STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 The unannounced Emergency Preparedness survey was conducted on 04/12/22 through 04/15/22. Corrections are required for compliance with the Emergency Preparedness requirements and with 42 CFR 483 Federal Long Term Care requirements. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 006	Continued From page 1	E 006		

facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.
(2) Include strategies for addressing emergency events identified by the risk assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 006	Continued From page 2 The findings included: During an interview on 04/14/22 at 11:15 A.M. with the Maintenance Director, Administrator and the Regional Vice President of Operations, the Administrator was asked for documentation of the facility's community based risk assessments that will assist the facility in addressing the needs of their patients. The Administrator stated the facility had not conducted an updated risk assessment for COVID 19 of it's emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan for COVID 19 had not been updated since 03/30/20.	E 006		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical	E 015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 015	Continued From page 3	E 015		

supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure adequate energy sources as well as provide for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 015	Continued From page 4 sewage and waste disposal. The findings included: During an interview on 04/14/22 at 11:27 A.M. with the Administrator, Vice President of Regional Operations (VPRO) and the Maintenance Director they were asked for documentation of the facility's policies and procedures to ensure adequate energy sources were maintained during an emergency as well as provide for sewage and waste disposal. The Maintenance Director and the VPRO, stated the facility did not have contract services to ensure alternate energy sources for sewage disposal. There was no Fire Watch Program presented for fire detection and staff training. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 03/30/20.	E 015		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 030	Continued From page 5 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 030	Continued From page 6 (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure an updated Communication Plan.	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 030	Continued From page 7 The findings included: During an interview on 04/14/22 at 11:53 A.M. with the Administrator, Vice President of Regional Operations (VPRO) and the Maintenance Director they were asked for documentation of the facility's Communication Plan documentation to ensure the communication plan included the names and contact information for Staff. A list of 55 staff names were presented for emergency contact information. A random selection of four staff names and contact information indicated that three of the four listed named employees no long were employed by the facility. The Maintenance Director, VPRO and Administrator, stated the facility had not updated the communication plan for employee contact information.	E 030		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 035	Continued From page 8 and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's communication plan which provides a means of sharing information with residents and family's. The findings included: During an interview on 04/14/22 at 12:20 P.M. with the Administrator, VPOR and the Maintenance Director they were asked for documentation of the Emergency Preparedness Communication Plan to provide a means of sharing information about the facility's Emergency Preparedness Plan with residents and family's. The Administrator stated the facility had included the communication notification plan in the admissions package for new admits. A review of the admissions package did not indicate information of the the facility's Emergency Preparedness Plan to include sharing information about the facility's Emergency Preparedness Plan with residents and family's.	E 035		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d),	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 036	Continued From page 9	E 036		

§441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).

*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 036	Continued From page 10	E 036		

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to have documentation of the facility's written training and testing program.

The findings included:

During an interview on 04/14/22 at 12:58 P.M. with the Administrator, VPRO and the Maintenance Director they were asked for documentation of the Emergency Preparedness Plan written training and testing program. Four staff names were provided to the facility staff for documentation of Emergency Preparedness training and testing program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 036	Continued From page 11 The Administrator and the Maintenance Director stated the facility had not implemented a written training and testing program.	E 036		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/12/22 through 4/15/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey: VA00053153 was substantiated with a deficiency and VA00054774 was unsubstantiated, lack of sufficient evidence. The census in this 108 certified bed facility was 91 at the time of the survey. The survey sample consisted of 38 current and closed Resident/record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 578	Continued From page 12	F 578		

residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record reviews and facility documentation review, the facility staff failed to ensure 2 of 38 residents in the survey sample, (Resident #10 and #33) were given the opportunity to formulate an advance directive.

The findings included:

1. The facility staff failed to ensure Resident #10 and or their Representative was given the opportunity to formulate an Advance Directive. Resident #10 was originally admitted to the nursing facility on 03/06/19. Diagnosis for Resident #10 included but not limited to Chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 578	Continued From page 13	F 578		

Obstructive Pulmonary Disease (COPD).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 04/14/22 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

Review of the clinical record revealed that there was no Advance Directive for Resident #10.

Review of Resident #10's Physician Order Sheet (POS) for April 2022 revealed the following order: Do Not Resuscitate (DNR) starting on 03/01/21.

An interview was conducted with the Social Worker on 04/13/22 approximately 3:59 p.m., who said an Advance Directive should have been completed upon admission then updated yearly. When asked if there was evidence that Resident #10 and or their Representative was given the opportunity to formulate an Advance Directive, she replied, "No."

On 04/14/22 at approximately 10:40 a.m., an interview was conducted with the Director of Nursing (DON) and Regional Director of Clinical Services who stated, Resident #10 and or their representative should have been given the opportunity to formulate an Advance Directive. The DON was asked what is the purpose of an Advance Directive. She stated, "In the event the resident becomes incapacitated, the medical professionals will know what the resident wishes are or who to contact in that event."

A debriefing was held with the Administrator, Director of Nursing,, Vice President of Operations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 578	Continued From page 14	F 578		

and Regional Director of Clinical Services on 04/14/22 at approximately 4:32 p.m., who were informed of the above findings; no further information was provided prior to exit.

Definitions:
-COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing (https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes).

2. The facility staff failed to execute the opportunity to provide an advance directive for Resident #33. Resident #33 was originally admitted to the facility 08/02/2019 after an acute care hospital stay. The current diagnoses included; Unspecified Psychosis not due to a substance or known physiological condition and Acquired absence of the left leg above the knee.

The Quarterly Revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/16/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #33 cognitive abilities for daily decision making were intact.

In section"G"(Physical functioning) the resident was coded as independent with no set- up help in bed mobility, transfers, locomotion on and off the unit and toilet use. Requiring set-up help only in personal hygiene, eating and bathing.

A review of the clinical record on 4/14/22 revealed there was no advance directive in the clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 578	Continued From page 15 record on the above resident or that the resident was offered an opportunity to create one. On 4/14/22 at approximately 2:00 PM., an interview was conducted with OSM (Other Staff Member) #3 concerning the above issue. She stated, " It wasn't done. I can't find it." On 4/15/2022 at approximately 1:15 PM., the above findings were shared with the Administrator, The Corporate Consultant, The DON and with the ADON. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on employee record review, facility document review and staff interviews the facility staff failed to implement their Abuse/Neglect Prevention Policy for screening of new employees. Criminal Background Checks were not obtained for 5 current employees 2 of which	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 16	F 607		

were agency staff within 30 days of their hire date and Sworn Statements were not obtained for 2 current agency staff employees upon hire.

The findings included:

On 4/13/22 twenty-five current employee records were reviewed. The employee record review revealed that 5 current employees 2 of which were agency staff did not have a Criminal Background Checks. There were also 2 current agency staff employees that had no Sworn Statements upon hire.

On 4/13/22 at 1:00 p.m. an interview was conducted with the Director of Human Resources regarding the missing employee Criminal Background Checks and Sworn Statements. The Director of Human Resources stated, "I know I ran them but I can't find them. I called the agency and spoke with the owner. The owner said that they were independent contractors and use a different company for the criminal background checks not the Virginian State Police. The also said they did not have the sworn statements for their 2 employees either. I will get it taken care of."

The facility policy titled "Contractor and Vendor Background Screening" last revised 3/2/2017 was reviewed and is documented in part as follows:

Policy: It is the policy of Saber to undertake background checks of all vendors and contractors to the fullest extent required by applicable law, and to retain on file applicable records of current contractors and vendors regarding such investigations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 17 B. All contractors and vendors must certify that they have not been convicted of any offense that would preclude them from providing items and services in a nursing facility. The facility policy titled "Virginia Resident Abuse Policy" last revised 5/26/2021 was reviewed and is documented in part, as follows: Policy: This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Procedure: 1. Screening: It is the policy of the facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The facility will do the following prior to hiring a new employee: iv. Conduct a criminal background check in accordance with State law and facility policy. On 4/13/21 at 3:00 p.m. a pre-ext debriefing was held with the Administrator and the Vice President of Operations regarding the missing employee Criminal Background Checks and Sworn Statements. The Administrator was asked what is the importance of the obtaining the Criminal Background Checks and Sworn Statements upon hire for all employees. The Administrator stated, "To ensure we do not hire staff with criminal records in order to keep our residents and other staff safe."	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 18	F 610		

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on a closed record review, staff and family interviews, and a complaint investigation, the facility staff failed to thoroughly investigate an incident of an injury of unknown source for one resident (Resident #89) in the survey sample of 38 residents.

