STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/29/2022 through 12/1/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/29/22 through 12/1/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints (VA00055571- substantiated with no deficiencies; VA00054789 - unsubstantiated; VA00053801 - unsubstantiated; VA00052956 - unsubstantiated; VA00052204 - unsubstantiated) were investigated during the survey. The census in this 169 certified bed facility was 155 at the time of the survey. The survey sample consisted of 40 current resident reviews and 11 closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to assess one of 51 residents in the survey sample for self-administration of	F 554	1. Medications were immediately removed from resident #48 beside during the survey. Resident #48 was discharged from the facility on 12/9/22 and no longer resides at	12/30/22

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

Electronically Signed | 12/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554	Continued From page 1 medication, Resident #48. The findings include: For Resident #48 (R48), the facility staff failed to assess for self-administration of medication. A bottle of docusate sodium (1) was observed unsecured at the bedside in R48's room. On the most recent MDS (minimum data set), a five-day admission assessment with an ARD (assessment reference date) of 10/13/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 11/29/2022 at 2:46 p.m., an observation of R48's room was conducted with R48 present. A bottle of docusate sodium softgels were observed sitting on top of the nightstand to the left of R48's bed. On 11/30/2022 at 9:36 a.m., an interview was conducted with R48 in their room. The bottle of docusate sodium was on top of the nightstand to the left of R48's bed. When asked about the medication, R48 stated that a family member had brought them in for them "a while ago" and they took one as needed for constipation. R48 stated that the nurses were aware that they took the medication when needed and did not mind. The bottle located on top of R48's nightstand read, "Docusate Sodium 100 mg (milligram)." The bottle was approximately one-quarter full. On 11/30/2022 at 11:48 a.m., an observation was made of wound care performed by LPN (licensed practical nurse) #5 to R48 in their room. The	F 554	Autumn Care of Mechanicsville. 2. All residents who reside in Autumn Care of Mechanicsville have the potential to be affected by this deficient practice. Observational 100% rounding audits were competed on all residents to ensure no meds were at bedside without self-administration assessment. 3. All licensed nurses were educated by the Director of Nursing or designee to observe for meds at bedside and to complete self-administration of medication. 4. Director of Nursing or designee will conduct ten random observational audits weekly for twelve weeks to identify medication(s) at the bedside and need for a self-administration of medication (s) assessment and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

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F 554	Continued From page 2	F 554		

bottle of docusate sodium softgels remained on top of the nightstand during the wound care observation.

The physician orders for R48 failed to evidence an order for docusate sodium or self-administration of medications.

Review of R48's clinical record failed to evidence an assessment for self-administration of medications.

On 11/30/2022 at 1:55 p.m., an interview was conducted with LPN #5. LPN #5 stated that residents were allowed to self administer medications if they were assessed to be able to do this. LPN #5 stated that if the resident expressed a wish to self administer their medications they would complete an assessment in the electronic medical record to determine if the resident was capable and obtain a physician order. LPN #5 stated that residents who self-administered their medication would be documented in the electronic medical record. LPN #5 stated that the medication would also be secured in the residents room because they had other residents that may wander into the room. LPN #5 stated that they assessed the resident prior to them administering the medication to ensure they were capable and did not overdose themselves. LPN #5 stated that they were aware that R48 had docusate sodium in their room that a family member had brought in previously and they thought it had been removed by staff.

The facility policy, "Self-Administration of Medication" with a revision date of 2/9/2021 documented in part, "Residents who have the desire to, and who have been assessed to be

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 554	Continued From page 3 capable and safe to, may self-administer medications. Procedure: 1. Verify physician's order in the resident's chart for self-administration of specific medications under consideration. 2. Complete the [Facility] Resident's Ability to Safely Self-Administer Medications Assessment with the resident..." On 12/1/2022 at 1:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the above concern. No further information was presented prior to exit. (1) docusate sodium Purpose: Stool Softener. Uses: For relief of occasional constipation. This product generally produces a bowel movement within 12 to 72 hours. Helps to prevent dry, hard stools. This information was obtained from the website: https://www.drugs.com/pro/docusate-sodium.html	F 554		
F 623 SS=E	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 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	F 623		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 623	Continued From page 4	F 623		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 623	Continued From page 5	F 623		

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 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

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 623	Continued From page 6 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 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the resident representative and/or the State LTC Ombudsman with written notification of hospital transfers for four of 51 in the survey sample; Residents #68, #147, #61, and #163, The findings include: 1. The facility staff failed to provide the resident representative and the ombudsman with written notice of a hospital transfer when the resident was sent to the hospital on 8/18/22 for Resident #68. On the 10/14/22 quarterly MDS (Minimum Data Set), Resident #68 was coded as being severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 8/18/22, that documented, "CNA (Certified Nursing Assistant)...found pt (patient) on floor and called nurse. nurse observe pt laying on left hip on floor next to bed, pt was wearing gripper socks. left hip has protrusion and blanchable redness. pt state [they] was trying to get to the hall, pt deny hit head. pt complain of left hip pain. yells it hurts...[Name of responsible party/family member] called and request since this is new pain to send [them] to ER (emergency room) to eval."	F 623	F623 □ Requirements before Transfer/Discharge 1. Social worker educated on transfer/discharge requirements. Social Worker or designee notified families of #68; #147; #61; #163 and ombudsman in written of transfer to ED. 2. All residents who transfer/discharge to the hospital have the potential to be affected by this deficient practice. 100% Audits were completed on all residents who went to hospital and then returned in the past 90 days. 3. Social workers were educated by administrator or designee to policy titled Discharge/Transfer Letter to ensure written notification is sent to responsible party and ombudsman when residents transfer to the hospital. 4. Social worker director or designee will conduct reviews on every resident who transfer/discharge out to the hospital to ensure clinical records include written notification. An audit will be completed weekly x 12 weeks, and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance	

