over the bed table and opened containers for Resident # 61 to eat. CNA # 2 was observed standing on Resident # 61's left side of the bed. Further observation revealed an oxygen concentrator running and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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		F 656		

Continued From page 11
nasal cannula connected to the oxygen concentrator lying on the floor on Resident # 61's left side.

On 06/08/21 at 2:19 p.m., CNA # 3 was observed leaving Resident # 61's room. Observation of Resident # 61's room revealed an oxygen concentrator running, and Resident # 61 lying in bed watching television. Observation of the nasal cannula connected to the oxygen concentrator revealed it was lying on the floor on Resident # 61's left side.

The physician's order dated 03/24/2021 for Resident # 61 documented, "Oxygen 2l/m [two liters per minute] via [by] nc [nasal cannula] [1] every shift for chronic respiratory failure."

The comprehensive care plan for Resident # 61 with a revision date of 03/16/2021 documented in part, "Focus. At risk for altered cardiac/resp [respiratory] status r/t [related to] htn [high blood pressure], hyperlipidemia [high cholesterol], Asthma, gerd [gastroesophageal reflux disease], copd, hypokalemia, respiratory failure Wheezing/SOB [shortness of breath] lying flat, on exertion and at rest." Under "Interventions" it documented in part, "O2 [oxygen] as ordered. Date Initiated: 05/25/2020."

On 06/08/21 at 11:42 a.m., an interview was conducted with Resident # 61 regarding their oxygen use. When asked how often they were to receive oxygen, Resident # 61 stated, "All the time."

On 06/09/2021 at approximately 1:15 p.m., an interview was conducted with CNA # 2 regarding the position of Resident # 61's nasal cannula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 When asked how the nasal cannula should be maintained for a resident's oxygen, CNA # 2 stated, "It should be in a bag when not in use. If they need to have oxygen it should be on them." When informed of the above observations of Resident # 61's nasal cannula, CNA # 2 stated, that they were no aware that Resident # 61 did not have their oxygen on. On 06/09/2021 at approximately 1:15 p.m., an interview was conducted with CNA # 3 regarding the position of Resident # 61's nasal cannula. When asked how the nasal cannula should be maintained for a resident's oxygen, CNA # 3 stated, "When not using it, it should be in a plastic bag, if they don't have it on and they are supposed to, I would go to nurse and let them know." When asked what they would do if they found the nasal cannula on the floor, CNA # 3 stated, "I would pick it up and put it in a bag and tell the nurse." When informed of the above observations of Resident # 61's nasal cannula, CNA # 3 stated, "I don't recall the nasal cannula on the floor." On 06/09/21 at 11:47 a.m., an interview was conducted with RN [registered nurse] # 3, unit manager. When asked how the nasal cannula should be maintained for a resident's oxygen, RN # 3 stated, "If not use it should be inside the protective bag." When asked to describe the procedure a CNA is required to follow if they find a resident is wearing the nasal cannula when they should be receiving oxygen continuously, RN # 3 stated, "They report it to the nurse." RN # 3 was informed of the above observations and asked if they were Resident # 61's nurse on 06/08/2021 and if CNA # 2 or CNA # 3 reported that Resident # 61 was wearing the nasal cannula therefore not	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 receiving oxygen. RN # 3 stated that they were Resident # 61's nurse on 06/08/2021 and that they were not notified by CNA # 2 or CNA # 3 of Resident # 61 not receiving oxygen. When asked to describe the purpose of a resident's comprehensive care plan, RN # 3 stated, "It directs the care for the resident for their health and well-being." After reviewing Resident # 61's comprehensive care plan for oxygen, RN # 3 was asked if Resident #61'a comprehensive care plan was implemented. RN # 3 stated, "Not in this instance." On 06/09/2021 at approximately 4:00 P.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 656		
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 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	F 695		7/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 14

by:
Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for three of 52 residents in the survey sample, (Residents #86, #12 and #61). The facility staff failed to administer oxygen at the physician ordered rate to Resident #86 and Resident #12, and failed to maintain Resident #12's oxygen concentrator in a sanitary manner. The Facility staff failed to provide Resident # 61's oxygen continuously according to the physician's orders and keep the nasal cannula off the floor.

The findings include:

1. Resident #86 was admitted to the facility on 1/27/21 with the diagnoses of but not limited to neuropathic bladder, diabetes, depression, high blood pressure, and quadriplegia. The most recent MDS (Minimum Data Set) assessment a quarterly assessment with an ARD (Assessment Reference Date) of 5/6/21, coded Resident #86 as moderately impaired in ability to make daily life decisions. Resident #86 was coded as requiring total care for all areas of activities of daily living.