The findings included:

Resident #44 was admitted to the facility on 01/07/20 with diagnoses which included coronary artery disease, dementia, benign prostatic hyperplasia and COPD. Resident #89 was sent out to the hospital with a change of condition and being unresponsive to verbal and tactile stimuli. This resident was identified as having a large subdural hematoma of unknown source.

A 10/15/21 Quarterly Minimum Data Set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 19	F 610		

assessed this resident in the area of Cognitive Pattern - Brief Interview for Mental Status (BIMS) as having a score of 15. This resident was assessed as requiring extensive assistance of one person in the areas of bed mobility, transfer, dressing and personal hygiene.

A care plan dated 10/17/21 assess Resident #89 as-
Focus: - Self care deficit- Goal- Will increase ability to provide own care needs. intervention: Assist with activities of daily living, dressing, grooming. toileting and oral care.

A Nursing Progress Note dated 11/14/21 at 1:09 (Late Entry) indicated: " After eating breakfast resident became unresponsive is not responding to verbal or tactile stimuli. Resident appears to be in a daze, staring into space. The , resident nonverbal at this time and drooling, will not obey commands, NP made aware with order to sent (sic) to ER, all paperwork sent with transport including careplan and bed hold policy, family notified."

A Interact SBAR summary dated 11/14/2021 1:08:45 (Late Entry) indicated: The change of condition/s reported on this CIC Evaluation are/were: Altered mental status Unresponsiveness at the time of evaluation resident/patient vital signs, weight and blood sugar were:
Blood Pressure: BP 119/86-11/14/21 09:00 position: lying l/arm
Pulse: P 81- 11/14/21 09:00 Type Regular - RR R-18.0 -11/14/21 09:00
Temp: T 97.9 - 11/14/21 09:00 Route: Oral
Weight: W 118.0 lb - 11/2/2021 - 09:58 Scale-Mechanical lift scale

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 20	F 610		

Pulse Oximetry: O 2 98.0 %- 09:00 Method: Room Air
Blood Glucose: Resident/Patient is in the facility for: Long Term Care
Primary Diagnosis is: Transient Cerebral Ischemic Unspecified
Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse)
Nursing observations, evaluation, and recommendations are Primary Care Provider Feedback:
Primary Care Provider responded with the following feedback:
A- Recommendations: Send to ER
B- New Testing Orders
C- New Intervention Orders

An EMT Patient Care Report dated 11/14/21 indicated: Incident Date/Time 11/14/21 08:54:29- address facility-
Information: Obtained from Health Care Personnel
Medical History: Dementia: Anemia; Neutropenia- Transient ischemic Attack (TIA)
Narrative: "Arrived on scene pt was in care of nurse gave staff (sic). Called because pt had altered mental status. Pt has dementia and is confused at baseline and is "wanderer". Staff stated pt had an episode of staring off and drooling and was not responding. On arrival pt was alert but confused. Pt turned over to RN at hospital."

Patient Complaints:
Complaint: Altered mental status
Duration of Complaint:
Not Reporting
Protocols Used: Altered mental Status-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 21	F 610		

Airways/Oxygenation/Ventilation

Incident Times:
PSAP Call- 11/14/21 08:49:27
Unit arrived at Scene 11/14/21 08:59:09
Unit left Scene 11/14/21 09:08:41
Patient Transfer Time- - Turn-Around Delay- None/No Delay
Destination_ Hospital (Reason- Closest Facility)."

ED Record - Comment:
Clinical Impression: Diagnosis- SDH (subdural hematoma) (HCC) Altered mental status, unspecified altered mental status type.

Diagnostic Study Results:
CT with large subdural with 1.2 cm of shift.

A Hospital ED Record dated 11/14/21 indicated:
"Arrival Date/Time 11/14/21 09:16, Resident #89 name. Emergency Department History and Physical Exam: 11/14/21 09:21 AM
Chief Complaint:
"Resident #89 is a 88 year old male past medical history of TIA's advanced dementia presents for transient alteration of awareness. Patient was seen in the nursing home and went unresponsive and was drooling. Unclear if he lost postural tone or not. EMS states he was normal just prior to that making his last known well time probably around 8:30 AM. Patient now arrives without complaint has baseline confusion but is oriented to self ad he feels pretty good."

Medical Decision Making:
Discussed with neurosurgery requested mannitol at 1 mg/kg and request transfer to another hospital.
Critical Care Time:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 22	F 610		

The services provided to this patient were to treat and/or prevent clinically significant deterioration that could result in the failure of one or more body systems and/or organ systems due to SDH with shift and mental status change.

Pt transferred to other hospital ER via ambulance. Stable at the time - date of service 11/14/21 1530 (3:30 PM)."

Hospital #2 notes indicated: "Arrived at Hospital 11/14/21 at 1550 (3:50 PM). Admitted with Subdural hematoma (HCC). Pt requires access to a telemetry box."

Hospital Course: "Pt was admitted with acute hypoxic respiratory failure, suspect due to aspiration so he was started on abx (antibiotic). CT was done for his altered mental status and he was found to have a large right hemispheric subacute subdural hematoma with 12 mm midline shift and Stable, small left frontal subacute subdural hematoma without significant mass effect but with brain compression. PC consulted to discuss goals of care given poor prognosis and pt was transitioned to hospice. Pt eventually expired on 11/27/21."

During an interview on 04/15/22 at 9:59 AM with the Authorized Representative (AR) she stated, the facility had called her on 11/14/21 around 9:00 AM and informed her that Resident #89 was being sent to the hospital. The RP stated, she went to the hospital and observed Resident #89 slumped over in wheelchair. He was responding to her when she got to the hospital. The AR stated, she had taken care of Resident #89 for 9 years. She stated, she contacted the nursing home and the patient has been wheelchair bound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 23	F 610		

with severe generalized weakness for the past 2 weeks unclear if he had a fall at that time but when she took him to the VA 1 month ago he was able to ambulate and that he was oriented x 3.

During an interview on 4/14/22 at 2:13 PM with Licence Practical Nurse (LPN #5) she was asked what condition was Resident #89 in when she sent him out. LPN #5 stated, it was a Sunday morning after breakfast and she could not remember his condition or why he was sent out. She said she could not remember if Resident #89 hand any injuries or had fallen.

During an interview on 04/15/22 at 1:18 PM with the Director of Nursing (DON) she stated, "We called to the hospital and was told he was being admitted for hemorrhage." The DON was asked did the facility staff conduct an investigation or file a Facility Reported Incident (FRI). The DON stated, "No."

The DON was asked if the hospital had made them aware that Resident #89 had a large subdural hematoma which was the source of the hemorrhage and she stated, "yes, the hospital made the staff aware."

A facility policy and procedure revised 05/26/21: Definitions: Injury of Unknown Source: "An injury is classified as an "Injury of Unknown Source" when both the following conditions are met:
a. The source of the injury is classified was not observed by any person, or the source of the injury could not be explained by the resident;and
b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 24	F 610		
	Complaint Deficiency			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 622	Continued From page 25	F 622		

exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 622	Continued From page 26	F 622		

(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan to include their goals after being transferred and admitted to the hospital for one resident (Resident #35) in survey sample of 38 residents.

The findings included:

Resident #35 was admitted to the facility 9/26/1991 and readmitted to the facility on 2/05/2022. Diagnoses for Resident #35 include: Contracture, unspecified and Quadriplegia, unspecified.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/21/2022 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was not conducted. Resident's cognitive skills for decision making were coded as severely impaired for daily decision making.