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 623	Continued From page 7 Further review of the clinical record revealed a nurse's note dated 8/18/22 that documented, "[Name of responsible party/family member] understands reason for transfer. Resident transferred to [name of hospital] via stretcher with [county] EMS (emergency medical services). Resident sent with face sheet, [name of progress note], bed hold policy, copy of mar/tar (medication/treatment administration records), and advance directive and transfer form." There was no documentation or evidence that a written notice of the hospital transfer was provided to the resident's responsible party or to the ombudsman. On 12/1/22 at 9:35 AM, a list given to ASM #1 (Administrative Staff Member) the Administrator, requesting evidence of written notice of the hospital transfer being provided to the resident's responsible party and to the ombudsman; at 10:55 AM, ASM #1 stated that the facility did not have them. On 12/1/22 at 11:24 AM, an interview was conducted with OSM #4 (Other Staff Member) the Director of Social Services. When asked about the written notices to the resident's responsible party and to the ombudsman, she stated, "I have not been sending them out for transfers to the ED (emergency department) who are only there for a few hours, but have been sending them out if they are admitted to the hospital. I was just trying to use common sense instead of confusing the RP (responsible party) by sending the bed hold and notification of transfer to them certified, they would have to go to the post office to pick it up and they did not understand, when the resident was back in the facility. I called my corporate	F 623	Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 623	Continued From page 8	F 623		

person and she said there is not a time frame on how long they are out of the building (i.e. ED visits) before you are required to send these."

The facility policy, "Resident discharge/transfer letter" was reviewed. This policy documented, "The facility will complete discharge letters appropriately and according to all federal, state, and local regulations....D. Discharge notices must have the following components: 1. The reason for discharge/transfer to include the appropriate verbiage...2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharged...4. A statement that the resident has the right to appeal...5. The name, address and telephone number of the local and State long term care ombudsman; 6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals...7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals...E. Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor if applicable. Copies will be sent to....ombudsman office..."

On 12/1/22 at 1:15 PM, ASM #1, ASM #2 (the Director of Nursing) and ASM #3 (Regional Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to provide the resident representative and the ombudsman with written notice of a hospital transfer when the resident

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 623	Continued From page 9	F 623		

was sent to the hospital on 9/23/22 for Resident #147.

On the 11/3/22 quarterly MDS (Minimum Data Set), Resident #147 was coded as being severely cognitively impaired in ability to make daily life decisions.

Review of the clinical record revealed a nurse practitioner / medical doctor note dated 9/23/22 that documented, "...The patient is seen today due to pocketing of food and continued worsening of left-sided weakness involving the left lower extremity. The patient is alert to self. Nursing staff reports no behaviors and the patient is more sleepy..."

Further review revealed another nurse's note dated 9/23/22 that documented, "Resident has been informed and understands reason for transfer. Resident transferred out to [name of hospital] via stretcher with EMT (emergency medical technician) at 1015 (AM). Resident sent with face sheet, [name of progress note], bed hold policy, copy of MAR/Tar (medication/treatment administration record), care plan, advance directives and transfer form. RP (responsible party) and MD (medical doctor) aware."

There was no documentation or evidence that a written notice of the hospital transfer was provided to the resident's responsible party or to the ombudsman.

On 12/1/22 at 9:35 AM, a list was given to ASM #1 (Administrative Staff Member) the Administrator, requesting evidence of written notice of the hospital transfer being provided to

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F 623	Continued From page 10	F 623		

the resident's responsible party and to the ombudsman; at 10:55 AM, ASM #1 stated that the facility did not have them.

On 12/1/22 at 11:24 AM, an interview was conducted with OSM #4 (Other Staff Member) the Director of Social Services. When asked about the written notices to the resident's responsible party and to the ombudsman, she stated, "I have not been sending them out for transfers to the ED (emergency department) who are only there for a few hours, but have been sending them out if they are admitted to the hospital. I was just trying to use common sense instead of confusing the RP (responsible party) by sending the bed hold and notification of transfer to them certified, they would have to go to the post office to pick it up and they did not understand, when the resident was back in the facility. I called my corporate person and she said there is not a time frame on how long they are out of the building (i.e. ED visits) before you are required to send these.

The facility policy, "Resident discharge/transfer letter" was reviewed. This policy documented, "The facility will complete discharge letters appropriately and according to all federal, state, and local regulations....D. Discharge notices must have the following components: 1. The reason for discharge/transfer to include the appropriate verbiage...2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharged...4. A statement that the resident has the right to appeal...5. The name, address and telephone number of the local and State long term care ombudsman; 6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 623	Continued From page 11	F 623		

disabled individuals...7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals...E. Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor if applicable. Copies will be sent to....ombudsman office..."

On 12/1/22 at 1:15 PM, ASM #1, ASM #2 (the Director of Nursing) and ASM #3 (Regional Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to provide the resident representative and the ombudsman with written notice of a hospital transfer when the resident was sent to the hospital on 9/10/22 for Resident #61.

On the 10/7/22 quarterly MDS (Minimum Data Set), Resident #61 was coded as being cognitively moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 9/10/22 that documented, "Resident laying on floor on left side. Writer assessed resident. Resident was bleeding from the left side of [Resident's] face. Resident C/O (complained of) pain on the left side of face.. Writer X2 (two times) assisted resident to wheelchair than [sic] to bed....Resident RP (responsible party) [name of RP] arrived to facility and was notified. NP (nurse practitioner) wanted to send resident out but RP [name] refused [RP] stated [RP] wanted to wait until Monday when [RP] could be with [Resident]. Writer made [RP] aware that [Resident] needs a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12	F 623		

head CT, [RP] still refused. PRN (as needed) acetaminophen given. Later RP stated [RP] spoke with family and they decided to send [Resident] out now. Writer call 911 , x2 EMT (emergency medical technician) transferred resident via stretcher to [name of hospital] hospital."

A second nurse's note dated 9/10/22 documented, "Resident understands reason for transfer. Resident transferred to [name of hospital] via stretcher with EMT. Resident sent with face sheet, [name of progress note], bed hold policy, copy of MAR/TAR (medication/treatment administration record), care plan, advance directive, and transfer form."

There was no documentation or evidence that a written notice of the hospital transfer was provided to the resident's responsible party or to the ombudsman.

