STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495196	A. BUILDING _____ B. WING _____	C 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF ALTAVISTA	1317 LOLA AVE ALTAVISTA, VA 24517

(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 5/22/2023 through 5/24/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/22/2023 through 5/24/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 111 certified bed facility was 104 at the time of the survey. The survey sample consisted of 21 current resident reviews and 3 closed record reviews. Two complaints were investigated during the survey and are as follows: VA00058545 allegations were unsubstantiated without deficiencies cited. VA00053533 allegations were unsubstantiated without deficencies cited.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/27/23

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

Electronically Signed | 06/07/2023

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F 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to follow physician orders for one of 24 residents. Resident #20 did not have physician ordered Geri sleeves in place. The Findings Include: Diagnoses for Resident #20 included; Convulsions, diabetes, pathological fracture, ostoarthritis, and Alzheimer's disease. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/5/23. Resident #20 was assessed with long and short-term memory problems with severely cognitive impairment with daily decion making. On 5/22/23 at 11:58 AM during an initial observation, Resident #20 was lying in bed with partial lower legs exposed. Resident #20's legs showed several small (dime to quarter size) faint bruising with no open areas. On 5/22/23 review of Resident #20's clinical record documented an active physician order that read: "Geri sleeves to BLE [bilateral lower extremities] daily..." On 5/23/23 at 10:55 AM, Resident #20 was again observed up in a chair and without Geri sleeves to legs in place. On 5/23/23 at 11:00 AM, the certified nursing assistant (CNA #5) assigned to Resident #20 was interviewed. CNA #5 verbalized unawareness that Resident #20 was ordered Geri sleeves and	F 684	1- Obtained order from md to discontinue geri sleeves for resident #20 2- 100% audit of all physician orders for Geri sleeves have been reviewed for accuracy, and necessity and are in place. No other issues observed 3- 100% licensed nurses will be educated by DON/designee on carrying out physician orders to ensure transcriptions are accurate for all geri sleeve orders and any other documentation. By 6/21/23 4- Random checks of residents with Geri Sleeve orders. will be completed by DON/designee 3 x week x 12 weeks to ensure complete documentation of administration and/or refusals. Audit results will be reviewed at the monthly QA committee meeting x 3 months. . 5- Date of completion 06/27/23	

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F 684	Continued From page 2 verbalized that Resident #20 did wear them at one time, but thought that the geri sleeves had been discontinued. On 5/23/23 at 11:03 AM, registered nurse (RN #5) assigned to Resident #20 was asked about Resident #20's Geri sleeves. RN #5 went to Resident #20's room to look for the Geri sleeves but could not find them and verbalized unawareness of an order for Geri sleeves. On 5/23/23 at 5:06 PM, the above finding was presented to the director of nursing and administrator. No other information was presented prior to exit conference on 5/24/23.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		6/27/23

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F 688	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to apply a hand splint for one of twenty-four residents in the survey sample (Resident #93). The findings include: Resident #93 was observed without a splint as required in his plan of care for management of a contracted right hand. Resident #93 was admitted to the facility with diagnoses that included diabetes, Alzheimer's, hypertension, benign prostatic hyperplasia, psychotic/mood disturbance, anxiety, glaucoma, and depression. The minimum data set (MDS) dated 5/3/23 assessed Resident #93 with short and long-term memory problems, severely impaired cognitive skills, and as having impaired range of motion of the upper extremity on one side. On 5/22/23 at 3:12 p.m., Resident #93 was observed seated in a wheelchair in the day area on his unit. Resident #93's right hand was contracted with fingertips positioned near the palm. There was no hand/wrist splint in place on the right hand. Resident #93 was observed again on 5/22/23 at 4:23 p.m. with no hand splint in place. Resident #93 was observed on 5/23/23 at 7:49 a.m. in bed eating breakfast with no right-hand splint in place. When questioned about the splint, Resident #93 stated that he did not know where the splint was located, that he used the splint in the day, and took it off at night. Resident #93 was observed again on 5/23/23 at 9:47 a.m. in bed with no hand splint in use.	F 688	1- Resident #93 continues to have an order for a hand splint and the order was updated to include documentation of refusal of his hand splint on 5/23/23. As he tolerates. No harm to resident. 2- 100% audit of physician orders for hand splints have been reviewed for accuracy and continued need. No issues were found. 3- 100% licensed nurses will be educated by DON/designee on carrying out physician orders to ensure transcription to TAR are accurate for all splinting orders and any other documentation. By 6/21/23 4- Random checks of residents with splints will be completed by DON/designee 3 x week x 12 weeks to ensure complete documentation of administration and/or refusals. Audit results will be reviewed at the monthly QA committee meeting x 3 months. 5- Date of completion 06/27/23	