A review of the clinical record show that Resident #35 was admitted to the hospital from 2/05/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 622	Continued From page 27 through 2/15/22 due to a clogged Foley catheter. On 04/14/22 at approximately 4:15 PM., an interview was conducted with the DON (Director of Nursing) concerning the above issue. She said that they can't find evidence that a care plan was sent. On 4/14/22 at approximately 4:35 PM., an interview was conducted with LPN (Licensed Practical Nurse) #1 concerning the above issue. She stated, "The documents are sent with the residents in a checklist folder. We also write a note in PCC (Point Click Care) saying we sent all of the documents." A review of the facility's documentation show that no care plan to include goals were sent with the resident to the hospital. On 4/15/2022 at approximately 1:15 PM., p.m., the above findings were shared with the Administrator, The Corporate Consultant, The DON and with the ADON. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 623	Continued From page 28	F 623		

representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 623	Continued From page 29	F 623		

transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 623	Continued From page 30	F 623		

written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 1 of 38 residents (Resident #88, a closed record resident) in the survey sample.

The findings included;

Resident #88 was originally admitted to the facility on 07/16/2010 and discharged on 2/23/2022 to an acute care facility. The current diagnoses included; Anemia and Coronary Artery Disease.

The quarterly Revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/12/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility. Requires total dependence of two person's physical assist with transfers. Requires total dependence of one person physical assist with bathing, locomotion on and off the unit and with toilet use. Requiring extensive assistance of one person with dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 623	Continued From page 31 and personal hygiene. Independent set-up help only with eating. The Discharge MDS assessments was dated for 2/19/2022 - discharged with return anticipated. According to the facility's documentation, on 2/19/2022 Resident #88 was transported to the local hospital. According to the facility's documentation on 2/21/22 Resident #88 was admitted back to the facility from the local hospital. A review of the Monthly List of Emergency Transfers for March 2022 does not include Resident #88's name on the list. On 4/15/22 at approximately 1:15 PM an interview was conducted with OSM (Other Staff Member/Social Worker) #3 concerning The Ombudsman Notification. She stated, "The Ombudsman Notification was not sent." On 4/15/2022 at approximately 1:15 PM., p.m., the above findings were shared with the Administrator, The Corporate Consultant, The DON and with the ADON. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32	F 657		

the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to revise 1 of 38 residents (Resident #10) comprehensive personal-centered care plan in the survey sample.

The findings included:

The facility staff failed to revise Resident #10's comprehensive person centered care plan to include her current code status of Do Not Resuscitate (DNR). Resident #10 was originally admitted to the nursing facility on 03/06/19. Diagnosis for Resident #10 included but not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 33	F 657		

limited to Chronic Obstructive Pulmonary Disease (COPD).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 04/14/22 coded the resident with a 02 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

Review of Resident #10's Physician Order Sheet (POS) for April 2022 revealed the following order: Do Not Resuscitate (DNR) starting on 03/01/21.

Resident #10's person-centered comprehensive care plan created on 03/07/19 document the resident/Responsible Party has chosen Full Code.

On 04/13/22 at approximately 8:58 a.m., an interview was conducted with the Social Worker and MDS Coordinator. When asked who is responsible for update/revising the Advance Directive/code status on the care plan. The MDS Coordinator stated, "The Social Worker is responsible for updating that portion of the care plan." On the same day at approximately 9:40 a.m., the MDS Coordinator presented a revise care plan.

Resident #10's person-centered comprehensive care plan with a revision date of 04/13/22 document the resident/Responsible Party has chosen DNR. The goal set for the resident by the staff was that the resident code status wish will be honored. Some of the interventions/approaches the staff would use to accomplish this goal is to notify the physician of any changes, if resident/responsible party

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 34	F 657		

chooses to change code status, necessary protocol will be completed as evidence of new order, update documentation/care plan and review code status annually, quarterly and as needed.

A debriefing was held with the Administrator, Director of Nursing, Vice President of Operations and Regional Director of Clinical Services on 04/14/22 at approximately 4:32 p.m., who were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled Comprehensive Care Planning - revised on 07/19/19. An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal requirements and on an as needed basis.

-Procedure include but not limited to:
P) The MDS Coordinator is responsible for reviewing and updating the Resident Assessment (MDS) as well as the previous plan of care prior to the scheduled Resident Care Plan conference.

S) Adjustments are made by the interdisciplinary team to ensure that all programs and identified category of needs are addressed and that the plan is oriented toward preventing a decline in functioning. Plans for discharged are viewed, revised and addressed accordingly.

V) The MDS Coordinator is to review the 24-Hour Report daily for significant changes or changes in resident's ADL status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on a daily basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 661	Continued From page 35	F 661		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, family interview, staff interview, and clinical record review, the facility staff failed to convey at the time of discharge a summary which include instructions to care for 1 of 38 residents (Resident #88B's), stage 2	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 661	Continued From page 36	F 661		

pressure ulcer and cluster wound.

The findings included:

Resident #88B was originally admitted to the facility 5/26/21 after an acute care hospital stay and discharged home 6/15/21. The resident's diagnoses included; a stroke, aphasia, dysphagia, right hemiparesis, and coronary artery disease.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/1/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #88B's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with personal hygiene, dressing, bathing, toileting and locomotion, extensive assistance of one person with transfers and eating, and extensive assistance of two people with bed mobility. Section "H0100" Bowels and Bladder; the resident was coded as utilizing an indwelling catheter. In section M0100 (Skin Disorders) the Resident was coded as having no pressure ulcer, a scar over bony prominence, or a non-removable dressing/device. M0150 - Resident was coded as at risk of developing pressure ulcers.

An interview was conducted with Resident #88B's daughter on 4/14/22 at approximately 2:05 p.m. The daughter stated during the period of time of her mother's stay in the facility the family wasn't allowed to enter the facility therefore she wasn't aware of her mother's exact needs. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 661	Continued From page 37	F 661		

daughter stated the Social Worker (SW) arranged transport by car for 6/15/21 but she learned during the transfer attempt that her mother was unable to be transported by car therefore the facility staff obtained transport by an ambulance resulting in a 6:00 p.m., discharge instead of the planned 1:00 p.m., discharge. The daughter also stated the medical equipment determined necessary by the facility staff had been delivered the day before her mother's discharge and the SW assured her that the order for home health services had been sent to the agency and all prescriptions were at the designated pharmacy.

Review of the wound care physician's progress note dated 6/15/22 revealed the following; the wound to the left medial buttock resolved on 6/15/2021 but the right buttock unstageable DTI and the right medial buttock cluster wound remained unhealed. The order for the right buttock DTI was changed on 6/15/22 to, cleanse the right buttock unstageable DTI with Seaclens, apply skin prep to the wound bed and cover it with a dressing every day beginning 6/16/22. The right medial buttock cluster wound was debrided 6/15/22 and the wound order continued as written for house barrier cream twice daily.

Review of the discharge summary document given to the resident and her daughter on 6/15/22 revealed the above wound care orders were not included on the discharge document. The wound care section was completely blank. Also review of the physician's discharge summary documentation revealed the following information regarding Resident #88B's skin; warm, dry, no rashes or ulcers visualized.

On 4/15/22 at approximately 1:00 p.m., the above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 661	Continued From page 38 information was shared with the Administrator, Director of Nursing, Regional Director of clinical Services and Regional Director of Operations. The Regional Director of Operations stated the wound care instructions should have been documented on the discharge instructions but they had no evidence the wound care instructions were provided at the time of Resident #88B's discharge home.	F 661		
F 684 SS=D	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to obtain weights and labs necessary for management of acute on chronic hypoxic and hypercapnic respiratory failure due to CHF and COPD exacerbations for 1 of 38 residents (Resident #61), in the survey sample. The findings included: Resident #61 was originally admitted to the facility	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39	F 684		

1/5/21 and readmitted 3/28/22 after an acute care hospital stay. The current diagnoses included; obstructive sleep apnea (OSA)congestive Heart failure (CHF), chronic obstructive pulmonary disease (COPD) and post COVID-19.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) 3/18/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #61's cognitive abilities for daily decision making were intact.