A review of the clinical record revealed a physician's order dated 6/2/21 for "OXYGEN @ (at) 2 LPM (liters per minute) VIA NASAL CANNULA."

Observations were made of Resident #86's oxygen concentrator as follows:

On 6/8/21 at 12:12 PM, revealed Resident #86's

F 695

F695-Respiratory/Tracheostomy Care and Suctioning

1. Resident # 86, resident # 12 and resident # 61 oxygen flow meter rate was corrected to the physician ordered rate, and the concentrators were cleaned. Resident #61 was provided a new nasal cannula. CNA#2 and CNA#3 were educated on notifying charge nurse when a resident is noted not to be wearing oxygen per patient centered care plan and how to properly store nasal cannula when not in use.

2. Comprehensive care plan and oxygen administration orders were reviewed for resident #61 and revisions made to reflect resident's current status.

Comprehensive care plan and oxygen administration orders were reviewed for resident #86 to ensure they reflect resident's current status.

Comprehensive care plan and oxygen administration orders were reviewed for resident #12 to ensure they reflect resident's current status.

2. Current residents who reside in Autumn Care of Mechanicsville and receive oxygen have the potential to be affected by this deficient practice. Quality review of current residents with oxygen orders was completed by DON or designee to ensure oxygen was delivered per professional standards and according

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 15 oxygen concentrator set at 2.5 liters per minute as evidenced by the ball in the flow meter sitting half way between the 2.0 liter and 3.0 liter marks, with the line for 2.5 liters crossing through the center of the ball. On 6/9/21 at 8:15 AM and 2:37 PM additional observations were made. During each observation the oxygen rate on Resident #86's oxygen concentrator flow meter was 2.75 liters as evidenced by the flow meter ball sitting between the 2.5 liter and 3.0 liter marks. On 6/9/21 at approximately 3:00 PM, an interview was conducted with RN #2 (Registered Nurse). RN #2 stated the (Resident #86's) oxygen should be set at 2 liters per minute. At this time RN #2 checked Resident #86's oxygen concentrator flow meter and stated that it was not set at the right rate, as the ball was between the 2.5 and 3 liter marks. On 6/10/21 at 8:31 AM in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that staff should squat down and observe the flowmeter straight-on at eye level. A review of the comprehensive care plan for Resident #86 revealed one dated 1/28/21 for "Due to COVID-19 outbreak, the resident is at risk for infection r/t (related to) potential virus exposure and resident's current health status." Interventions included one dated 1/28/21 for "Oxygen as ordered...." A review of the facility policy, "Oxygen Administration" documented, "Licensed clinicians with demonstrated competence will administer	F 695	to person-centered care plan. Quality walking rounds of current residents with oxygen orders was completed by DON or designee to ensure all residents were wearing a nasal canal according to person centered care plan. As well as to ensure nasal cannula is stored properly in a protective bag. Quality review of current residents with oxygen orders was completed by DON or designee to ensure oxygen is administered per physician ordered rate. Quality review of current residents on oxygen was completed by DON or designee to ensure oxygen was administered according to physician order and nasal cannula was off the floor. 3. AC of Mechanicsville licensed and agency nurse staff were educated by Director of Nursing or designee to policy entitle "Oxygen Administration (all routes)" to ensure implementation of a comprehensive care plan for oxygen administration per physician orders. AC of Mechanicsville licensed and agency nurse staff were educated on administering oxygen per patient centered care plan and on how to properly store nasal cannula when not in use. 4. The Director of Nursing or designee will conduct 100% audit of residents on oxygen to ensure administration per physician order and proper storage of nasal cannula, and cleaning of concentrators per facility protocol. These audits will be accomplished weekly x 12 weeks and PRN as indicated to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 16	F 695		

oxygen via the specified route as ordered by the provider....Procedure: 1. Verify provider order...."

On 6/9/21 at approximately 4:00 PM, ASM #1 and #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.

2. Resident #12 was admitted to the facility on 12/1/20 with the diagnoses of but not limited to depression, hypothyroidism, dementia, psychosis, high blood pressure, acute respiratory failure, senile degeneration of the brain and palliative care. The most recent MDS (Minimum Data Set), assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 3/10/21, coded Resident #12 as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, transfers, and toileting; extensive assistance for dressing and hygiene; and supervision for eating.

A review of the clinical record revealed a physician's order dated 3/23/21 for "OXYGEN @ (at) 2LPM (two liters per minute) VIA NASAL CANNULA every shift for SOB (shortness of breath) related to resp failure."

