DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/02/2024 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ COMPLETED C 495256 B. WING 12/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST **AUTUMN CARE OF CHESAPEAKE** CHESAPEAKE, VA 23320 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 000 **Initial Comments** E 000 An unannounced Emergency Preparedness survey was conducted 12/05/23 through 12/08/23. The facility was in substantial compliance with 42 CFR Part 483.73. Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. F 000 **INITIAL COMMENTS** F 000 An unannounced Medicare/Medicaid standard survey was conducted from 12/05/23 through 12/08/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Ten complaints were investigated during the survey: VA00048704 Substantiated (Sub), no deficiency; VA00049344 Sub, with deficiency; VA00049591 Sub, with deficiency; VA00052041 Unsubstantiated (Unsub), lack of sufficient evidence; VA00052410 Unsubstantiated, lack of sufficient evidence; VA00053928 Unsubstantiated, lack of sufficient evidence; VA00056601 Sub, with deficiency; VA00057812 Unsubstantiated, lack of sufficient evidence; VA00059167 Sub, with deficiency; VA00059193. The census in this 117-certified-bed facility was 105 at the time of the survey. The survey sample consisted of 55 resident reviews. F 554 Resident Self-Admin Meds-Clinically Approp F 554 SS=E CFR(s): 483.10(c)(7)

Wanini strator Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

§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. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 554	This REQUIREMEN by: Based on observati interviews, facility do clinical record review assess and determined bedside, for six Residents. The findings included 1. For Residents #4 whom had medicati facility staff failed to safe to self-administically staff failed to safe to self-administ	on, resident interview, staff ocumentation review and w, the facility staff failed to ne if a Resident was safe to ications that were at the idents (Resident #42, 54, 77, survey sample of 55	F 554	1. The facility failed to assess residents (#42, 54, 77, 51, 78 #7) for self- administration as evidenced by 6 residents having observational rounds. All residence from bedside during observational rounds. All residence from bedside. All residence from bedsidence from bedsi	and ng dent sidents to be er % % tion / ent's ately vill d g staff and or dent will audits assess based ule for it will		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(20) 1411	TIDI	FORMETRIA	OMB	NO. 0938-039	1
	OF CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION		ATE SURVEY	
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		495256	B. WING			4	C 12/08/2023	
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		12/06/2023	-
AUTUMN	CARE OF CHESAPEAKE				715 ARGYLL ST			
041) ID	CULLANDY OTH			_	CHESAPEAKE, VA 23320			
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	prescription label, which Resident #394. Per the interview with CNA #1 expired on 11/10/23. e. Resident #78 had represcription label and a freeze at the bedside. approximately 1 PM, a was made of Resident was still noted to be at On 12/05/23 at 02:14 F conducted with LPN #5 medications must be kneedication cart or med asked if medications carooms, LPN #5 said, "T in room, but it is based interview for mental state score over a certain thin Being a nursing home to medications in the room where families are non-what we ask, so if we fin	ch indicated it belonged to be clinical record and an and and and and and and and and	F	554				
; ; ; ; ; ;	#5 accompanied the sur and #77's room. LPN # observations and remov hemorrhoid cream from LPN #5 also removed th Resident #78's room but #5 went on to say that th Resident #78 and her fa	red the eye drops and Resident #77's room. The eye drops from The left the bio freeze. LPN They have difficulty with The mily with bringing items						
6	n. The surveyor explain easily identified upon ob	servation and did not						

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320			
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F 554	require that the Resinspected to locate that the items were enhave been removed On 12/5/23-12/6/23, conducted of each of findings were as follows. Resident #42 had if he/she was safe to the care plan did now was able to self-admithem at the bedside include an order for b. Resident #54's clicurrent physician or supplement. On 12 note was entered in nurse in to eval resing Multivitamin. Pt has d/x of major depressassessment resider meds. Pt educated along with the risks without nurse and Minimunderstanding. c. Resident #77's porder dated 10/4/22 Relief Cream 5 % (to rectum topically apply to rectum as order was entered Solution (Carboxyres).	dent's personal items be the items. LPN #5 agreed easily identified and should by facility staff. clinical record reviews were of the Resident's charts. The bows: no assessment to determine of self-administer medications. On identify that the Resident continuister medications and keep. The physician orders did not any hair growth supplements. dinical record revealed no der for a multi-vitamin (5/23 at 5:26 PM, a progress to the record that read, "This dent for self-administration of BIMS of 14 however pt has a	F	554			