In section "G" (Physical functioning) the resident was coded as requiring total care of two with transfers, total care of one with locomotion in room and toileting, extensive assistance of two with bed mobility, extensive assistance of one person with locomotion off the unit, personal hygiene and dressing, help with bathing, and independent after set-up with eating.

During the initial tour on 4/12/22 at approximately 12:25 p.m., the resident was observed receiving oxygen therapy at 3 liter per minute by nasal cannula, and with a nebulizer machine and C-pap at her bedside.

An interview was conducted with Resident #61. She stated she had been to the hospital three times recently for problems breathing and there were more flare-ups since having COVID-19. The resident also stated the hospital physician's stated her problems were related to congestive heart failure and COPD not another case of COVID-19. The resident was with a cough during the interview but capable of conversation without breathing problems

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40	F 684		

Review of the hospital's discharge summary revealed the resident was admitted to the hospital 1/24/22 - 1/27/22, 2/11/22 - 2/14/22 and 3/22/22 -3/28/22 for shortness of breath. The 1/27/22 hospital's discharge summary read the resident was admitted for acute on chronic hypoxic and hypercapnic respiratory failure due to CHF and COPD exacerbation. The 2/14/22 discharge summary read the resident was admitted for acute on chronic hypoxic and hypercapnic respiratory failure due to CHF and COPD exacerbation. The 3/28/22 discharge summary revealed the resident was admitted to the hospital for an acute exacerbation of COPD.

Review of the clinical record revealed upon readmission 3/28/22, Resident #61 had the following order; weigh on admission, for 3 days afterwards and then weekly for 4 weeks. Review of the clinical record revealed Resident #61's admission weight on 3/28/22 was 302 pounds, 3/29/22, 302 pounds, 3/30/22 311.4 pounds, 311.4 pounds on 3/31/22 and 311.4 pounds on 4/1/22. A practitioner's progress note dated 4/8/22 read continue weight 3 times each week.

Basic Metabolic Panels (BMP) were ordered for 4/1/22, 4/4/22, 4/7/22 and 4/11/22 for CHF. The 4/1/22 and 4/11/22 labs weren't available on the clinical record for review and there was no weight documentation available for 4/4/22.

An interview was conducted with the Licensed Practical Nurse (LPN) on 4/14/22 at approximately 11:10 p.m. LPN #2 stated she had no information regarding the undocumented information regarding the weights and labs but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

she would get the information and get back with me.

An interview was conducted with the Director of Nursing (DON) on 4/14/22 at approximately 12:00 p.m. The DON stated she had no additional information regarding the the missing weights for Resident #61 but; the DON stated the 4/1/22 lab was completed and she obtained it directly from the laboratory. She stated she couldn't attest the practitioner was aware of the results but the DON provided a progress note written by the practitioner on 4/8/22 in, it included lab results from the 4/4/22 and 4/7/22 lab draws but not the 4/1/22 results. The progress note also stated the plan was to increase the potassium to 40 mEq two times each day for 4 days then resume 20 mEq two times each day. Repeat BMP next week, Continue Lasix 40 mg two times daily and Metolazone 2.5 mg 3 times a week. Continue to weigh 3 times a week. The DON stated the 4/11/22 results weren't available because the staff didn't process the order in the system for the lab to be obtained.

An active order to weigh the resident 3 times a week related to CHF, was not on the active physician order summary on or before 4/8/22.

Review of the active care plan revealed a problem with a revision date of 08/12/2021 (name of resident) requires oxygen and C-pap on at bedtime for CHF, COPD, and OSA. The goal read; Residents oxygen levels will be kept as desired levels per MD orders through next review, 6/17/22. The interventions included; medications as ordered, monitor lung sounds as ordered and as needed. Observe for signs and symptoms of dyspnea; labored respirations, low O2 sats, use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42 of accessory muscles, cyanosis, change in mental status, and tachypnea. There was no care plan for management of CHF and COPD related to the three hospitalizations secondary to acute on chronic hypoxic and hypercapnic respiratory failure due to exacerbations. On 4/13/22, Resident #61 continued with periods of shortness of breath and cough requiring an evaluation by the practitioner. The chest x-ray obtained 4/12/22 revealed pneumonia of bilateral lower lobe. Antibiotic therapy was ordered 4/13/22. On 4/15/22 at approximately 1:00 p.m., the above information was shared with the Administrator, Director of Nursing, Regional Director of clinical Services and Regional Director of Operations. The Facility's staff offered no further information regarding the above information.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 43	F 686		

new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review, and review of facility documents, the facility staff failed to ensure one resident (Resident #38) entering the facility did not develop pressure ulcers unless they were unavoidable. For Resident #38, the facility failed to identify two pressure ulcers prior to being found at an advanced stage (unstageable), which constituted in harm. For Resident #58, the facility staff failed to provide care and services to prevent pressure ulcer development and to identify a left heel pressure ulcer prior to progression to an advanced stage (stage 3) which constituted harm. For Resident #88B, a new stroke victim who required total care for all activities of daily living (ADL), the facility staff failed to provide care and services to prevent development of an unstageable deep tissue injury (DTI) of the right buttock. The survey sample consisted of 38 residents.

The findings included:

1. The staff failed to identify Resident #38's pressure ulcer to his left and right heel prior to being found at an advanced stage (unstageable) which constituted in harm. The first wound was to the left heel, identified on 11/15/21 as an unstageable pressure ulcer measuring 3 cm x 3.5 cm; appearance necrotic/black. The second pressure ulcer was to the right heel, identified as an unstageable pressure ulcer measuring 3 cm x 2.7 cm; appearance necrotic/black.

Resident #38 was originally admitted to the facility on 08/24/21. Diagnoses for Resident #38

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 44	F 686		

included but are not limited to Tracheotomy, absent of a larynx, Peripheral Vascular Disease (PVD) and Protein-Calorie Malnutrition.

Resident #38's Admission Assessment (14-day) with an ARD of 09/21/21 coded Resident #38 a 15 out of a possible score of 15 indicating no cognitive impairment. Resident #38 was coded extensive assistance of one with toilet use, personal hygiene, dressing, toilet use and bathing, limited assistance of one with bed mobility and transfer and supervision with eating for Activities of Daily Living (ADL). Under section H - (Bladder and Bowel) was coded for frequently incontinent of bladder and bowel. Under section G0400 - Functional Limitation in Range of Motion (ROM) coded Resident #38 with no impairment to his upper and lower extremity. Resident #38 was coded as having no mood, rejection of care or behavioral problems.

Resident #38's Admission Assessment (14-day) with an ARD of 09/21/21 under section M; (Skin Condition - M0100) was coded no for Resident #38 having a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded no and under section (M0300) for having current number of unhealed pressure ulcer at each stage for admitted with or facility acquired was coded as none under section (0130), number of venous and arterial wound present coded with one. Under section (M1040), other ulcers, wounds, and skin problems (foot) problems were coded for none present and under section (1200) for skin, ulcer treatments were coded for having pressure reducing device for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 45	F 686		

chair and bed, and applications of ointments/medications other than feet.

Resident #38's quarterly MDS with an ARD date of 02/22/22 coded Resident #38 a 15 out of a possible score of 15 indicating no cognitive impairment. Resident #38's MDS coded Resident #38 requiring supervision with all ADLs except for bathing which requires extensive assistance of one for Activities of Daily Living (ADL) care. Under section G0400 - Functional Limitation in Range of Motion (ROM) coded Resident #38 with no impairment to his upper and lower extremity. Resident #38 was coded as having no mood, rejection of care or behavioral problems. Under section M; (Skin Condition - M0100) was coded for the using a
Formal Assessment Instrument/tool (e.g., Braden, Norton or other) for the determination of Pressure Ulcer Risk. Under section (M0300) the resident was coded as having two (2) facility acquired unstageable pressure ulcers.

Resident #38's person-centered care plan initiated on 11/17/21 identified a pressure ulcer to left and right heel. The goal set for the resident by the staff was that the resident will show signs of healing. Some of the interventions/approaches the staff would use to accomplish this goal is to turn and reposition every 2 hours, keep the physician and Responsible Representative (RR) updated, treatment as ordered and weekly wound documentation.