Observations were made of Resident #12's oxygen concentrator as follows:

On 6/8/21 at 12:07 PM, the resident's oxygen concentrator was observed with particles resembling dust and crumbs sitting on a ledge below the flow meter. In addition, the filter on the

Audit results will be presented monthly to the Quality Assurance Performance Improvement committee for review and recommendation.

Date of Compliance: June 28, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 17	F 695		

back of the concentrator was observed partially covered in a white substance appearing to be an accumulation of dust.

On 6/9/21 at 8:15 AM the oxygen concentrator and filter remained unchanged and appeared dirty. Further observation revealed the oxygen rate on the concentrator's flow meter was set at the incorrect rate of 1 liter per minute as evidenced by the ball on the flow meter positioned so that the 1 liter mark on the flow meter passed through the center of the ball.

On 6/9/21 at 2:16 PM, the concentrator was again observed. There was no change regarding the dirty concentrator and filter, and the oxygen flow rate. However, this time, the resident did not have the cannula on. It was in the bed next to the resident. A visitor of the resident stated that she did not have the oxygen on at the moment.

On 6/9/21 at approximately 3:00 PM an interview was conducted with RN #2 (Registered Nurse). RN #2 stated Resident #12's oxygen should be set at 2 liters per minute. At this time RN #2 checked the resident and oxygen concentrator. Observation revealed RN #2 first located and replaced the nasal cannula on the resident. She then checked the oxygen concentrator and stated that it was not set at the right rate, as the ball was positioned on the 1 liter mark. Observation revealed as RN #2 was adjusting the concentrator to set it on the correct flow rate, the flow meter demonstrated a delayed response to the adjusted setting and was slow to indicate if it was on the correct rate. RN #2 stated that this concentrator may have an issue that needs to be addressed by the company that services them. When asked about cleaning the concentrator and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 18	F 695		

cleaning/changing the filter, RN #2 stated that the staff should clean the concentrator but that the company that services the concentrators clean/changes the filters. She stated that staff does not do anything with the filters.

On 6/9/21 at 3:37 PM in a follow up interview with RN #2, she stated that Resident #12's oxygen concentrator was supplied and maintained by her Hospice nurse, and that they (the Hospice company) were being notified of the concern for the dirty filter and possible faulty flow meter.

A review of the comprehensive care plan revealed one dated 12/2/20 for "At risk for altered cardiac/resp (respiratory) status r/t (related to) htn (hypertension - high blood pressure), gerd (gastroesophageal reflux disease), hypothyroidism, sob (shortness of breath) related to resp failure." The interventions included one dated 12/2/20 for "02 (oxygen) as ordered."

A review of the facility policy, "Oxygen Administration" documented, "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by the provider....Procedure: 1. Verify provider order....Cleaning....Clean concentrator external filters weekly...."

A review of the oxygen concentrator manual from hospice documented on page 24 for "Cleaning the Cabinet Filter" documented, "1. Remove the filter and clean as needed. NOTE: Environmental conditions that may require more frequent cleaning of the filters include but are not limited to: high dust, air pollutants, etc."

A review of the oxygen concentrator manual from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 19 hospice did not include any direction on how to properly read the flowmeter. On 6/10/21 at 8:31 AM in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that staff should squat down and observe the flowmeter straight-on at eye level. Regarding cleaning, ASM #2 stated that the facility staff should wipe down and clean a concentrator that is visibly soiled, but that regarding the filters, the facility has the concentrators maintained and nursing does not do anything with the filter. ASM #2 stated that the hospice staff maintains the concentrator provided for hospice residents and that Resident #12's concentrator was provided by hospice. On 6/9/21 at approximately 4:00 PM, ASM #1 and #2 (Administrative Staff Members - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 3. Resident # 61 was admitted to the facility with diagnoses that include but not limited to: asthma, shortness of breath and chronic obstructive pulmonary disease [1]. Resident # 61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/23/2021, coded Resident # 61 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 13	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ___ B. WING ___	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 20	F 695		

for "Oxygen Therapy" while a resident.

On 06/08/21 at 11:40 a.m., an observation of Resident # 61's room revealed an oxygen concentrator running, and Resident # 61 lying in bed watching television. Observation of the nasal cannula connected to the oxygen concentrator revealed it was lying on the floor on Resident # 61's left side.

On 06/08/21 at 12:26 p.m., an observation of Resident # 61's room revealed an oxygen concentrator running. Resident # 61 was lying in bed watching television. Observation of the nasal cannula connected to the oxygen concentrator revealed it was lying on the floor on Resident # 61's left side.