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F 688	Continued From page 4	F 688		

Resident #93 was observed on 5/23/23 at 10:28 a.m. seated near the nursing desk, at 11:23 a.m. seated in the day area, and at 1:38 p.m. seated in his room. There was no hand/wrist splint in use during any of these observations.

Resident #93's clinical record documented that Resident #93 had limited range of motion of the right hand/wrist due to contracture. Resident #93's plan of care (revised 5/3/23) documented Resident #93 had self-care deficits due to limited mobility. Interventions to maintain mobility included, "Apply resting hand splint to RT [right] hand as therapy recommends for 8H [8 hours] as tolerated..." Nurses had documented on the treatment administration record each day and evening shift of May 2023, including 5/22/23 and 5/23/23, that Resident #93's hand splint was in place. The clinical record, including the treatment administration record, plan of care, and clinical notes, made no mention of any problems and/or refusals by Resident #93 regarding application of the splint.

On 5/23/23 at 1:41 p.m., the certified nurses' aide (CNA #2) caring for Resident #93 was interviewed about the hand/wrist splint. CNA #2 stated that some days Resident #93 did not want the splint because it hurt. CNA #2 located the splint in the drawer of the bedside table and applied the splint to Resident #93's right hand with no comment or refusal from the resident. CNA #2 stated that the splint was usually on in the day and off at night.

On 5/23/23 at 1:49 p.m., the registered nurse unit manager (RN #2) was interviewed about the hand splint. RN #2 stated Resident #93 was supposed to wear the splint during the day to minimize and

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F 688	Continued From page 5 prevent further contracture of the right hand. RN #2 stated that if the resident refused the splint, nurses were supposed to document the refusal on the treatment record. RN #2 reviewed the clinical record and stated that no refusals were listed and nurses had documented as recently as today (5/23/23) at 11:05 a.m., that the splint was in place. On 5/23/23 at 2:12 p.m., licensed practical nurse (LPN #1) caring for Resident #93 was interviewed about the splint. LPN #1 stated that sometimes Resident #93 did not want to wear the splint. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 5/23/23 at 5:05 p.m. No further information was provided regarding application of Resident #93's hand splint.	F 688		
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 §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 observation, staff interview, and clinical record review, the facility staff failed to implement interventions for fall/injury prevention for one of twenty-four residents in the survey sample (Resident #93)	F 689	1- Resident #93 fall interventions implemented. Bilateral fall mats placed at bedside. No injury to resident. Fall interventions placed on Kardex/Tasks in POC to make aides more aware of interventions that have been put in place	6/27/23