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in the second se	staff conducted an ass Resident #77 could se The assessment ident #77 had a diagnosis of candidate. d. Review of Resident the Resident had not be ability to self-administe e. Resident #78 was a the ability to self-admin 12/5/23 at 5:24 PM. To not be a candidate. The previously assessed p have medications at the obysician order for the Con 12/6/23 at 3:00 PM conducted with the Dire The DON confirmed the had assessments conce the Resident's rooms. A review was conducted self-Administration of from the policy read, "1 the resident's chart for expecific medications ur Complete the Self-Adm assessment with the re complete the Self-Adm assessment of medic complete the Self-Adm assessment with the re complete the Self-Adm assessment wit	23 at 5:22 PM, the facility sessment to determine if elf-administer medications. iffied that since Resident if dementia, they were not a #51's chart revealed that been assessed for the er medication. It is sessed by facility staff for nister medications on the Resident was noted to the Resident had not been rior to being permitted to the bedside and had no bio freeze. If an interview was ector of Nursing (DON), at many of the Residents ducted the evening prior in found by the surveyors in the facility policy titled, Medication". Excerpts If Verify physician's order in self-administration of the der consideration. 2. In the mas determined the ster medication(s), ation(s) will be Care	F	554			

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F 554	reassessed by the In Medication(s) kept at a locked drawer". On 12/6/23, in the lat Administrator was mindings. No further information of the self-application of external cream 1 per admitted to the facility Resident #7 included depressive disorder. Resident #7's Minim protocol) a quarterly Assessment Referent under cognitive status Interview for Mental as independent for an and reasonable. The care plan with a revision date of 10/2 on antidepressant the resident by the staff discomfort or adverse the staff would use the administer antidepresseribed by the phynamicist, MD, medose reduction if apprentices.	s until the resident can be terdisciplinary Team. 7 the bedside must be kept in the bedside must be kept in the afternoon, the facility ade aware of the above in was provided. It is a provided. It i	F	554		

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	approximately 1:59 p.r #7's overbed table was hydrocortisone cream she has a rash to her used and under her breast. dries up the rash and so the stated the hydrocortisone for a while. A review of Resident # Medication Administrative revealed the following: External Cream 1 %, a topically every 4 hours starting on 11/14/23. A Self-Administration in was completed on 09/0 documented the reside self-administer her own. An interview was conduct Manager on 12/08/23 as he had removed the hof Resident #7's room. beside was a house stonurse probably applied remove it from the reside the following (DON) on 12/06 stated Resident #7 had assessment completed pass. She stated Resided depression and with a definition of the stated depression and with a definition of the stated Resided depression and with a definition of the stated Resided depression and with a definition of the stated Resided pass.	of the facility on 12/05/23 at m., observed on Resident so an open tube of 1%. The resident stated upper arms, upper back She stated the cream stops her skin from itching. Ortisone cream had been in 7's December 2023, ion Record (MAR) order: Hydrocortisone pply to chest, and arms as needed for itching nedication assessment 16/23 and 12/06/23	F	554			

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F 554	A final meeting was had Director of Nursing, a Clinical Services on were informed of the information was proved. The facility policy title Medication with a reverse Residents who have been assessed to be self-administer medical Procedure read in path 1. Verify physician's for self-administration under considerations 4. If the Interdiscipling determined the reside medication (s), admir be care planned for medication. 5. Self-administration reviewed by the (IDT). 6. When a resident medications, the menurse until the reside (IDT). 7. The MAR must in self-administered, and the medication and each medication pash bedside must be kell Definitions: -Major depression is when feelings of sac frustration get in the	neld with the Administrator, and Regional Director of 12/08/23 at 1:30 p.m., who above findings. No further yided prior to exit. ed Self-Administration of vision date of 11/28/23. The desire to, and who have a capable and safe to, may cations. ert: order in the resident's chart in of specific medications.	F	554		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