On 12/1/22 at 9:35 AM, a list given to ASM #1 (Administrative Staff Member) the Administrator, requesting evidence of written notice of the hospital transfer being provided to the resident's responsible party and to the ombudsman; at 10:55 AM, ASM #1 stated that the facility did not have them.

On 12/1/22 at 11:24 AM, an interview was conducted with OSM #4 (Other Staff Member) the Director of Social Services. When asked about the written notices to the resident's responsible party and to the ombudsman, she stated, "I have not been sending them out for transfers to the ED (emergency department) who are only there for a few hours, but have been sending them out if they are admitted to the hospital. I was just trying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 13	F 623		

to use common sense instead of confusing the RP (responsible party) by sending the bed hold and notification of transfer to them certified, they would have to go to the post office to pick it up and they did not understand, when the resident was back in the facility. I called my corporate person and she said there is not a time frame on how long they are out of the building (i.e. ED visits) before you are required to send these.

The facility policy, "Resident discharge/transfer letter" was reviewed. This policy documented, "The facility will complete discharge letters appropriately and according to all federal, state, and local regulations....D. Discharge notices must have the following components: 1. The reason for discharge/transfer to include the appropriate verbiage...2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharged...4. A statement that the resident has the right to appeal...5. The name, address and telephone number of the local and State long term care ombudsman; 6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals...7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals...E. Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor if applicable. Copies will be sent to....ombudsman office..."

On 12/1/22 at 1:15 PM, ASM #1, ASM #2 (the Director of Nursing) and ASM #3 (Regional Director of Clinical Services) were made aware of the findings. No further information was provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 623	Continued From page 14	F 623		

by the end of the survey.
4. The facility staff failed to evidence provision of written RP (responsible party) and/or ombudsman notification at the time of hospital transfer for Resident #163. Resident #163 was transferred to the hospital on 7/4/22.

The most recent MDS (minimum data set) assessment, a 5-day Medicare assessment, with an ARD (assessment reference date) of 9/20/22, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

There was no evidence of written RP or ombudsman notification for Resident #163 when sent to the hospital on 7/4/22.

A review of the nursing progress note written 7/4/22 at 2:45 PM, revealed, "Nurse had just walked down hall 25 minutes prior and witnessed patient sleeping in bed. while nurse charting heard man yell out and found patient on the floor to door side of the bed. Patient very agitated and yelling at staff not to help him. Patient was laying on left side. Patient yelling at staff not to touch him, to "get on out of here" nurse was able to get patient to explain some parts of incident in between patient yelling at staff to leave him alone and that he was not going to answer any questions that we were not asking...Once in wheelchair nurse attempted to ask about details of fall and patient began to yell at nurse that she does not need to ask anything...patient stood up and lunged punching towards nurse. No contact made. informed patient that if harm comes to staff, police will have to be called. patient state 'then call them and my sister'. Patient state

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 15	F 623		

self-back in wheelchair and told staff to 'get the hell out of here'. Sister called and notified of details known of fall, patient refusal of help & assessments. notified sister of patient's attempt to punch nurse. Sister asked if she needed to come to building, informed her that patient is calming self while sitting in wheelchair. Patient had left side bed rail down and refused to answer about bed rail preference."

A review of the nursing progress note written 7/4/22 at 4:14 PM, revealed, "Resident and sister understand reason for transfer. Resident transferred to hospital via stretcher with emergency medical transport. Resident sent with face sheet, SBAR (situation/background/assessment/recommendation), bed hold policy, copy of MAR/TAR (medication administration record/treatment administration record), care plan, advance directives, and transfer form."

A request for written RP or ombudsman notification for the resident was made on 11/30/22 at 4:00 PM.

On 12/1/22 at 7:30 AM, ASM #1 stated they do not have the ombudsman notice for this resident; and at 10:55 AM, ASM #1 stated they do not have the written RP (responsible party) or ombudsman notification.

An interview was conducted on 12/1/22 at 11:24 AM, with OSM (other staff member) #4. When asked what notification is provided when the resident is sent to the hospital, OSM #4 stated, "I have not been sending them out for transfers to the ED who are only there for a few hours but have been sending them out if admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 623	Continued From page 16 hospital. I was just trying to use common sense instead of confusing the RP by sending the bed hold and notification of transfer to them certified, they would have to go to the post office to pick it up and them did not understand, when the resident was back in the facility. I called my corporate person and she said there is not a time frame on how long they are out of the building (i.e., ED visits) before you are required to send these." On 12/1/22 at approximately 1:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services was made aware of the findings. A review of the facilities "Resident Transfer/Discharge Letter" policy, dated 9/2017, revealed the following: "Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. Copies will be sent to Department of Health, Ombudsman Office and filed in the business file and/or scanned into PCC (point click care) documents tab with administrator/designee signature, with the certified receipt if applicable. For emergency transfers, one list can be sent to the Ombudsman at the end of the month." No further information was provided prior to exit.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete and accurate MDS (minimum data set) assessment for three of 51 residents in the survey sample, Residents #115, #132 and #106. The findings include: 1. For Resident #115 (R115), the facility staff failed to complete Sections B - Hearing, Speech and Vision, Section C - Cognition, and Section D - Mood on the Quarterly assessment dated 9/27/2022. On the most recent MDS assessment, a quarterly assessment, with an assessment reference date (ARD) of 9/27/2022, the resident was coded in Section B - Hearing, Speech and Vision, as being understood and understanding when spoken to. Sections C and D had dashes in all the boxes indicating it was not completed. On the quarterly MDS assessment, with an ARD of 9/7/2022, the resident was coded in Section B as being understood and understanding when spoken to. Section C had dashes in all the boxes. In Section C0600, Should the staff assessment for mental status be conducted, a "yes" was coded. In Section C0600, the resident was coded as having no difficulty with short- or long-term memory. The resident was coded as having modified independence in making daily cognitive decisions. An interview was conducted 11/30/2022 at 2:11	F 641	1. Resident #115 Minimum Data Set (MDS) quarterly, with an assessment reference date (ARD) of 9/27/2022 for MDS Section B Hearing, Speech, and Vision; Section C cognition, and Speech Section D- Mood was reviewed and was unable to be modified. Resident #132 Minimum Data Set (MDS) quarterly, with an assessment reference date (ARD) of 11/5/2022 for MDS Section B Hearing, Speech and Vision and Section C- Cognitive patterns were modified and re-submitted. Resident #106 annual MDS assessment reference date (ARD) of 7/15/2022 for MDS Section L oral/dental status was modified and re-submitted. Social worker set up dental consultation for Resident #106 to have his teeth evaluated. 2. All residents who reside at Autumn Care of Mechanicsville have the potential to be affected by this deficient practice. A 100% audit of section B, C, D and L of all MDS for residents was conducted to determine other residents affected. 3. The Administrator or designee educated the MDS and social worker staff on accuracy of coding and completing MDS assessments to reflect the resident s current status and services provided. To include not dashing MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 641	Continued From page 18 p.m. with RN (registered nurse) #4, the MDS nurse. The above MDS assessments were reviewed with RN #4. When asked why the dashed sections were not done, RN #4 stated, "I'm sure it should have been done. Maybe we missed doing it before the ARD." When asked when she signs off on the MDS does she check to ensure it is complete, RN #4 stated, "I guess I should be." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/30/2022 at 3:04 p.m. The above MDS assessments were reviewed with ASM #2 and when asked if the two MDS assessment were coded correctly, ASM #2 stated, no, the need to be corrected. An interview was conducted with RN #4 on 12/1/2022 at 12:13 p.m. RN #4 was asked what reference they use to complete the MDS assessments, RN #4 stated the RAI (resident assessment instrument) manual. The RAI manual, Version 1.17.1, documented in part, "Steps for Assessment 1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700-C1000, Staff Assessment of Mental Status...If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and	F 641	assessment. 4. MDS coordinator or designee will conduct quarterly monitoring of MDS assessments prior to submitting to ensure accuracy of completing Section B Hearing, Speech, and Vision and Section C - Cognition, Speech Section D- Mood and Section L Dental (Oral/Dental) is accurately coded to reflect the resident s current status and services provided within the specified ARD. MDS Coordinator or designee will audit 10 residents weekly for Sections B, C, D and L for accuracy x 12 weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19	F 641		