Resident #38's person-centered care plan with a revision date 12/01/21 identified the resident at risk for impaired skin integrity related to current wounds, occasional bladder incontinence and diagnosis of PVD. The goal set for the resident by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 46	F 686		

the staff was that the resident will be free of further skin breakdown. Some of the interventions/approaches the staff would use to accomplish this goal is to elevate heels off mattress per routine and/or as needed, inspect skin during routine care daily, treatments as ordered, help to reposition resident for comfort per routine and as needed, and skin assessment per routine and as needed.

A Braden Risk Assessment Report was completed on 10/06/21 with the following coded under sensory perception slightly limited and responds to verbal commands, but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.

The clinical record revealed the weekly skin assessment to be completed by the license nurse for the week of 11/07/21, but it was not completed for Resident #38.

Review of Resident #38's Weekly Wound Assessment completed by License Practical Nurse (LPN) #1 (wound nurse) revealed the following documentation:

-11/15/21 - an unstageable pressure ulcer to the left heel measured 3.0 cm x 3.5 cm; appearance necrotic/black with no drainage or odor. The treatment on 11/16/21 is to paint left heel with Betadine Solution every day shift.

-11/15/21 - an unstageable pressure ulcer to the right heel measured 3.0 cm x 2.7 cm; appearance necrotic/black with no drainage or odor. The treatment on 11/16/21 is to paint right heel with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 47	F 686		

Betadine Solution every day shift.

A phone interview was conducted with the VOHRA wound care specialist/physician on 04/14/22 at approximately 9:04 a.m., who stated the left and right heel were both identified at an unstageable stage. The wound specialist (VOHRA) initial assessment made on 11/17/21 documented an unstageable Deep Tissue Issue (DTI) to the right heel but it should have been documented unstageable pressure ulcer because the area was noted with thick black necrotic tissue (eschar).

The wound care specialist documented the following:

-11/17/21 - unstageable DTI to right heel (partial thickness) etiology of wound (pressure) area measured 1.5 cm x 1.5 cm with no drainage. Chief complaint: resident has multiple wounds. Treatment: continue betadine daily. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed. The resident appears to have associated pain evidenced by restless and grimacing.

-11/17/21 - unstageable to left heel due to necrosis, etiology of wound (pressure) area measured 2 cm x 2 cm with no drainage. Chief complaint: resident has multiple wounds. Treatment: continue betadine daily. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed. The resident appears to have associated pain evidenced by restless and grimacing.

-12/27/21 - unstageable to the right heel (due to necrosis - full thickness), area measured 0.7 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 48	F 686		

x 0.6 cm with 50 % thick adherent black necrotic tissue and 50% thick adherent devitalized necrotic tissue. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. Treatment plan: apply Dakins solution moistened gauze with Santyl ointment daily. Debridement refused. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed.

-12/27/21 - unstageable to left heel due to necrosis, area measured 1.5 cm x 1.5 cm with no drainage with 20 % thick adherent black necrotic tissue and 50% thick adherent devitalized necrotic tissue and 30% granulation tissue. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. Treatment plan: apply Dakin's solution moistened gauze with Santyl ointment daily. Debridement refused. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed.

-01/17/22 - unstageable to the right heel (due to necrosis - full thickness), area measured 1.1 cm x 1.0 cm with 20% thick adherent black necrotic tissue and 50% thick adherent devitalized necrotic tissue and 30% granulation tissue and light serous drainage. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. Treatment plan: apply Dakins solution moistened gauze with Santyl ointment daily. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed.

-01/17/22 - unstageable to left heel (due to necrosis) area measured 1.8 cm x 1.5 cm with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49	F 686		

light sero-sanguinous drainage with 50% thick adherent devitalized necrotic tissue and 50% granulation tissue. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm (wound has improved). Treatment plan: Treatment plan: apply Dakin's solution moistened gauze with Santyl ointment daily. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed.

The clinical record revealed Resident #38 had a wound evaluation from (name of podiatry center) on 01/26/22 with the following new orders: apply Santyl to Right and Left foot wound daily and offload lower extremities in prevalon boots while in bed. Recommendation: Off-load wound, reposition per facility protocol and float heel in bed.

During the initial tour on 04/12/22 at approximately 1:30 p.m., and again on 04/13/22 around 9:30 a.m. During each observation, Resident #38 was observed lying in bed with prevalon boots in place to bilateral heels.

On 04/13/22 at approximately 9:30 a.m., an interview was conducted with Resident #38. Resident #38 is without his voice box which made him not able to communicate verbally but is able to point to areas on his body with concerns and nodded his head when asked simple and direct questions. When asked if he had sores to his heels, he nodded his head yes but was not able to identify when the areas occurred.

On 04/13/22 at approximately 10:05 a.m., wound care observation was conducted with LPN #1. Resident #38 was lying in bed, positioned in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 50	F 686		

supine position with prevalon boot in place to both heels. The left heel pressure ulcer wound bed noted with necrotic tissue with a moderate amount of serosanquineous drainage with no odor present. The right heel pressure ulcer noted with yellow/red wound bed with a small amount of serous drainage with no odor present. Wound care was conducted per wound care orders and infection control precautions maintained.

A phone call was placed to Resident #38's Resident Representative (RR) on 04/14/22 at approximately 1:35 p.m., who stated, "My brother, Resident #38 FaceTimed me complaining of severe pain to both of his heels. I called the facility and spoke to his nurse, LPN #1, who stated she would assess Resident #38 and call me back. On the same day, not sure of the time, LPN #1 called me and said my brother had an unstageable pressure ulcer to both of his heels."

On 04/14/22 at approximately 3:25 p.m., an interview was conducted with LPN #1 who was assigned to Resident #38 on 11/15/21 (7-3 shift). The LPN stated she spoke with Resident #38's (RR) on 11/15/21 who said Resident #38 had called her and reported having severe pain to his heels. The LPN said a skin assessment was completed and observed an unstageable pressure ulcer to both heels. When asked, if the CNA's had reported any skin issues with Resident #38 heels, she replied, "No."

A phone call was placed Certified Nursing Assistant (CNA) #4 on 04/14/22 at approximately 1:40 p.m. The CNA was assigned to provide care and services to Resident #38 on 11/15/21 (7-3 shift). A message was left, the CNA never

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 51	F 686		

returned the call.

A phone call was placed CNA #5 on 04/14/22 at approximately 1:40 p.m. The CNA was assigned to provide care and services to Resident #38 on 11/15/21 (7-3 shift). A message was left, the CNA never returned the call.

An interview was conducted with the Director of Nursing (DON) and Regional Director of Clinical Services on 04/14/22 at approximately 10:37 a.m. The DON stated, "(Resident #38's Name) FaceTimed his sister and showed her the areas located to his bilateral heels." She said the sister called and spoke to LPN #1 who was Resident #38's nurse. The nurse assessed Resident #38 heels and observed an unstageable pressure ulcer to his left and right heel. The DON was asked, at what stage should pressure ulcer to be first identified, she replied, "Preferably at a stage one." The DON stated, The CNA's are to do skin checks while providing care daily on every shift and on their shower days. She (DON) said, the CNA 's are looking at all pressure point areas including the resident heels and if they identify any changes in the resident skin condition such a redness, bruising or an open area, the changes are to be reported to the nurse right away who will document the findings in the resident clinical record and notify the physician. When asked if there were preventative measure put in place prior to the development of Resident #38's unstageable pressure first identified on 11/15/21, she replied, "No, none that I could find."

Another interview was conducted with the DON on 4/14/22 at 3:46 p.m. When asked if the weekly skin assessment was completed the week of 11/07/21, she replied, "I did not see where a skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 52	F 686		

assessment was completed." The DON said she expect for the nurse nurse's to do their skin assessments on a weekly basis. When asked, What was the purpose of weekly skin assessment and why are they important, she replied,"It's imperative that weekly skin assessments are being done and that way we could have found Resident #38's pressure ulcers prior to being found at an unstageable pressure ulcer."