AUTUMN CARE OF CHESAPEAKE STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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FACH DEFICIENCY MUST BE DESCRIBED THE THE		<u> </u>		715 ARGYLL ST		
TAGE DECLIFATION OF LCC IDENTIFY AND INFORMATION	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
Continued From page 8 works (https://medlineplus.gov/ency/article/000945.htm). -Hydrocortisone cream is used to treat redness, swelling, itching, and discomfort of various skin conditions. It works by activating natural substances in the skin to reduce swelling, redness, and itching (https://medlineplus.gov/ency/article/000945.htm). F 641 Accuracy of Assessments CFR(s): 483.20(g) Accuracy of Assessments The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for one of fifty five residents in the survey sample (Resident # 62). The findings include: Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incomplete. Resident # 62's (R62's) MDS dated 9/07/23 was incompleted with diagnoses that included athiemers, depression, dementia with psychotic disturbance, auditory hallucinations and epilepsy. The MDS dated 9/07/23 assessed R62 as being cognitively intact.	works (https://medlineplus.gi -Hydrocortisone crear swelling, itching, and conditions. It works by substances in the skin redness, and itching (https://medlineplus.gi F 641 SS=D CFR(s): 483.20(g) §483.20(g) Accuracy of The assessment must resident's status. This REQUIREMENT by: Based on staff intervier review, the facility staff accurate minimum data for one of fifty five resid (Resident # 62). The findings include: Resident # 62's (R62's incomplete. R62 was admitted with alzhiemers, depression disturbance, auditory here MDS daated 6/7/2 cognitively intact. R62's clinical record do 9/7/23. Sections C0200	ov/ency/article/000945.htm). In is used to treat redness, discomfort of various skin y activating natural in to reduce swelling, ov/ency/article/000945.htm). In the Assessments. In accurately reflect the is not met as evidenced ew and clinical record if failed to ensure an a set (MDS) assessment dents in the survey sample Of MDS dated 9/07/23 was diagnoses that included in, dementia with psychotic allucinations and epilepsy. Some assessed R62 as being occumented a MDS dated		F 641 1. Facility failed to ensure an accurate minimum data set assessment for 1 resident (#62), cognitive assessment immediated corrected for affected resident. 2. 100% of residents have the potential to be affected, A 100% audit of all current residents verifying accurate completion of cognitive assessment completed most recent MDS will be complete by the facility MDS Coordinator and/or Director of Nursing. 3. 100% of all MDS nurses, Social Service Director, and Speech Therapist, educated by DON or designee on the accurate completion of cognitive assessment within the MDS. 4. MDS and/or designee will conduct for audit completion of all cognitive assessment for all new residents and current residents based on the MDS Careplan schedule weekly for 12 weeks. Results of the audit will be submitted to QAPI committee for review and recommendation.	on ed al	