the standard "no information" code (a dash "-") entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done."

ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were made aware of the above findings on 12/1/2022 at 1:15 p.m.

No further information was obtained prior to exit.

#2, For Resident # 132 (R132) the facility staff failed to code Section B - Hearing, Speech and Vision, and Section C - Cognitive Patterns, accurately.

On the most recent MDS assessment, a quarterly assessment, with an ARD of 11/5/2022, the resident was coded in Section B - Hearing, Speech and Vision as usually understood and usually understands. In Section C - Cognitive Patterns, it was coded the resident was rarely/never understood, so the resident interview was not completed. The staff interview was completed and the resident was coded as having both short and long term memory difficulties and was coded as being severely impaired for making cognitively daily decisions.

The MDS assessment, a quarterly assessment, with an ARD of 8/5/2022, coded the resident in Section B as usually understood and usually understands. In Section C - Cognitive Patterns, it was coded the resident was rarely/never understood, so the resident interview was not completed. The staff interview was completed, and the resident was coded as having both short-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

and long-term memory difficulties and was coded as being severely impaired for making cognitively daily decisions.

An interview was conducted with RN #4 on 11/30/2022 2:23 p.m. When asked if she completed either of the two MDS assessments above, RN #4 stated she had done the 11/5/2022 one. When asked if before she signs the MDS, is she to check to ensure the assessment is complete and accurate, RN #4 stated, "I guess. I'm new doing MDS." When asked what training she had had, RN #4 stated she had training for corporate and went and shadowed a MDS nurse at another facility. When asked if Section B and Section C should be accurate, RN #4 stated, yes. When asked if the two of the assessments were correct, RN #4 stated, no.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 11/30/2022 at 3:04 p.m. The above MDS assessments were reviewed with ASM #2. When asked if these two MDS assessment were coded correctly, ASM #2 stated, no, they need to be corrected. ASM #2 stated R132 is not understood and can't understand others.

ASM #1, the administrator, ASM #2, and ASM #3, the regional director of clinical services, were made aware of the above findings on 12/1/2022 at 1:15 p.m.

No further information was obtained prior to exit.

3. The facility staff failed to accurately code the annual MDS dated 7/15/22 in Section L "Oral/Dental Status" for Resident #106.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21	F 641		

On the 10/15/22 quarterly MDS (Minimum Data Set), Resident #106 was coded as being cognitively intact in ability to make daily life decisions. Resident #106 was coded as requiring extensive assistance for bathing; and supervision only for all other areas of activities of daily living.

On 11/29/22 at approximately 1:00 PM, an interview was conducted with Resident #106. During this interview, Resident #106 expressed having some dental issues, and revealed their teeth to the surveyor. The resident had extremely poor dental condition, with teeth missing, broken, significant carries, and teeth worn down.

A review of the 7/15/22 annual MDS, which included a section for Oral/Dental Status, had the following options to be marked:
A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose).
B. No natural teeth or tooth fragment(s) (edentulous).
C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn).
D. Obvious or likely cavity or broken natural teeth.
E. Inflamed or bleeding gums or loose natural teeth.
F. Mouth or facial pain, discomfort or difficulty with chewing.
G. Unable to examine.
Z. None of the above were present.

The box for "Z. None of the above were present" was marked.

A review of the clinical record revealed a nurse practitioner / medical doctor note dated 8/9/21 (almost a year prior to the 7/15/22 MDS) that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22	F 641		

documented, "...Teeth and gum pain....Chipped multiple teeth noted with caries causing gum line pain.....Gingivitis and dental caries..."

On 12/01/22 at 9:48 AM, an interview was conducted with RN #4 (Registered Nurse), the MDS nurse. Regarding the completion of July MDS regarding resident's dental condition, she stated that MDS does look at the teeth. She stated that she will look into why it was documented the resident had no dental issues.