A debriefing was held with the Administrator, Director of Nursing, Vice President of Operations and Regional Director of Clinical Services on 04/14/22 at approximately 4:32 p.m., who were informed of the above findings; no further information was provided prior to exit.

The facility policy titled Pressure Ulcer Prevention and Treatment policy revised on 09/18/20. Residents admitted with existing pressure injuries will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable.

Definitions:

-Tracheotomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube (https://medlineplus.gov).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 53	F 686		

-Absence of larynx - your voice box (larynx) is made of cartilage, muscle and mucous membranes located at the top of your windpipe (trachea) and the base of your tongue. Your vocal cords are two flexible bands of muscle tissue that sit at the entrance of the windpipe. Sound is created when your vocal cords vibrate, without your larynx, sound cannot be created (https://www.mayoclinic.org/diseases-conditions/voice-disorders/symptoms-causes).

-PVD is the narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms (Source: http://www.cdc.gov/DHDSP/data_statistics/fact_sheets/fs_PVD.htm).

-Protein-Calorie Malnutrition refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function (https://www.ncbi.nlm.nih.gov/pmc/articles).

-Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

-Unstageable Pressure Injury: Obscured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 54	F 686		

full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

-Betadine Solution a topical antiseptic used to prevent and treat minor wounds and skin infections. This medicine works by killing germs and preventing the spread of infection (a topical antiseptic (www.betadine.com/firstaid).

-Dakin's solution is a type of hypochlorite solution. It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses (http://www.webmd.com/drugs/2/drug-62261/dakin's-misc/details).

-Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (http://www.webmd.com).

-Prevalon boots give patients the most advanced protection against heel pressure ulcers and foot drop. Prevalon helps minimize pressure, friction and shear on your patient's feet, heels and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 55	F 686		

ankles. By elevating the foot and separating the heel from the mattress, it delivers total heel pressure relief (http://www.sageproductsglobal.com/en/prevalon.cfm).

2. The facility staff failed to provide care and services to prevent pressure ulcer development and to identify a left heel pressure ulcer prior to progression to an advanced stage (stage 3) measuring 0.4 centimeters by 0.4 centimeters by 0.2 centimeters (cm), for Resident #58) which constituted harm.

Resident #58 was originally admitted to the facility 11/12/21 after an acute care hospital stay. The resident has not been discharged from the facility. The current diagnoses included; coronary artery disease, peripheral vascular disease and congestive heart failure.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/15/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #58's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with personal hygiene, dressing, toileting, limited assistance of one person with bed mobility, transfers, walking and locomotion, help with the bathing activity, and supervision after set-up with eating.

On 4/12/22 at approximately 12:15 p.m., Resident #58 was observed in bed lying on her left side. The resident stated my left foot hurts. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 56	F 686		

she hadn't told her nurse but the nurse knew it was painful that's why she puts a bandage on it. The resident stated she knew of nothing that helps her left foot feel better. Beneath the bed linens, bilateral feet were observed to be elevated by some type of device.

Review of the facility's matrix revealed Resident #58 had a current pressure ulcer staged at a stage IV.

Review of the clinical record revealed a progress note dated 4/6/22 which revealed Resident #58 was identified with a stage 3 pressure of the left heel which measured 0.4 cm by 0.4 cm by 0.2 cm. The stage 3 left heel pressure ulcer's wound bed was red, the periwound was pink there was scant drainage, and no odor. The treatment order was Santyl ointment and Dakins solution.

The 3/12/22, 3/19/22, 3/26/22, 4/2/22, and 4/9/22 Weekly Skin Evaluation were coded for no current skin issues.

The Nutrition Monitor and Nutrition Evaluation dated 2/15/2022 revealed Resident #58's weight was 127.6 pounds and the Resident showed significant weight gain soon after admission to the facility but had a significant weight loss over the past 30 days at 5.5%. Resident is currently within her ideal body weight range. Weight maintenance within 5 pounds of current weight is planned at this time. Po intake of Regular consistency diet is typically 26 to 100% with most meals at 50%. Nutritional needs for wound healing and weight maintenance are currently being met. Daily use of multiple laxatives. Fluids should be strongly encouraged during waking hours. Added to the weekly weight schedule for close monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 57	F 686		

The 4/6/22 Braden Scale Pressure Ulcer Risk Assessment revealed Resident #58 was a low risk for pressure ulcer development because she had no sensory deficit which would limit her ability to feel or voice pain or discomfort, her skin is only occasionally moist, her ability to walk is severely limited or non-existent, she makes frequent though slight changes in body or extremity position independently, rarely eats a complete meal and generally eats only about half of any food offered and moves feebly or requires minimum assistance.

Further review of the clinical record revealed a wound assessment report by the wound care physician dated 4/11/22 which read, Resident presents with a wound on her left heel. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today. She has a stage 3 pressure wound of the left heel. There is light sero-sanguinous exudate. There is no indication of pain associated with this condition. The left heel pressure ulcer measured 0.3 x 0.3 x 0.2 cm and presented with 100 percent granulation tissue. The dressing treatment plan was documented as Iodosorb gel followed by a gauze island with border every two days for 30 days.

The active care plan was reviewed on 4/12/22. It revealed a potential for a skin integrity problem with a revision date of 11/16/21 but there wasn't a left heel pressure ulcer problem. On 4/15/22 a care plan problem was developed for the stage 3 pressure ulcer to the left heel which was identified on 4/6/22. The goal read; Area to the left heel will show signs of healing through next review 5/19/22. The interventions included; treatments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 58	F 686		

as per physicians/designee order, monitor for signs and symptoms of infection and weekly wound documentation

Review of the physician order summary revealed there wasn't a treatment order in place for Resident #58's left heel pressure ulcer until 4/12/22. There was no evidence in the clinical record that an active treatment was in place and care and services were rendered to the resident's left heel pressure ulcer from 4/6/22 through 4/11/22.

The physician order summary's revealed an order dated 04/12/22, which read Iodosorb Gel 0.9 % (Cadexomer Iodine); Apply to the left lateral heel topically every day shift for wound care. This order was not what the wound care physician ordered. The wound care physician order was for every two days not daily. Completion of the left heel pressure ulcer treatment was documented on the TAR for 4/12/22, 4/13/22 and 4/14/22.

An interview was conducted with Certified Nursing Assistant CNA) #2 on 4/14/22 at approximately 5:57 p.m. CNA #2 stated Resident #58 is fully alert and oriented and capable of making her needs known. She stated the resident likes one pillow at her back, one under each arm and one under her legs when in bed and she wears boots in bed Crocs when out of bed. CNA #2 stated the resident is unable to self turn since she wears the boots therefore she is fully dependent upon staff when wearing them. She stated she wasn't aware of what was wrong with Resident #58's left foot but she knew a dressing was on it. CNA #2 stated the resident is always compliant with care and feeds herself usually 50% of the dinner meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 59	F 686		

An interview was conducted with Certified Nursing Assistant CNA) #3 on 4/15/22 at approximately 9:55 a.m. CNA #2 stated Resident #58 is out of bed about three days per week and she can walk from the bathroom door to the commode in the room. She stated when the resident is out of bed she wears Crocs, does a lot for herself and feeds herself approximately 50% of meals.

An interview was conducted with MDS Coordinator #4 on 4/15/22 at approximately 11:30 a.m. MDS Coordinator #4 stated Resident #58's care plan wasn't updated with the left heel pressure ulcer because she was off and didn't get the update until 4/15/22.

An interview was conducted with the wound care nurse on 4/15/22 at approximately 10:45 a.m. The wound care nurse stated she couldn't explain how the resident obtained the pressure ulcer for the resident has always been so particular about relieving pressure with multiple pillows propping her body. The wound care nurse also stated she assessed the resident's pressure ulcer on 4/6/22 but failed to document the results timely. The wound care nurse stated it is not good to find a pressure ulcer at stage 3 or above. She stated they should be identified early, where there is redness, ideally.