On 06/08/21 at 12:58 p.m., an observation of Resident # 61's room revealed CNA [certified nursing assistant] # 2 entered Resident # 61 room with a lunch tray, set it on the over the bed table and opened containers for Resident # 61 to eat. CNA # 2 was observed standing on Resident # 61's left side of the bed. Further observation revealed an oxygen concentrator running and a nasal cannula connected to the concentrator lying on the floor on Resident # 61's left side.

On 06/08/21 at 2:19 p.m., CNA # 3 was observed leaving Resident # 61's room. Observation of Resident # 61's room revealed an oxygen concentrator running, and Resident # 61 lying in bed watching television. Observation of the nasal cannula connected to the oxygen concentrator revealed it was lying on the floor on Resident # 61's left side.

The physician's order dated 03/24/2021 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 21	F 695		

Resident # 61 documented, "Oxygen 2l/m [two liters per minute] via [by] nc [nasal cannula] [1] every shift for chronic respiratory failure."

The comprehensive care plan for Resident # 61 with a revision date of 03/16/2021 documented in part, "Focus. At risk for altered cardiac/resp [respiratory] status r/t [related to] htn [high blood pressure], hyperlipidemia [high cholesterol], Asthma, gerd [gastroesophageal reflux disease], copd, hypokalemia, respiratory failure Wheezing/SOB [shortness of breath] lying flat, on exertion and at rest." Under "Interventions" it documented in part, "O2 [oxygen] as ordered. Date Initiated: 05/25/2020."

On 06/08/21 at 11:42 a.m., an interview was conducted with Resident # 61 regarding their oxygen use. When asked how often they were to receive oxygen, Resident # 61 stated, "All the time."

On 06/09/2021 at approximately 1:15 p.m., an interview was conducted with CNA # 2 regarding the position of Resident # 61's nasal cannula. When asked how the nasal cannula should be maintained for a resident's oxygen CNA # 2 stated, "It should be in a bag when not in use. If they need to have oxygen it should be on them." When informed of the above observations of Resident # 61's nasal cannula, CNA # 2 stated, that they were not aware that Resident # 61 did not have their oxygen on.

On 06/09/2021 at approximately 1:15 p.m., an interview was conducted with CNA # 3 regarding the position of Resident # 61's nasal cannula. When asked how the nasal cannula should be maintained for a resident's oxygen, CNA # 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 22	F 695		

stated, "When not using it, it should be in a plastic bag, if they don't have it on and they are supposed to, I would go to nurse and let them know." When asked what they would do if they found the nasal cannula on the floor CNA # 3 stated, "I would pick it up and put it in a bag and tell the nurse." When informed of the above observations of Resident # 61's nasal cannula, CNA # 3 stated, "I don't recall the nasal cannula on the floor."

On 06/09/21 at 11:47 a.m., an interview was conducted with RN [registered nurse] # 3, unit manager. When asked how the nasal cannula should be maintained for a resident's oxygen, RN # 3 stated, "If not use it should be inside the protective bag." RN #3 was asked to describe the procedure a CNA is required to follow if they find a resident is not wearing the nasal cannula when they should be receiving oxygen continuously. RN # 3 stated, "They report it to the nurse." When informed of the above observation RN # 3 was asked if they were Resident # 61's nurse on 06/08/2021 and if CNA # 2 or CNA # 3 reported that Resident # 61 was not wearing the nasal cannula therefore not receiving oxygen. RN # 3 stated that they were Resident # 61's nurse on 06/08/2021 and that they were not notified by CNA # 2 or CNA # 3 of Resident # 61 not receiving oxygen. After reviewing the physician's order for Resident # 61's oxygen, RN # 3 stated that Resident 361 should have been receiving it [oxygen] continuously.