On 12/1/22 at 12:13 PM, in follow up with RN #4, she stated that she did not see any evidence of tooth problems. When asked how does MDS staff ascertain if a resident is having dental problems, she stated, that MDS staff should observe the resident or ask the nursing staff if anything is going on. She stated that the MDS is not coded correctly. When asked what process does MDS staff follow to complete an MDS, she stated that she uses the RAI (Resident Assessment Instrument) manual to complete the MDS.

On 12/1/22 at 12:16 PM, an interview was conducted with ASM #2 (Administrative Staff Member), the Director of Nursing, who also was formerly an MDS nurse. She stated that when interviewing the resident, MDS should look at a resident's mouth themselves. She stated that the MDS was not coded accurately. She stated that if they (MDS) had done an oral assessment it would have been coded that the resident had issues. She stated that "about a year and a half ago the nurse practitioner talked to [Resident] about seeing a dentist and we did an oral assessment and [Resident] did not want to see anyone. [Resident] said [Resident] teeth were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23	F 641		

sore at times but they did not bother [Resident]. [Resident] had missing and broken teeth then, with cavities."

A review of the RAI manual, Version 1.17.1, dated October 2019, page L-1 documented, "Poor oral health has a negative impact on:
- quality of life
- overall health
- nutritional status

Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes....Steps for assessment...4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth....Coding Instructions:

-Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk.
-Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth.
-Check L0200C, abnormal mouth tissue (ulcers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24 masses, oral lesions): select if any ulcer, mass, or oral lesion is noted on any oral surface. -Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen. -Check L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip. -Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing. -Check L0200G, unable to examine: if the resident's mouth cannot be examined. -Check L0200Z, none of the above: if none of conditions A through F is present." On 12/1/22 at 1:15 PM, ASM #1, ASM #2 (the Director of Nursing) and ASM #3 (Regional Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 656	Continued From page 25 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 51 residents in the survey sample, Resident #113 (R113).	F 656	1. Comprehensive care plan for resident #113 was reviewed and corrections made to reflect resident current fall prevention status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 26 The findings include: For (R113), the facility staff failed to implement the comprehensive care plan for the placement of two fall mats next to (R113's) bed. (R113) was admitted to the facility with a diagnosis that included but was not limited to: muscle weakness and a history of falling. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 09/26/2022, the (R113) was coded as having both short- and long-term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. On 11/29/22 at approximately 3:13 p.m., (R113) was observed lying in bed with one fall mat on floor next to the left side of (R113's) bed. On 12/01/22 at approximately 7:10 a.m., (R113) was observed lying in bed with one fall mat on floor next to the left side of (R113's) bed. The physician's order for (R113) documented, "Fall mats every shift for safety to bilateral (two) sides of bed when resident in bed. Order Date: 05/24/2022." The comprehensive care plan for (R113) with dated 03/03/2022 documented in part, "Resident is at risk for falls characterized by history of falls, injury and / or multiple risk factors related to weakness, right hip fracture repair, dementia. Revision on: 05/24/2022." Under "Interventions" it documented in part, "Implement preventative	F 656	2. All residents that have fall mats have the potential to be affected. An audit of all residents with care plans for floor mats was completed to determine accuracy of orders, placement and necessity of floor mats. 3. The Director of Nursing or designee educated licensed nurses on policy titled Comprehensive Care Plan, to ensure use of patient centered interventions to reduce the risk of fall related injuries. 4. The Director of Nursing or designee will conduct quality monitoring audits to ensure the comprehensive care plan accurately reflect patient centered care preventive fall interventions. 100% of fall care plans will be audited weekly x 12 weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 656	Continued From page 27 fall interventions / devices. Date Initiated: 03/03/2022." On 12/01/22 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about (R113's) fall mats LPN #3 stated that (R113) could have one or two fall mats placed next to their bed. When asked to describe the purpose of a resident's care plan LPN #3 stated that it dictated the care of a resident. After informed of the above observation and the documentation in (R113's) comprehensive care plan regarding the implementation of preventative fall interventions, specifically the fall mats, LPN #3 was asked if the care plan was being implemented. LPN #3 stated no. The facility's policy "Comprehensive Care Planning Policy" documented in part, "Z) All direct care staff must always know, understand, and follow their Resident's Care Plan ..." On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/30/22

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F 689	Continued From page 28 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, it was determined that the facility staff failed to implement interventions to reduce the risk of fall related injury, for one of 51 residents in the survey sample, Resident # 113 (R113). The findings include: For (R113), the facility staff failed to place fall mats on the right and left side of bed while (R113) was lying in bed. (R113) was admitted to the facility with a diagnosis that included but was not limited to: muscle weakness and a history of falling. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 09/26/2022, the (R113) was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. On 11/29/22 at approximately 3:13 p.m., an observation of (R113) revealed they were lying in bed and one fall mat on floor next to the bed on (R113's) left side. On 12/01/22 at approximately 7:10 a.m., an observation of (R113) revealed they were lying in bed and one fall mat on floor next to the bed on (R113's) left side.	F 689	1. Comprehensive care plan for resident #113 was reviewed and corrections made to reflect resident current fall prevention status. 2. All residents that have fall mats have the potential to be affected. An audit of all residents with care plans for floor mats was completed to determine accuracy of orders, placement and necessity of floor mats. 3. The Director of Nursing or designee educated licensed nurses on policy titled Comprehensive Care Plan, to ensure use of patient centered interventions to reduce the risk of fall related injuries. 4. The Director of Nursing or designee will conduct quality monitoring audits to ensure the comprehensive care plan accurately reflect patient centered care preventive fall interventions. 100% of fall care plans will be audited weekly x 12 weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 689	Continued From page 29	F 689		

The physician's order for (R113) documented, "Fall mats every shift for safety to bilateral (two) sides of bed when resident in bed. Order Date: 05/24/2022."

The comprehensive care plan for (R113) with dated 03/03/2022 documented in part, "Resident is at risk for falls characterized by history of falls, injury and / or multiple risk factors related to weakness, right hip fracture repair, dementia. Revision on: 05/24/2022." Under "Interventions" it documented in part, "Implement preventative fall interventions / devices. Date Initiated: 03/03/2022."