An observation was made of Resident #58's left lateral heel pressure ulcer on 4/15/22 at approximately 11:05 a.m., with the wound care nurse. The resident was again lying on the left side, wearing bilateral pressure reducing boots and there were pillows beneath her knees and bilateral arms. The previous dressing was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 60	F 686		

undated and the gauze next to the pressure ulcer was medium brown and dry. The wound was without odor or drainage and the resident didn't express pain when the wound care nurse touched the left foot pressure ulcer.

On 4/15/22 at approximately 1:00 p.m., the above information was shared with the Administrator, Director of Nursing, Regional Director of clinical Services and Regional Director of Operations. The Director of Nursing and the Regional Director of Clinical Services stated they knew they had pressure ulcer problems therefore they developed an in-house plan of correction but it failed January 2022 and they didn't revise or develop an new plan for pressure ulcers. They also acknowledged they had more recent pressure ulcer concerns as well. The Regional Director of Operations stated they tried to manage the pressure ulcers, they just weren't successful.

A stage 3 pressure ulcer is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. (CMS RAI Version 3.0 Manual, Chapter 3 page M-14).

The information below was obtain from the following website on 4/19/22. Iodosorb Gel is a sterile antimicrobial dressing formulation of Cadexomer Iodine. When applied to the wound, Iodosorb absorbs fluids, removing exudate, slough and debris and forming a gel over the wound surface. As the gel absorbs exudate, iodine is released, killing bacteria and changing color as the iodine is used up. (https://www.smith-nephew.com/professional/pro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 61	F 686		

ducts/advanced-wound-management/iodosorb--iodoflex/iodosorb-gel/)

The information below was obtain from the following website on 4/19/22.
Iodosorb Gel speeds up the healing process and reduces pain. Can be used for up to 3 months in a single course of treatment. 1. IODOSORB Paste should be changed when saturated with wound fluid, indicated by a loss of color, usually 2-3 times a week or daily if the wound is discharging heavily (https://www.smith-nephew.com/documents/canada/canada%20english/iodo-ag-1601en%20(ca11740)%20-%20application%20and%20usage%20guide%20(1).pdf).

3. The facility staff failed to provide care and services to prevent development of an unstageable deep tissue injury (DTI) of the right buttock measuring 6.5 cm by 5.5 cm by 0., for Resident #88B; a new stroke victim who required extensive assistance to total care with all activities of daily living (ADL).

Resident #88B was originally admitted to the facility 5/26/21 after an acute care hospital stay and discharged home 6/15/21. The resident's diagnoses included; a stroke, aphasia, dysphagia, right hemiparesis, and coronary artery disease.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/1/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #88B's cognitive abilities for daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 62	F 686		

decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with personal hygiene, dressing, bathing, toileting and locomotion, extensive assistance of one person with transfers and eating, and extensive assistance of two people with bed mobility. Section "H0100" Bowels and Bladder; the resident was coded as utilizing an indwelling catheter. In section M0100 (Skin Disorders) the Resident was coded as having no pressure ulcer, a scar over bony prominence, or a non-removable dressing/device. M0150 - Resident was coded as at risk of developing pressure ulcers.

A deep tissue injury is a Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. A deep tissue injury may precede the development of a stage 3 or 4 pressure ulcer even with optimal treatment. (CMS RAI Version 3.0 Manual, Chapter 3 page M-24)

During investigation of a complaint, information was gleamed revealing Resident #88 B acquired skin impairments including an unstageable DTI.

An interview was conducted with Resident #88B's daughter on 4/14/22 at approximately 2:05 p.m. The daughter stated the mother's husband visited the resident daily at her window because the facility was not allowing visitors inside the facility. The mother's husband told the daughter the staff wasn't repositioning the resident or consistently assisting her with meals and she wasn't capable of feeding herself. The husband stated often the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 63	F 686		

meals were placed far away from the resident.

The 5/26/21, 5/27/21, and 6/3/2, 6/10/21 Weekly Skin Evaluation revealed no skin problems. The 6/10/21 Weekly Skin Evaluation revealed a right buttock area.

The 6/11/21 Weekly Wound Assessment revealed an unstageable deep tissue injury (DTI) of the right buttock, etiology pressure. The DTI measured 3.0 centimeters (cm) by 4.0 cm by 0 cm., and presented with maroon discoloration on intact skin. The assessment stated Triad cream was ordered as the treatment.

The Treatment Administration Record (TAR) revealed and order dated 6/11/21 for Triad Hydrophilic Wound Dress Paste (Wound Dressings) Apply to right buttock topically every day and evening shift for unstageable DTI. The treatment wasn't signed as completed on 6/11/21.

The care plan had a problem dated 6/11/21 which read; wounds to right buttock on 6/11/21, left medial buttock on 6/11/21, right medial buttock on 6/11/21. The goal read; Area to right buttock with show signs of healing through next review 6/15/21, Area to left medial buttock will show signs of healing through next review 6/15/21, and Area to right medial buttock will show signs of healing through next review 6/15/21. The Interventions included; treatment as ordered, specialty mattress, and turn and reposition every two hours.

The specialty mattress was ordered and instituted on 6/11/21 after the DTI and other skin impairment developed, based on the TAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 64	F 686		

The wound to the left medial buttock resolved on 6/15/2021 but the right buttock unstageable DTI and right medial buttock cluster wound remained unhealed per the wound care physician progress note dated 6/15/21.

The Treatment Administration Record (TAR) revealed an order dated 6/11/21 for Triad Hydrophilic Wound Dress Paste (Wound Dressings) Apply to right buttock topically every day and evening shift for unstageable DTI. The treatment wasn't signed as completed on 6/11/21.

On 6/15/21 the unstageable DTI was assessed by the wound care physician. The findings was the Resident had an unstageable DTI of the right buttock for at least 4 days duration. It measured 6.5 cm x 5.5 cm. x Not Measurable cm. There was no exudate. There is no indication of pain associated with this condition. Wound progress: Deteriorated. Primary Dressing Skin prep apply once daily for 30 days; Gauze island (with a border) apply once daily for 30 days. Recommendations included reposition per facility protocol; Off-load wound.

The TAR revealed the following order to be started 6/16/21; cleanse right buttock with seaclens, apply skin prep to wound bed, cover with a dressing daily every day shift for an unstageable DTI.

Review of a hospital admission assessment dated 6/18/21, the resident presented to the emergency department with septic shock, a perirectal abscess and a stage 2 pressure ulcer.

The Braden Scale for Prediction of Pressure completed on 10/6/21; revealed Resident #58

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 65	F 686		

had no sensory deficit which would limit ability to feel or voice pain or discomfort, skin was occasionally moist, requiring an extra linen change approximately once a day, was confined to bed, made occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, rarely eats a complete meal and generally eats only half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, and moves feebly or requires minimum, and required moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.