On 06/09/2021 at approximately 4:00 P.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, were made aware of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 23 No further information was provided prior to exit. References: [1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	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, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 a complete pain management program for one of 52 residents in the survey sample, Resident #107. The facility staff failed to administer the correct dosage of prn (as needed) oxycodone (1) per physician's order, based on Resident #107's pain rating on 5/14/21. The findings include: Resident #107 was admitted to the facility on 10/13/20. Resident #107's diagnoses included but were not limited to heart disease, high blood pressure and a history of a hip fracture. Resident #107's significant change in status minimum data set assessment with an assessment reference	F 697	F697 Pain Management 1. Comprehensive care plan and prn pain administration orders were reviewed for resident #107 and revisions made to reflect resident's current status. 2. Current residents who reside in Autumn Care of Mechanicsville and receive prn pain medication have the potential to be affected by this deficient practice. Quality review of current residents that receive PRN pain medication was completed by DON or designee to ensure staff administered the correct dosage of PRN pain medication per physician order and per resident's pain rating. 3. Nurses were educated by Director of	6/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 24 date of 5/17/21, coded the resident's cognition as severely impaired. Review of Resident #107's clinical record revealed the following physician's orders: -5/10/21- oxycodone 5 mg (milligrams) - Give 0.5 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain 1-5. -5/10/21- oxycodone 5 mg - Give 1 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain scale 6-10. Resident #107's comprehensive care plan revised on 5/11/21 documented, "At risk for pain r/t (related to) DJD (degenerative joint disease)... right hip incision. Interventions: meds (medications) as ordered..." Review of Resident #107's May 2021 eMAR (electronic medication administration record) revealed Resident #107 was administered 0.5 tablet, instead of one tablet as ordered on 5/14/21 for a pain rating of seven. The nurse who administered the as needed oxycodone to Resident #107 on 5/14/21 was not available for interview during the survey. On 6/9/21 at 1:53 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was shown Resident #107's as needed oxycodone physician's orders and shown Resident #107's May 2021 eMAR that documented the resident was administered 0.5 mg of oxycodone for a pain rating of seven on 5/14/21. LPN #1 stated, "He should have gotten a whole tablet." LPN #1 was asked why it was important to follow Resident #7's as needed oxycodone physician's orders. LPN #1 stated,	F 697	Nursing or designee to policy entitled "Care Plan" and "Pain Management and Pain Protocol" to ensure care plan is followed regarding PRN pain medication administration. AC of Mechanicsville licensed and agency nurse staff were educated on administering PRN pain medication per patient centered care plan. 4. The Director of Nursing or designee will audit 10 medical records of residents who receive PRN medication to ensure residents are free from unnecessary medications. And PRN medications for pain are administered patient pain rating. These audits will be completed weekly x 12 weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: June 28, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 25 "LPNs are not allowed to assess so we have to follow physician's orders. It really takes the guess work out of what you should give." On 6/9/21 at 4:10 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, "Pain Management and Pain Protocol" failed to document specific information regarding pain medication administration. No further information was presented prior to exit. Reference: (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 697		
F 757 SS=D	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	F 757		6/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 757	Continued From page 26 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 52 residents in the survey sample, (Resident #107), was free from unnecessary medication. The facility staff failed to attempt non-pharmacological interventions prior to administering prn (as needed) oxycodone to Resident #107 on 5/12/21. The findings include: Resident #107 was admitted to the facility on 10/13/20. Resident #107's diagnoses included but were not limited to heart disease, high blood pressure and a history of a hip fracture. Resident #107's significant change in status minimum data set assessment with an assessment reference date of 5/17/21, coded the resident's cognition as severely impaired. Review of Resident #107's clinical record revealed a physician's order dated 5/10/21 for oxycodone 5 mg (milligrams) - Give 0.5 tablet by mouth every 6 hours as needed for pain for 7 days. Give for pain 1-5. Resident #107's comprehensive care plan revised on 5/11/21 documented, "At risk r/t (related to) DJD (degenerative joint	F 757	F757 -Drug Regimen is Free from Unnecessary Drugs 1. Comprehensive care plan and prn pain administration orders were reviewed for resident #107 and revisions made to reflect resident's current status. 2. Current residents who reside in Autumn Care of Mechanicsville and receive prn pain medication have the potential to be affected by this deficient practice. Quality review of current residents that have PRN pain medication was completed by DON or designee to ensure residents were free of unnecessary medications Quality review of current residents with PRN pain medication was completed by DON or designee to ensure non-pharmacological interventions were offered prior to administering PRN (as needed) pain medications. 3. Nurses were educated by Director of Nursing or designee to policy entitled "Care Plan" and "Pain Management and Pain Protocol" to ensure care plan is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 757 Continued From page 27

disease)...right hip incision. Interventions: Provide distractions prn such as television, or activities, interaction with others, reading material as able..."

Review of Resident #107's May 2021 eMAR (electronic medication administration record) revealed the resident was administered 0.5 mg of oxycodone on 5/12/21 for a pain rating of three. Further review of Resident #107's clinical record, including the May 2021 eMAR and nurses' notes dated 5/12/21, failed to reveal Resident #107 was offered non-pharmacological interventions prior to the administration of prn oxycodone on 5/12/21.

On 6/9/21 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who administered prn oxycodone to Resident #107 on 5/12/21. LPN #2 was asked what should be done prior to administering prn pain medication. LPN #2 stated nurses should ask the resident his or her pain level, ask the resident why they need the pain medication and document. LPN #2 stated she did not recall attempting/offering non-pharmacological interventions to Resident #107 prior to administering prn oxycodone on 5/12/21.