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F 689	Continued From page 6 The findings include: Resident #93, assessed as a high fall risk, was in bed without protective floor mats in place for injury prevention. Resident #93 was admitted to the facility with diagnoses that included diabetes, Alzheimer's, hypertension, benign prostatic hyperplasia, psychotic/mood disturbance, anxiety, glaucoma, and depression. The minimum data set (MDS) dated 5/3/23 assessed Resident #93 with short and long-term memory problems, severely impaired cognitive skills, and as having impaired range of motion of the upper extremity on one side. On 5/23/23 at 7:54 a.m., Resident #93 was observed in bed with no protective floor mats on either side of the bed. Resident #93 was observed again on 5/23/23 at 9:45 a.m. in bed with no floor mats in place on either side of the bed. A mat was observed at this time folded and positioned upright next to the wall near the bedside table. No second mat was observed in Resident #93's room. Resident #93's clinical record documented that Resident #93 was assessed on 3/1/23 as a high fall risk due to history of falls, cognitive impairment, and impaired mobility. The record documented a physician's order dated 3/9/23 for, "Padded floor mats to both sides of bed, when resident is in bed every shift." Resident #93's plan of care (revised 5/3/23) documented the resident was at risk of falls due to history of falls, impaired mobility, and cognitive impairment. Interventions to minimize fall related	F 689	for fall injury prevention. Education completed by 6/21/23. 2- 100% audit for physician orders and careplan interventions for fall interventions to include fall mats have been reviewed for continued need and placement. 3- 100% licensed nurses and aides will be educated by DON/designee on interventions that have been put in place for fall/injury prevention. Education to be completed by 6/21/23. 4- Random checks of fall interventions will be completed by DON/designee 3 x week x 12 weeks to ensure that interventions are in place. Audit results will be reviewed at the monthly QA committee meeting x 3 months. 5- Date of completion 06/27/23.	

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F 689	Continued From page 7 injuries included, "...Padded floor mats to both sides of the bed when resident is in bed as ordered..." On 5/23/23 at 1:42 p.m., the certified nurses' aide (CNA #2) caring for Resident #93 was interviewed. CNA #2 stated that she moved the mat on the window side of the bed to place the over-bed table for breakfast. CNA #2 stated that there was only one mat in the room. CNA #2 stated, "Never had but one mat. I'm not sure where the other one is." On 5/23/23 at 1:48 p.m., the registered nurse unit manager (RN #2) was interviewed. RN #2 stated Resident #93 had a history of falls. RN #2 reviewed the clinical record and stated protective floor mats were ordered to be on both sides of the bed. On 5/23/23 at 2:15 p.m., the licensed practical nurse (LPN #1) caring for Resident #93 was interviewed about the mats not being in place. LPN #1 stated, "I don't know about the mats." LPN #1 stated that she was not aware that there was only one mat available for placement by his bed. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 5/23/23 at 5:05 p.m. with no further information presented regarding the mats.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		6/27/23

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F 842	Continued From page 8	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

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F 842	Continued From page 9 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure an accurate clinical record for two of 24 residents. Resident #20 and Resident #93 had an inaccurate Treatment Administration Record (TAR). The Findings Include: 1. Nurses inaccurately documented use of an intervention for Resident #93, when it was not being applied. Diagnoses for Resident #20 included; Convulsions, diabetes, pathological fracture, ostoarthritis, and Alzheimer's disease. The most current MDS (minimum data set) was a	F 842	1- Resident #93 continues to have an order for a hand splint and the TAR was corrected to include refusal of his hand splint on 5/23/23. Resident #20 Order for Geri-sleeves reviewed and discontinued due to lack of necessity. Nurses that made documentation errors were in-serviced 1-1 on accurate documentation on MAR/TAR. No harm to resident. 2- 100% audit of all physician orders for Geri Sleeves and hand splints have been reviewed for accuracy and are being	

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F 842	Continued From page 10 quarterly assessment with an ARD (assessment reference date) of 5/5/23. Resident #20 was assessed with long and short-term memory problems with severely cognitive impairment. On 5/22/23, review of Resident #20's clinical record documented an active order that read: "Geri sleeves to BLE [bilateral lower extremities] daily..." On 5/23/23, review of Resident #20's TAR documented (with a check and initials of a nurse) that Geri sleeves had been placed on Resident #20 dated 5/23/23. On 5/23/23 at 10:55 AM, Resident #20 was observed up in a chair and without Geri sleeves in place. On 5/23/23 at 11:00 AM, the certified nursing assistant (CNA #5) assigned to Resident #20 was interviewed. CNA #5 verbalized unawareness that Resident #20 was ordered Geri sleeves and verbalized that Resident #20 did wear them at one time, but thought that the Geri sleeves had been discontinued. On 5/23/23 at 11:03 AM, registered nurse (RN #5) assigned to Resident #20 was asked about Resident #20's Geri sleeves. RN #5 went to Resident #20's room to look for the Geri sleeves but could not find them and verbalized unawareness of a physician order for Geri sleeves. RN #5 then reviewed the order for Geri sleeves and again verbalized that she was unaware of the order. RN #5 was then asked to review the TAR (pointing out the initials documenting placement	F 842	followed. 3- 100% licensed nurses will be educated by DON/designee on carrying out physician orders to ensure transcription to MAR/TAR are accurate and to document refusals as needed. Will be completed by 6/21/23. 1-1 inservices with nurses that inaccurately documented on resident #20 and resident #93 to ensure compliance with accurate clinical records. Completed on 6/7/23. 4- Random checks of MARS and TARS will be completed by DON/designee 3 x week x 12 weeks to ensure accurate clinical records. Audit results will be reviewed at the monthly QA committee meeting x 3 months. 5- Date of completion 06/27/23.	