On 12/01/22 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about (R113's) fall mats LPN #3 stated that (R113) could have one or two fall mats placed next to their bed. When informed of the observations and the physician's order as stated above LPN #3 stated that they were under the impression that the physician's order had been adjusted to allow for one or two fall mats. LPN #3 further stated that since the order had not been adjusted, (113) should have had two fall mats down next to their bed.

On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 690	Continued From page 30	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		12/30/22

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 690	Continued From page 31 Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide care and services for an indwelling urinary catheter, for one of 51 residents in the survey sample, Residents #24 (R24). The findings include: For (R24), the facility staff failed to keep the indwelling urinary catheter (1) tubing off the floor. (R24) was admitted to the facility with diagnoses that included but were not limited to: benign prostatic hyperplasia (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/13/2022, (R24) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R24) was cognitively intact for making daily decisions. Sect H "Bladder and Bowel" code (R24) as having an indwelling catheter. On 11/29/22 at approximately 1:26 p.m., an observation of (R24) revealed they were sitting in their wheelchair in their room with the catheter tubing under the wheelchair; a portion of the catheter tubing was resting on the floor. On 11/29/22 at approximately 2:26 p.m., an observation of (R24) revealed they were sitting in their wheelchair in their room with the catheter tubing under the wheelchair; a portion of the catheter tubing was resting on the floor. On 11/30/22 at approximately 9:05 a.m., an observation of (R24) revealed they were sitting in	F 690	1. Resident #24 indwelling catheter tubing was repositioned to prevent tubing from resting on floor 2. All residents who have an indwelling catheter have the potential to be affected by this deficient practice. The Director of Nursing or designee conducted 100 % observational quality review of all residents with indwelling catheters to ensure tubing was secured and positioned off of floor. 3. The Director of Nursing or designee educated licensed nurses to policy titled Indwelling Urinary Catheter Care Procedure to ensure no Foley tubing is resting on floor 4. The Director of Nursing or designee will conduct 100% observational review of resident□s with a Foley weekly to ensure catheter tubing is maintained off of floor x twelve (12) weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 690	Continued From page 32	F 690		

their wheelchair in their room with the catheter tubing under the wheelchair; a portion of the catheter tubing was resting on the floor.

On 11/30/22 at approximately 2:16 p.m., an observation of (R24) revealed they were sitting in their wheelchair in their room with the catheter tubing under the wheelchair; a portion of the catheter tubing was resting on the floor.

The physician's order for (R24) documented, "Foley Cath (catheter) size 16Ff (French) with a 10ml (milliliter) balloon. Start Date: 07/18/2021."

The comprehensive care plan for (R24) dated 07/19/2021 documented in part, "Focus. Alteration in elimination r/t (related to) foley catheter d/t (due to) Obstruction Uropathy 16FR 10 cc. Revision date: 11/09/2022." Under "Interventions" it documented, "Foley catheter care per orders/routine. Date Initiated: 07/19/2021."

On 11/30/2022 at approximately 2:25 p.m., an interview and observation of (R24's) catheter tubing was conducted with RN (registered nurse) #2. After observing the position of the catheter tubing RN #2 stated that it was resting on the floor. When asked how the catheter tubing should be positioned RN #2 stated that the tubing should not have been resting on the floor because it was a safety issue and could get caught on something, and it was an infection control concern because the floor was dirty.

On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 690	Continued From page 33 the above findings. No further information was provided prior to exit. References: (1) An indwelling urinary catheter is a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine. Once inserted, a balloon is inflated which keeps the catheter in place. This information was obtained from the website: https://www.cdc.gov/hai/prevent/cauti/indwelling/overview.html (2) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care and services consistent with professional standards of practice, for one of 51	F 695	1. Resident #24 CPAP mask was sanitized and placed in designated oxygen bag at bedside at time of discovery. 2. All residents who have a CPAP	12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 34 residents in the survey sample, Residents #24 (R24). The findings include: For (R24), the facility staff failed to store a CPAP (continuous positive airway pressure) (1) mask in a sanitary manner. (R24) was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD) (2). On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 06/13/2022, (R24) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R24) was cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded (R24) for "CPAP" while a resident. On 11/29/22 at approximately 1:26 p.m., an observation of (R24's) CPAP mask revealed it was placed on top of their bedside table and uncovered. On 11/29/22 at approximately 2:26 p.m., an observation of (R24's) CPAP mask revealed it was placed on top of their bedside table and uncovered. On 11/30/22 at approximately 9:03 a.m., an observation of (R24's) CPAP mask revealed it was lying on the floor behind the bedside table uncovered. On 11/30/22 at approximately 2:16 p.m., an	F 695	machine and use a CPAP mask have the potential to be affected by this deficient practice. The Director of Nursing or designee conducted 100% observational quality review of all residents with CPAP mask to ensure mask were secured inside plastic (oxygen) bag at bedside. 3. The Director of Nursing or designee educated licensed nurses to policy titled BIPAP/CPAP to ensure CPAP Mask are placed in plastic (oxygen) bag 4. The Director of Nursing or designee will conduct observational review of all resident□s with CPAP mask x 12 weeks to ensure CPAP mask are stored in plastic (oxygen) bag to keep clean and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 695	Continued From page 35	F 695		

observation of (R24's) CPAP mask revealed it was lying on the floor behind the bedside table uncovered.

The physician's order for (R24) documented, "CPAP at bedtime for COPD and remove per schedule. Start Date: 01/03/2022."

The comprehensive care plan for (R24) dated 07/09/2021 documented in part, "Focus. At risk for sleep apnea, copd,...Revision date: 06/28/2022." Under "Interventions" it documented, "C-PAP as ordered. Date Initiated: 07/12/2021."

On 11/30/2022 at approximately 2:25 p.m., an interview and observation of (R24's) CPAP mask was conducted with RN (registered nurse) #2. After observing (R24's) C-PAP mask lying on the floor behind the bedside table uncovered RN #2 stated that the mask should be placed on top of (R24's) bedside table and placed in a plastic bag to keep it clean.

The facility's policy "BiPAP/CPAP Policy" documented in part, "Cleaning: Mask: wash mask with soap and water or (sic) CPAP masks after each use, let air dry. Once dry store mask in plastic bag to keep it clean ..."