On 6/9/21 at 1:53 p.m., an interview was conducted with LPN #2. LPN #2 stated a non-pharmacological intervention should be attempted prior to administering prn pain medication because nurses have to attempt to maintain residents' comfort without always pushing a pill in their face.

On 6/9/21 at 4:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above

F 757

being followed regarding PRN medication administration and non-pharmacological interventions.

AC of Mechanicsville licensed and agency nurse staff were educated on administering PRN pain medication per patient centered care plan.

4. The Director of Nursing or designee will audit 10 medical records of residents who receive PRN medication to ensure residents are free from unnecessary medications and to ensure non-pharmacological interventions are used prior to administering pain medication. These audits will be accomplished weekly x 12 weeks and PRN as indicated to ensure ongoing compliance.
Audit results will be presented monthly to the Quality Assurance Performance Improvement committee for review and recommendation.

Date of Compliance: June 28, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 757	Continued From page 28 concern. The facility policy titled, "Pain Management and Pain Protocol" documented, "3. Non-pharmacological interventions will be attempted prior to the administration of PRN pain medications." No further information was presented prior to exit. Reference: (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		6/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842	Continued From page 29 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842 Continued From page 30

determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review, and during the course of a complaint investigation, it was determined the facility staff failed to provide a complete and accurate medical record for two of 52 residents in the survey sample, (Resident #479 and Resident #40). The facility staff failed to provide a complete and accurate medical record of progress notes for Resident #479's Foley catheter being pulled out, reinserted and scratches on the residents fingers while the resident was admitted to the facility for respite care 2/17/21 through 2/22/21, and staff failed to maintain a complete and accurate clinical record documenting activities of daily living tasks completed for Resident #40.

The findings include:

1. Resident #479was admitted to the facility on 2/17/21. Resident #479's diagnoses included but were not limited to: congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), chronic obstructive pulmonary disease (chronic, non-reversible lung disease) (2) and anxiety disorder (acute episode of intense anxiety and feelings of panic) (3).

Resident #479's most recent MDS (minimum data set) assessment, a discharge return not anticipated assessment, with an assessment

F 842

F842 -Resident's Records - Identifiable Information

1. Resident #479 no longer resides in the facility

Comprehensive care plan reviewed for resident #40 and updated to reflect resident's request for activities of daily living.

2. Current residents who reside in Autumn Care of Mechanicsville have the potential to be affected by this deficient practice. Quality review of current residents with a Foley was completed by DON or designee to ensure Foley documentation per policy. Quality review of current residents ADL documentation was completed by DON or designee to ensure complete and accurate medical record.

3. AC of Mechanicsville licensed and agency nurse staff were educated by Director of Nursing or designee to Lippincott Nursing Procedures, "Documentation" regarding importance of providing complete and accurate medical record, complete and accurate medical record of progress. As well as, maintaining a complete and accurate clinical record documenting activities of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842 Continued From page 31

reference date of 2/22/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as extensive assistance with bed mobility, transfers, personal hygiene and bathing; dressing and walking / locomotion limited assistance and supervision for eating. A review of MDS Section H- bowel and bladder coded the resident as frequently incontinent for bowel and indwelling catheter for bladder. A review of MDS Section N-medications coded the resident as zero days (in the previous seven look back days) as receiving antianxiety medications or opioids.

A review of Resident #479's comprehensive care plan dated 2/17/21, documented in part, "FOCUS-The resident has a terminal prognosis. INTERVENTIONS-Observe/assess resident for signs of pain, administer pain medications as ordered and notify physician of any changes."

Review of a FRI (facility reported incident) dated 2/25/21, evidenced documentation in witness statements of the events. On 2/20/21 at 7:30 AM, CNA (certified nursing assistant) #7, documented in part the following, "I went into the bathroom to answer the bathroom emergency bell. Resident reported that he was bleeding from his penis. Resident sitting on toilet with small amount of blood on the floor and in the toilet. Foley catheter and bag was connected to the bed. Resident stated, 'I walked myself to the bathroom.' Resident unable to give further details."
LPN (licensed practical nurse) #6, documented in part, "Catheter was re-inserted, without incident. Urine was slightly blood tinged upon re-insertion, but cleared up later in the shift."

F 842

daily living tasks.

4. The Director of Nursing or designee will audit 20 resident ADL documentation and progress notes to ensure they have a complete an accurate clinical record. These audits will be accomplished weekly x 12 weeks and PRN as indicated to ensure ongoing compliance.
Audit results will be presented monthly to the Quality Assurance Performance Improvement committee for review and recommendation.