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F 641	nurse MDS coordina completing the MDS incomplete MDS. LP services usually common them. LPN#4 also structured to complete during the missed. The Long-Term Care Assessment Instrum Chapter 3 page C-2 mental statusas, "Attinterview with ALL reconducted during the Assessment Reference On 12/8/23 at 9:45 a reviewed with the action and the regional nurinformation presented (1) Long-Term Care Instrument 3.0 User Centers for Medicar Revised October 20 Develop/Implement CFR(s): 483.21(b)(1) The frimplement a compression of the co	m, the licensed practical tor (LPN#4) responsible for was interviewed about R62's N#4 stated that social upleted section C and we help ated the assessment was not elook back period and it got e. Facility Resident leent (RAI) 3.0 User's Manual documents steps for coding tempt to conduct the esidents. This interview is elook-back period of the nee Date (ARD)" (1) arm these findings were diministor, director of nursing se consultant with no further ed. Facility Resident Assessment is Manual, Version 1.18.11, e. & Medicaid Services, 23. Comprehensive Care Plan (13)		641				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that w under §483.24, §483.2 provided due to the re under §483.10, includ treatment under §483. (iii) Any specialized se rehabilitative services provide as a result of I recommendations. If a findings of the PASAR rationale in the resider (iv)In consultation with resident's representati (A) The resident's goa desired outcomes. (B) The resident's pref future discharge. Facil whether the resident's community was assess local contact agencies entities, for this purpos (C) Discharge plans in plan, as appropriate, ir requirements set forth section. §483.21(b)(3) The serv by the facility, as outlin care plan, must- (iii) Be culturally-compe This REQUIREMENT by: Based on observation,	re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not sident's exercise of rights ing the right to refuse .10(c)(6). Ervices or specialized the nursing facility will PASARR acallity disagrees with the R, it must indicate its nt's medical record. The resident and the ve(s)-list for admission and erence and potential for ities must document desire to return to the sed and any referrals to and/or other appropriate e. the comprehensive care accordance with the	F	656	F 656 1. Facility failed to implement carplan interventions for one resider (#5). Mattress was immediately placed in proper position beside to 2. 100% of residents have the potential to be affected, 100% of current residents audited for accurately fail careplan interventions in place 3. 100% of all licensed nurses educated by DON or designee on completion of fall careplans and ensuring interventions. 4. MDS and Fall committee to complete audit of all falls weekly for 12 weeks to ensure fall interventions are planned. Results of the audit be submitted to QAPI committee for review and recommendation. 5. Compliance date 1/19/2024.	or ons	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
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F 656	the facility staff failed interventions for one survey sample of 55 The findings included For Resident #5 the intervention to prevent the sesident as identified intervention to prevent was an additional mait was pushed mid-way positioned beside the construction of the sesident was noted into the sesident was noted into the sesident was noted into the sesident was pushed mid-way positioned beside the construction of the sesident was noted into the sesident was noted into the sesident with LPN (minimum data set) in the mattress in the fluoritioned directly be precaution to "protect asked to observe the "They had to move it her catheter had leal have moved it". LPN be directly beside the the Resident were to the construction of the sesident were to the survey of the sesident were to the survey of the sesident were to the survey of the survey of the sesident were to the survey of the survey	to implement care plan Resident (Resident #5) in a Residents. d: facility staff failed to ensure a mmediate bedside of the d in the care plan as a fall int injury. dimately 12:30 PM, Resident ing in bed. In the room there attress noted on the floor, but ay of the room and not be bed. M., Resident #5 was g in bed. The additional to be lying on the floor, but s placed mid-way of the room d wall. MM, an interview was #7, who is an MDS nurse. When asked about oor, LPN #7 said it is to be eside the bed as a fall of from injury". LPN #7 was e mattress and she said, t to clean in there, it was as if ked so housekeeping must N #7 confirmed that it was to e bed to prevent any injury if of fall out of bed.	F	656			
		wed and revised on 11/8/23.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	PROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320	_ [12	/08/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	mobility, impaired cogni behavior of placing sel	"[Resident #5's name fall r/t [related to] impaired nition. Resident also has fon floor". Interventions uded, "mattress to floor for afternoon, the facility de aware of the above	F6	56		
SS=D	Services Provided Mee CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Compreh The services provided as outlined by the compreh the services provided	et Professional Standards mensive Care Plans or arranged by the facility, orehensive care plan, andards of quality. s not met as evidenced resident interview, staff mentation review, and me facility staff failed to etice for two Residents in a survey sample of 55 et facility staff failed to ing practice by failing to ders to apply compression of for edema.	F 69	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495256	B. WING			12	/08/2023
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		_		71	5 ARGYLL ST		
AUTUMN	CARE OF CHESAPEAK	E		CI	HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	Street Control	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	heart failure), and complete the put on in the evening. On 12/6/23 in the mafternoon, Resident her room and no complete the room and no complete the put on the BLE. On 12/7/23 after lumber on the best of the put on the master of the put on in the master of the put on in the master of the put on in the master of the put on the	ompression hose ordered for in the morning and removed orning and again in the #85 was observed sitting in mpression stockings were on the compression stockings. orning, after breakfast, observed in her room sitting in the elchair and no rigs were on her bilateral oriew was conducted and in order for compression hose morning and removed in the resident's edema. A nurses on 12/7/23 stated that the oly after shower and on dent didn't want applied now ack later. oriem, an interview was sident #85, resident stated that is and didn't return hose after she is waiting on more to be 44am, an interview was N #6, and she verbalized that are put on the resident in the tried to put them on yesterday	F	658	F 658 1. Facility failed to follow stan of practice for two residents (#26). Resident #85 immediate received ordered ted hose. Education for nurse for reside and #26 was educated on lide patch process and medication documentation process and procedures for unavailable medications. 2. 100% of residents have the potential to be affected. A 10 audit has been conducted to all residents with ted hose an lidocaine orders have them a per resident compliance and order. Nurse educated by D0 noted deficiencies 12/7/23. 3. 100% education of all licen nursing staff regarding application of all licens nurses on 5 rights of medica administration completed by designee. 4. The DON or designee will complete audits of residents medication at bedside and application of ordered ted homedication patches 5x weeks. Results of the audit submitted to QAPI committer review and recommendation 5. Compliance Date 1/19/20	#85 and ely ent #85 pocaine of the second of	