On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of the above findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 36 (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to conduct performance evaluations for two of five CNA's (certified nursing assistants) reviewed. The findings include: During the Sufficient and Competent Staffing facility task review on 11/30/22 at 2:30 PM there was no evidence of performance evaluations for	F 730	1. CNA #2 performance evaluation was completed CNA #3 performance evaluation was completed 2. All employees who work for Autumn Care of Mechanicsville have the potential to be affected by this deficient practice. A 100% quality review was completed for active nurse aids to ensure annual	12/30/22

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F 730	Continued From page 37 two of five CNA's (certified nursing assistants) reviewed. On 11/30/22 at approximately 11:00 AM, ASM (administrative staff member) #1, the administrator, was provided with the list of five CNA's highlighted with request for evidence of performance reviews. At 2:00 PM, ASM #1, the administrator, provided the employee files requested which revealed the following: 1. CNA #2 with a date of hire of 9/25/17, revealed the last performance evaluation dated 10/23/21. There were no performance evaluation within the last 12 months. 2. CNA #3 with a date of hire of 3/1/16, revealed the last performance evaluation dated 8/15/21. There were no performance evaluation within the last 12 months. On 11/30/22 at 3:00 PM, ASM #1, the administrator and former director of nursing stated, the performance evaluations are to be completed within the twelve-month time period. On 12/1/22 at approximately 1:45 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services was made aware of the findings. A review of the "Facility Assessment" dated 1/3/22, revealed, "The facility assessment will help to determine staffing levels and competencies. The facility assessment will include and evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs. Facility will use a	F 730	performance evaluation was completed. 3. Leadership team was educated by administrator or designee on the importance of completing employee annual performance evaluations timely. 4. Human resources will audit ten (10) active CNA employee files monthly for (3) months to ensure annual performance evaluations are completed timely and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 730	Continued From page 38 competency-based approach to determine the knowledge and skill among staff." There was no facility policy regarding performance evaluations. No further information was provided prior to exit.	F 730		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to prepare food in the facility kitchen in a sanitary manner in one of one facility kitchens. The findings include:	F 812	1. Dietary staff was educated immediately on preparing food in a sanitary manner including the drying process per Autumn Care of Mechanicsville policies. 2. All residents who consume food in our	12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 39 On 11/30/2022 at approximately 9:50 a.m., an observation of the facility's dish room revealed OSM (other staff member) #8, dietary staff member, removing clean, wet cups, bowls and plate covers that had just come out of the automatic dishwasher and drying them with a towel and stacking them on drying racks. On 11/30/2022 at approximately 1:45 p.m. an interview was conducted with OSM #6, dietary manager. When asked about hand drying the plate covers OSM # 6 stated that it was their understanding that it was okay to hand dry the dishes as long as staff were wearing gloves. After reviewing the facility's policy "Dish Machine Use Policy" OSM # 6 stated that they were not aware that the dishes were not to be dried with a towel and needed to air dry. The facility's policy "Dish Machine Use Policy" documented in part, "11. Allow the dishes to air dry on the dish racks or open shelving. Do not dry with towels. During the unloading process, visually inspect dishes for cleanliness and dryness, and put away if clean." On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 812	facility can be affected by this deficient practice. 100% of meals were audit x 3 days to determine other affected residents. 3. Dietary staff was educated by administrator or designee on policy titled Dish Machine Drying to ensure dishes are allowed to air dry on dish racks or open shelving. 4. Dietary manager will randomly and periodically conduct ten (10) observational audits weekly x twelve weeks to ensure dishes air dry. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 814	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain one of three dumpsters in a sanitary manner. The dumpster used for cardboard, was observed with debris, including several pieces of cardboard, plastic bags, used face masks and trash lying on the ground on the right and back side of the dumpster. The findings include: On 11/29/2022 at approximately 11:40 a.m., an observation of the facility's dumpsters was conducted with OSM (other staff member) #1, director of maintenance and OSM #2, maintenance helper. The observation revealed that the facility had one dumpster specifically for cardboard surrounded by a wooden fence. Observation of the area around the dumpster revealed several pieces of cardboard, plastic bags, used face masks and trash were found lying on the ground on the right and back side of the dumpster. When asked who was responsible for maintaining the immediate area around the dumpsters in a clean and sanitary manner and how often it was checked and cleaned OSM #1 stated that it was the maintenance department that was responsible for the dumpster area and OSM #2 stated that the dumpster area was checked and cleaned every morning. OSM # 1 further stated that the area described above was unacceptable. On 12/01/2022 at approximately 1:15 p.m., ASM (administrative staff member) #1, administrator,	F 814	1. Debris was immediately removed from right side and back of dumpster at time of discovery. 2. Residents and staff can be affected by deficient practice. Dumpster was checked three times a day x 5 day initially. 3. Maintenance and dietary staff was educated by administrator or designee on policy tilted Waste Disposal to ensure dumpster area is free from debris 4. Quality observational audits will occur twice a day times twelve weeks to ensure dumpster area is free from debris and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 814	Continued From page 41 ASM #2, director of nursing and ASM #3, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 814		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, staff interview, and facility document review it was determined the facility staff failed to	F 885	1. Evidence of documentation could not be corrected in medical records for residents #24, #68, #85, #132 and #48.	12/30/22