Date of Compliance: June 28, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842		F 842		

Continued From page 32

A review of the facility incident form dated 2/22/21 at 8:00 AM, written by LPN #6, documented in part, "Resident was noted to have fresh blood on two fingers. I cleaned fingers with normal saline, patted them dry with sterile gauze, applied skin prep so bandage would stay, and covered them with telfas. New dressings were dated and initialed by writer. Resident was asked what happened to his fingers and he stated 'he started to pick/scratch his knuckle areas'. Physician made aware and approved treatment."

Review of the nursing progress notes failed to evidence documentation of Resident 479's Foley being pulled out / re-inserted and documentation of scratches on fingers.

Attempts were made to interview CNA #7, who was unavailable and LPN #6, who no longer works at the facility.

An interview was conducted on 6/9/21 at 9:36 AM with LPN #8. When asked what events should be documented in the medical record, LPN #8 stated, "We should document any events with the resident where interventions are needed, or if there is a change in condition."

An interview was conducted on 6/9/21 at 11:34 AM with ASM (administrative staff member) #2, the director of nursing. When asked if the statements by staff regarding Resident #479's Foley being pulled out and re-inserted and blood on the residents fingers should be documented in the medical record in addition to the FRI, ASM #2 stated, "Yes".

ASM #1, the administrator and ASM #2, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842		F 842		

Continued From page 33
director of nursing were made aware of the above concern on 6/9/21 at 3:45 PM.

On entrance to the building 6/8/21, ASM #2 stated, "The nursing standard of practice is Lippincott. I will send you the notations."

According to Lippincott Nursing Procedures, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Document information as soon as possible to ensure the accuracy of the information and to reflect ongoing care. Delayed documentation increases the potential for omissions, errors and inaccuracy due to memory lapse." (4)

No further information was provided prior to exit.

Complaint Deficiency.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 42.
(4) Lippincott Nursing Procedure, 6th edition, Wolters Kluwer, pages 230.
2. Resident #40 was admitted to the facility with diagnoses that included but were not limited to heart failure (1) and chronic obstructive pulmonary disease (2). Resident #40's most recent MDS (minimum data set), an annual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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 842	Continued From page 34	F 842		

assessment with an ARD (Assessment Reference Date) of 4/8/21 coded Resident #40 as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (Brief Interview for Mental Status). Section G coded Resident #40 as requiring extensive assistance of one person for bed mobility, transfers, dressing, toileting and personal hygiene. It further coded Resident #40 being totally dependent on staff for bathing.

On 6/8/2021 at approximately 11:30 a.m., an interview was conducted with Resident #40 in their room. Resident #40 was observed lying in bed dressed in a hospital gown. Resident #40 stated that he had requested to get out of bed and was waiting for the CNA (certified nursing assistant) to come back to assist him out of bed. Resident #40 stated that the CNA had been in earlier and "cleaned him up" but did not have time to get him up at that point so was coming back later.

On 6/8/2021 at approximately 2:00 p.m. and 3:45 p.m., Resident #40 was observed in bed wearing the hospital gown. Resident #40 stated that the CNA had come back in to "change him" but had not gotten him out of bed yet.

On 6/9/2021 at approximately 8:30 a.m., Resident #40 was observed in bed wearing the hospital gown. Resident #40 stated that staff had not assisted him out of bed on 6/8/2021. Resident #40 stated that he was getting ready to go to the shower and get up for the morning.

On 6/9/2021 at approximately 10:00 a.m., Resident #40 was observed dressed and out of bed in a wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842	Continued From page 35	F 842		

The Documentation Survey Report dated "April 2021" failed to evidence documentation for the following activities of daily living tasks on the following dates:
- "ADL- Dressing." On 4/6/21, 4/11/21, 4/14/21, 4/15/21, 4/16/21 and 4/30/21.
- "ADL- Mouth Care." Days on 4/2/21, 4/6/21, 4/8/21, 4/11/21, 4/14/21, 4/15/21, 4/16/21, 4/17/21, 4/19/21, 4/20/21, 4/22/21 and 4/30/21. Evenings on 4/1/21, 4/3/21, 4/6/21, 4/11/21, 4/12/21, 4/14/21, 4/15/21, 4/16/21, 4/18/21, 4/24/21 and 4/27/21.
- ADL- Personal Hygiene." Days on 4/1/21, 4/2/21, 4/6/21, 4/8/21, 4/11/21, 4/14/21, 4/15/21, 4/16/21, 4/17/21, 4/19/21, 4/20/21, 4/22/21 and 4/30/21. Evenings on 4/1/21, 4/3/21, 4/6/21, 4/11/21, 4/12/21, 4/15/21, 4/16/21, 4/18/21, 4/24/21, 4/27/21, 4/29/21 and 4/30/21. On nights on 4/4/21, 4/7/21, 4/13/21, 4/14/21, 4/15/21, 4/16/21, 4/19/21, 4/20/21, 4/21/21 and 4/29/21.