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F 842	Continued From page 11	F 842		

of Geri sleeves). RN #5 verbalized that the initials on the TAR was her's and the initials indicated that the Geri sleeves were in place. When asked about documenting on the Geri sleeves being placed on Resident #20, RN #5 said that she is not supposed to be documenting something is in place when it wasn't.

On 5/23/23 at 5:06 PM, the above finding was presented to the director of nursing and administrator.

No other information was presented prior to exit conference on 5/24/23.

2. Nurses inaccurately documented on Resident #93's treatment administration record (TAR), that a hand splint was applied when the splint was not in use.

Resident #93 was admitted to the facility with diagnoses that included diabetes, Alzheimer's, hypertension, benign prostatic hyperplasia, psychotic/mood disturbance, anxiety, glaucoma, and depression. The minimum data set (MDS) dated 5/3/23 assessed Resident #93 with short and long-term memory problems, severely impaired cognitive skills, and as having impaired range of motion of the upper extremity on one side.

On 5/22/23 at 3:12 p.m., Resident #93 was observed seated in a wheelchair in the day area on his unit. Resident #93's right hand was contracted with fingertips positioned near the palm. There was no hand/wrist splint in place on the right hand. Resident #93 was observed again

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495196	A. BUILDING _____ B. WING _____	C 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF ALTAVISTA	1317 LOLA AVE ALTAVISTA, VA 24517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 12	F 842		

on 5/22/23 at 4:23 p.m. with no hand splint in place. Resident #93 was observed on 5/23/23 at 7:49 a.m. in bed eating breakfast with no hand splint in place. Resident #93 was observed again on 5/23/23 at 9:47 a.m. in bed with no hand splint in use. Resident #93 was observed on 5/23/23 at 10:28 a.m. seated near the nursing desk, at 11:23 a.m. seated in the day area and at 1:38 p.m. seated in his room. There was no hand/wrist splint in use during any of these observations.

Resident #93's TAR documented the hand/wrist splint was in place during the evening shift on 5/22/23 and on the day shift on 5/23/23. Nurses checked off and initialed use of the splint with no refusals documented.

On 5/23/23 at 1:49 p.m., the registered nurse unit manager (RN #2) was interviewed about the TAR indicating use of the splint when the splint was not applied. RN #2 stated that nurses were supposed to document if the resident refused the splint or if he removed it during the shift. RN #2 reviewed the TAR and stated that yesterday (5/22/23) nurses signed off that the splint was in use on the day and evening shifts with no mention of refusal. RN #2 stated that nursing had signed off the TAR today (5/23/23) at 11:05 a.m., indicating the splint was in use.

On 5/23/23 at 2:12 p.m., licensed practical nurse (LPN #2) and RN #3 caring for Resident #93 were interviewed about the documentation regarding splint use. When questioned specifically, RN #3 did not provide an explanation of why she documented the splint was in place. RN #3 stated, "I guess I should have documented he refused." LPN #1 stated that sometimes Resident #93 did not want the splint. LPN #1

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	495196	A. BUILDING _____ B. WING _____	C 05/24/2023

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F 842	Continued From page 13 stated, "We just signed it off as done." This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 5/23/23 at 5:05 p.m. with no further information provided about the inaccurate TAR.	F 842		