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F 885	Continued From page 42 evidence notification of facility COVID-19 activity to residents and/or their responsible party (RP) and families for five of five residents reviewed, Residents #24, #68, #85, #132 and #48. The findings include: The facility staff failed to evidence notification by 5:00 p.m. the next calendar day following a single confirmed infection of COVID-19 (1) to sampled residents (Residents #24, #68, #85, #132 and #48) and/or their responsible party and families. On 11/29/2022 at 10:40 a.m., during entrance meeting with RN (registered nurse) #3, the infection preventionist and ASM (administrative staff member) #1, the administrator, RN #3 stated that residents/RP's and families were notified of new cases of COVID-19 in the facility by staff members after a case was identified and a progress note was entered into each residents medical record regarding the update regarding the facility status. On 11/29/2022 at approximately 1:00 p.m., ASM #1 provided a survey readiness book which included a typed document that read, "The mechanism to inform residents and their representatives of confirmed or suspected COVID-19 cases is verbal communication in person for residents and via telephone. This is then documented in the progress not [sic] section in the resident's record in PCC (point click care) (electronic medical record)." On 11/30/2022 at approximately 8:00 a.m., ASM #1 provided COVID-19 tracking calendars for October 2022 and November 2022 which documented newly identified COVID-19 cases in	F 885	Facility enrolled in Regroup Broadcast Communication system to ensure timely notification to resident representatives/families of positive COVID-19 cases within our facility 2. All resident representative/ families have the potential to be affected by this deficient practice. Quality reviews were completed for 5 days to ensure resident representatives/families were contacted when positive COVID-19 cases occurred within facility. 3. Leadership team was educated by Administrator or designee on policy Resident Family Responsible Party Notification to ensure importance of notifying resident representatives of positive COVID-19 test activity within the facility on the next calendar day following confirmed cases. 4. Administrator or designee will conduct 100% audit of positive results of resident /staff weekly for notification to representatives/families x twelve weeks and PRN as indicated to ensure ongoing compliance. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. Date of Compliance: December 30, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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F 885	Continued From page 43	F 885		

the facility on 10/10/2022, 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

On 11/30/2022 at approximately 11:30 a.m., ASM #1 provided a list of staff and residents with suspected or confirmed COVID-19 over the past four weeks. The list documented COVID-19 cases on 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022 and 11/20/2022.

A sample of five residents were chosen for review for resident/responsible party/family notification.

1. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2022, Resident #24 (R24) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 11/29/2022 at 2:27 p.m., an interview was conducted with R24. R24 did not express any concerns regarding notification of COVID-19 activity in the facility from staff.

Review of R24's progress notes dated 10/1/2022-11/30/2022 failed to evidence notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility by 5:00 p.m. the next calendar day following confirmed cases on 10/10/2022, 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022,

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	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 885	Continued From page 44	F 885		

11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

2. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/14/2022, Resident #68 (R68) was assessed as being severely impaired for making daily decisions.

Review of R68's progress notes dated 10/1/2022-12/1/2022 failed to evidence notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility by 5:00 p.m. the next calendar day following confirmed cases on 10/10/2022, 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

3. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/4/2022, Resident #85 (R85) scored 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions.

Review of R85's progress notes dated 10/1/2022-12/1/2022 failed to evidence notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility by 5:00 p.m. the next calendar day following confirmed cases on 10/10/2022, 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 885	Continued From page 45	F 885		

On 11/29/2022 at 4:13 p.m., an interview was conducted with R85's responsible party. R85's responsible party stated that the facility contacted them when there was a change in R85's condition or treatment often.

4. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/5/2022, Resident #132 (R132) was assessed as being severely impaired for making daily decisions.

Review of R132's progress notes dated 10/1/2022-11/30/2022 failed to evidence notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility by 5:00 p.m. the next calendar day following confirmed cases on 10/10/2022, 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

5. On the most recent MDS (minimum data set), a five-day admission assessment with an ARD (assessment reference date) of 10/13/2022, Resident #48 (R48) scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 11/30/2022 at 9:36 a.m., an interview was conducted with R48 in their room. R48 stated that they were not aware of any COVID-19 in the facility at the current time but had not asked anyone and did not leave their room that much.

Review of R48's progress notes dated 10/13/2022-12/1/2022 failed to evidence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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F 885	Continued From page 46	F 885		

notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility by 5:00 p.m. the next calendar day following confirmed cases on 10/17/2022, 10/25/2022, 10/27/2022, 10/28/22, 10/29/2022, 10/30/2022, 10/31/2022, 11/1/2022, 11/2/2022, 11/3/2022, 11/4/2022, 11/6/2022, 11/8/2022, 11/13/2022, and 11/20/2022.

On 12/1/2022 at 8:54 a.m., an interview was conducted with RN #3, infection preventionist. RN #3 stated that when they identified a positive COVID-19 case in the facility they notified all residents and responsible parties. RN #3 stated that residents were notified in person by the nursing staff and the responsible parties were notified by telephone of the COVID activity in the building. RN #3 stated that the staff had assigned residents that they were responsible for notification of the residents and responsible parties. RN #3 stated that the staff were to document a progress note in the medical record to evidence the notification was done. RN #3 reviewed R85's progress notes and stated that they did not see any documentation of notification of the resident or the responsible party. RN #3 stated that they would check the other requested residents for the documentation.

On 12/1/2022 at approximately 10:00 a.m., a request was made to ASM #1, the administrator, for evidence of notification of the resident/responsible party/family of confirmed COVID-19 activity in the facility for Residents #24, #68, #85, #132 and #48.

On 12/1/2022 at approximately 12:10 p.m., ASM #1 stated that they were still working on the request for the requested residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

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F 885	Continued From page 47	F 885		

The facility policy "Resident/Family/Responsible Party/DOH (department of health) COVID19 Notification Requirements" dated 7/1/20 documented in part, "First Probable or Positive Case: 1. Call each responsible party and inform each resident using Script #1 provided within 12 hours. 2. Send Letter "Family Letter for Confirmed or Probable COVID19" to each responsible party ASAP. 3. Inform DOH...Subsequent Probable or Positive Case: 1. Call each responsible party and inform each resident using Script #2 by 5 pm the next day. 2. Send Letter "Family Letter for SUBSEQUENT Confirmed or Probable COVID19" to each responsible party ASAP. 3. Inform DOH..." The policy failed to evidence requirements for documentation to evidence notification.

On 12/1/2022 at 1:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the above concern.

On 12/1/2022 at 2:25 p.m., ASM #2 provided four progress notes for additional residents written by RN #3, in infection preventionist regarding notification of the responsible party of COVID-19 activity in the building for 11/4/2022 and 11/18/2022 and stated that they were what they were able to find. ASM #2 stated that the process was for the staff to notify the residents and call the responsible parties when they have a case within the required timeframe.

No further information was presented prior to exit.

Reference:
(1) COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 48 COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads	F 885		