Nutrition Risk/Diagnosis (Dx): Resident has increased nutrition/hydration risk related to dx of dysphagia, hyperlipidemia, gout, high blood pressure, malnutrition; need for mechanically altered diet and thickened liquids related to dysphagia; inadequate intakes. The Resident is being seen for an admission assessment. The Nutrition assessment conducted 5/27/2021 revealed the following; Diet order: Regular/pureed texture/nectar thickened liquids. Resident is with poor by mouth intake. Current Body Weight: 175.2 pound and Body Mass Index was 29.2 reflecting overweight/ in healthy range for age. No skin breakdown noted per skin assessment. Resident may benefit from high calorie supplement to increase available nutrients given poor intakes as well as fortified foods. Estimated Needs: calories: 1420-1705 protein: 57-68 fluid: 1500 ml. Diet Provides: calories: 2000-2400 protein: 80-90 fluid: not <1500 ml Intake meets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 66 needs. Intake meets resident's needs. On 4/15/22 at approximately 1:00 p.m., the above information was shared with the Administrator, Director of Nursing, Regional Director of clinical Services and Regional Director of Operations. The Director of Nursing and the Regional Director of Clinical Services stated other than the clinical record documentation there was no additional information regarding the status of Resident #88B.	F 686		
	COMPLAINT DEFICIENCY			
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure a Registered Nurse (RN) coverage for 8 hours, 7 days a week. The facility staff failed to ensure RN coverage for	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 727	Continued From page 67 8 consecutive hours for 24 days. The findings included: On 04/14/22 at approximately 11:00 AM, the facility's actual worked schedule was reviewed with Other Staff #2 (Nursing Scheduler) and revealed there was no RN coverage for the following days: 1/01/22,1/02/22, 1/08/22, 1/15/22, 1/16/22, 1/22/22, 1/23/22, 1/30/22, 1/31/22, 2/05/22, 2/12/22, 2/13/22, 2/19/22, 2/20/22, 2/26/22, 2/27/22, 3/05/22, 3/06/22, 3/12/22, 3/13/22, 3/19/22, 3/19/22, 4/02/22, 4/03/22. 04/15/22 at approximately, 1:15 PM a pre-exit interview was conducted with The Director of Nursing (DON) and the facility Administrator concerning the above issue. The DON was asked what should have been done concerning the above issue. She stated, I have an RN (Registered Nurse) that provides weekend coverage. The ADON (Assistant Director of Nursing) stated she worked weekends since she started in October (2021). Neither the DON or the ADON could not explain why the above dates were not covered by an RN.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 756	Continued From page 68	F 756		

irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility staff failed to ensure drug regimen of each resident were reviewed monthly for two residents (Resident #44 and #56) in the survey sample of 38 residents.

The findings included:

1. Resident #56 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 756	Continued From page 69	F 756		

09/09/21 with diagnoses which included hypertension, depression, dementia, Parkinson's disease, hypothyroidism, coronary artery disease and psychosis. This resident did not have monthly drug regimen reviews provided by a pharmacist for irregularities.

Resident #56 was coded on a Quarterly Minimum Data Set (MDS) dated 3/15/22 in the area of Cognitive Pattern for Basic Interview for Mental Status (BIMS) as a (06). In the area of medications this resident was coded as receiving Antipsycotic and Antidepressant medications on a routine basis.
Resident #56 was noted to be receiving the following medications Seroquel, Klonopin, and Effexor on a routine basis.

A review of Pharmacy Reviews did not include reviews for the months of October 2021 through January 2022.

2. Resident #44 was admitted to the facility on 3/30/21 with diagnoses of peripheral vascular disease, depression, end stage renal disease, epilepsy, legal blindness, type 2 diabetes , hypertension and A-Fib. This resident did not have monthly drug regimen reviews provided by a pharmacist for irregularities.

Resident #44 was coded on a Re-Admission MDS dated 3/3/22 in the area of Cognitive pattern for BIMS as a (15). In the area of medications this resident was coded as receiving Insulin and Antidepressant medications on a routine basis.

A review of the Pharmacy Reviews did not include reviews from October 2021 through January 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 756	Continued From page 70 A facility Medication Regimen Review dated 12/01/07 indicated: "Policy for Medication Regimen Review (MRR) Procedures: 1. The Consultant Pharmacist will conduct MRRs if required under a Pharmacy Consultant Agreement. 5. Facility should independently review each resident's medication regimen directly from the resident's medical chart and with Interdisciplinary Care Team members, resident or Responsible Party, as needed. 6. Facility should ensure that Facility Physicians/Prescribers are provided with copies of the MRRs."	F 756		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 71	F 842		

§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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 72	F 842		

and resident review evaluations and 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 staff interview, clinical record review, review of facility documents and during the course of a complaint investigation, the facility's staff failed to accurately document in one residents medical record for 1 of 38 residents (Resident #35), in the survey sample.

The findings included:

Resident #35 was admitted to the facility 9/26/1991 and readmitted to the facility on 2/05/2022. Diagnoses for Resident #35 include: Contracture, unspecified and Quadriplegia, unspecified.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/21/2022 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was not conducted. Resident's cognitive skills for decision making were coded as severely impaired for daily decision making.

In section "G"(Physical functioning) the resident was coded as requiring total dependence of one person with bed mobility, locomotion on and off units, dressing, eating, toilet use, personal hygiene and bathing. Requiring total dependence of two persons with transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 73	F 842		

The Care Plan dated 3/01/22 reads: Focus: Wound focus: Stage 3 right ischium (worsen upon re-admission). Stage 3 to scrotum. Stage 3 to lateral lower back. Stage 3 to medial lower back. DTI to L ankle, L elbow, R elbow, medial upper back. (Found upon admission). Goals: Areas to will show signs of healing through next review. Interventions: Assess for pain PRN (as needed), Encourage compliance, Keep MD and RP updated, Monitor for S/S (signs/symptoms) of infection, Pressure relieving mattress to bed, Treatment's per MD (Medical Doctor) orders, turn and reposition every 2 hours as tolerated, Weekly wound documentation.

A review of the POS (Physician Order Summary) and TAR (Treatment Administration Record) for April 2022 reads:

Cleanse Left ear wound with wound cleanser, cover with DSD (Dry Sterile Dressing) every day shift for wound care. Start date: 3/22/2022. (Missed wound care days per the April 2022 TAR/Treatment Administration Record): 4/04/22, 4/05/22, 4/08/22, 4/11/22 and 4/13/22).

Cleanse mid-upper back with wound cleanser, paste with betadine every day shift for wound care. Start date: 02/18/2022. (Missed wound care days per the April 2022 TAR/Treatment Administration Record): 4/04/22, 4/05/22, 4/08/22, 4/11/22 and 4/13/22).

Cleanse wound to Lateral lower back, apply santyl and calcium, alginate, cover with DSD every day shift for wound care. Start date: 02/23/2022. (Missed wound care days per the April 2022 TAR/Treatment Administration Record): 4/04/22, 4/05/22, 4/08/22, 4/11/22 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 74	F 842		

4/13/22).

Santyl Ointment 250 UNIT/GM (Collagenase) Apply to groin topically every day shift for wound care. Start date: 03/15/2022. (Cleanse left elbow with wound cleanser, apply calcium alginate and 2 x 2 gauze every day shift for wound care. Start Date: 3/04/2022. Discontinue Date: 4/06/2022). (Missed wound care days per the April 2022 TAR (Treatment Administration Record): 4/04/22, 4/05/22, 4/08/22, 4/11/22 and 4/13/22).

Santyl Ointment 250 UNIT/GM (Collagenase) Apply to lower medial back topically every day shift for wound care. Apply calcium alginate. Start date: 2/23/2022. Discontinue date: 4/06/2022. (Missed wound care days per the April 2022 TAR (Treatment Administration Record): 4/04/2022 and 4/05/2022).

Cleanse Right elbow with wound cleanser, paste with betadine. Every day shift for wound care. Start Date: 2/23/2022. Discontinue date: 4/06/2022. (Missed wound care days per the April 2022 TAR (Treatment Administration Record): 4/04/2022 and 4/05/2022).

Cleanse left ankle with wound cleanser, paste with betadine every day shift for wound care. Start date: 2/18/2022. Discontinue date: 4/06/2022. (Missed wound care days per the April 2022 TAR (Treatment Administration Record): 4/04/2022 and 4/05/2022).

A review of the facility's wound care documentation on Resident #35's shows improvement of resident's wounds with some wounds being healed with no deterioration of wounds per wound care documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(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 75 On 4/15/22 at approximately 10:00 AM., an interview was conducted with the DON (Director of Nursing) concerning Incomplete TARs (Treatment Administration Records) for wound care. She stated, "The TARs should be completed before you leave off your shift." On 4/15/22 at approximately 10:30 AM an interview was conducted with LPN (Licensed Practical Nurse/Wound Care Nurse) #3 concerning the above issues. She stated, "Some of the missed days on the TARs were on the days that I did the woud care treatments. I never missed doing treatments. I may have forgotten to check them off. The wounds were improving or healed. I will double check the TARs the next time." On 4/15/2022 at approximately 1:15 PM., the above findings were shared with the Administrator, The Corporate Consultant, and The DON and with the ADON (Assistant Director of Nursing). An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 842		