The Documentation Survey Report dated "May 2021" failed to evidence documentation for the following activities of daily living tasks on the following dates:
- "ADL- Mouth Care." Days on 5/3/21, 5/4/21, 5/8/21, 5/9/21, 5/11/21, 5/13/21, 5/14/21, 5/15/21, 5/19/21, 5/22/21, 5/23/21, 5/28/21, 5/29/21 and 5/31/21. Evenings on 5/1/21 and 5/21/21.
- ADL- Personal Hygiene." Days on 5/3/21, 5/4/21, 5/8/21, 5/9/21, 5/11/21, 5/13/21, 5/14/21, 5/15/21, 5/19/21, 5/22/21, 5/23/21, 5/28/21, 5/29/21 and 5/31/21. Evenings on 5/1/21 and 5/21/21. Nights on 5/1/21, 5/6/21, 5/8/21, 5/10/21, 5/17/21, 5/19/21, 5/20/21, 5/21/21, 5/22/21, 5/25/21, 5/27/21, 5/28/21, 5/29/21 and 5/31/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842		F 842		

Continued From page 36

The Documentation Survey Report dated "June 2021" failed to evidence documentation for the following activities of daily living tasks on the following dates:
- "ADL- Dressing." On 6/7/21.
- "ADL- Mouth Care." Days on 6/1/21, 6/5/21, 6/6/21 and 6/7/21. Evenings on 6/2/21, 6/3/21 and 6/7/21.
- ADL- Personal Hygiene." Days on 6/1/21, 6/5/21, 6/6/21 and 6/7/21. Evenings on 6/2/21, 6/3/21 and 6/7/21. Nights on 6/3/21, 6/4/21, 6/5/21 and 6/7/21.

The comprehensive care plan dated 5/18/2021 for Resident #40 documented in part, "Needs assistance with ADL's (activities of daily living) muscle weakness. History of at times refuses TML (patient lift equipment) for transfer. Date Initiated: 08/12/2019. Revision on: 11/20/2020."

On 6/9/2021 at approximately 12:45 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the unit manager. LPN #1 stated that on 6/8/2021 Resident #40 had requested to get out of bed during the lunch service and they were unable to get him up at that time because they were serving the other residents. LPN #1 stated that they had personally spoken to Resident #40 after lunch to offer him to get out of bed and he had refused. LPN #1 stated that normally Resident #40 was up each day and ate meals in the dining room but he had refused to get up prior to lunch that day. LPN #1 stated that the CNAs documented their care in the computer in the tasks including refusals of care. When asked what the blank areas on the task summary meant, LPN #1 stated that the CNA probably did not get a chance to document the care provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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 842	Continued From page 37	F 842		

On 6/09/2021 at approximately 1:20 p.m., an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 stated that residents were bathed every day and received showers twice a week at a minimum. CNA #6 stated that all residents were offered the opportunity to get out of bed each day. CNA #6 stated that Resident #40 required two staff members present during transfers for safety and at times this delayed him getting up with them having to find a CNA who was available to assist them. CNA #6 stated that on 6/8/2021 Resident #40 had refused to get out of bed in the morning during their rounds and then requested to get out of bed when the lunch service was beginning. CNA #6 stated that Resident #40 had not wanted to get out of bed after the lunch service was over and they had respected his choice. CNA #6 stated that all ADL's were completed each day on residents and evidenced by signing off in the computer on the tasks. When asked what the blank spaces on the task summary meant, CNA #6 stated that they meant the CNA had forgotten to document the care provided.

On 6/9/2021 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on documentation in the medical record.

On 6/10/2021 at 7:15 a.m., ASM #2 provided the document, "Lippincott's Nursing Procedures Sixth Edition" pages 230 and 232. It documented in part, "...Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows the extent and quality of the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 842	Continued From page 38	F 842		

Continued From page 38

that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors..." It further documented, "...Document information as soon as possible to ensure the accuracy of the information and to reflect ongoing care..." and "...If information listed on a form doesn't apply to your patient, write N/A (not applicable) rather than leaving the space blank..."

On 6/9/2021 at approximately 10:05 a.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.

Reference:

1. Heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

2. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.