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
I			495256	B. WING				С
		ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STR:	EET ADDRESS, CITY, STATE, ZIP CODE ARGYLL ST ESAPEAKE, VA 23320		12/08/2023
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
		On 12/8/23 at 10:00an interviewed again. The and no compression hextremities, she stated until last night and staff and removed at 9:00pm morning after her show has to apply because shose on herself. The "Lippincott Manual eighth edition, was revize-3, "Common Legal C Standards of Care" wellimited to: " failure to treatment or procedure implement a physician/a timely fashion". Administrator and DON on 12/7/23. No further information veconclusion of the survey conclusion of the survey of the physician of 12/6/23 at 8:22 AM, observed and met during observation of medication in the survey of the physician of the survey of the physician of the survey of the physician of medication of med	n, Resident #85 was e resident was in her room ose were on her lower I she didn't receive hose of applied hose at 7:00pm on and staff is to apply this over. Resident stated staff she isn't able to put the I of Nursing Practice", iewed. On page 18, in box laims for Departure from ore noted to include, but not perform a nursing properly, failure to NP/PA order properly or in made aware of findings vas provided prior to the y. e facility staff failed to the correct location as on. Resident #85 was on administration. it was chad a Lidcaine patch on	F	658			

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
LAN OI	***************************************	100000000000000000000000000000000000000				C	0.0000	
		495256	B. WING	6	TREET ADDRESS, CITY, STATE, ZIP CODE	12/0	8/2023	
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			7	15 ARGYLL ST CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE	
F 658	was conducted. Dur that Resident #85 ha read, "Lidoderm Exter Apply to left lower bar related to polyarthritis stated to apply to the revealed it was applicated was lidocaine patch on he asked about it, the Rewhen it was put on the when it was put on the conducted with LPN about Resident #85' reported, "it is supported, "When asked supposed to have owas not. When asked supposed to have owas not. When ask this, LPN #6 said shit was visible to the medication administration administration at 8:22 AM. Does looked". On 12/06/23 at 09:10 the surveyors to the confirmed the patch location and removed the	ing this review it was noted id a physician order that ernal Patch 5 % (Lidocaine) ack topically one time a day is." The physician order is lower back, observations ed to the thigh. AM, during an interview with noted that she had a er left posterior thigh. When desident said she was unsure but a nurse had applied it. 8 AM, an interview was idea and an interview was idea and an interview was idea and an interview was	F	658				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MIII	TIDLE COMPANY	OMB NO. 0938-
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME ::		495256	B. WING		С
	PROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CO 715 ARGYLL ST CHESAPEAKE, VA 23320	12/08/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE COMPLET E APPROPRIATE DATE
	According to the "Lippi Practice, Eighth Edition for Departure from Sta on page 18. The list in	ncott Manual of Nursing n", "Common Legal Claims ndards of Care" were listed cluded, but was not limited r medications properly and	F 6		
(;	On 12/6/23 at 8:16 AM,	sing practice, as ting that medications were			
R C (0	Pin #6 prepared the me Resident #26 with 4 med Capsule 100 MG, Coreg Carvedilol), Peridex Mod	uth/Throat Solution 0.12			
no Oi Pa	ollowing the administrate onducted to reconcile the oted that LPN #6 had do ral Tablet 20 MG (Furos acket 17 GM (Polyethyla Iministered when neithe	emide), and MiraLAX			
abi bei adi sur	n 12/6/23 at 9:12 AM, and nducted with LPN #6. Lout the medications do en given during the 8:16 ministration that was obveyors. LPN #6 confirmation to been given	.PN #6 was asked cumented as having 6 AM, medication served by two ned that I asix and			

CENTERS FOR MEDICARE & MEDICARD SERVICES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	IPLE CON	(X3) DATE SURVEY COMPLETED				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER (X2) PROVIDER/SUPPLIER (X3) PROVIDER/SUPPLIER (X4) PROVIDER/SUPPLIER (X5) PROVIDER/SUPPLIER (X6) PROVIDER/SUPPLIER (X7) P		IDENTIFICATION NUMBER:	A. BUILDI	NG		С		
			B. WING			1:	2/08/2023	
		495256	B. WING	STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PR	OVIDER OR SUPPLIER				RGYLL ST			
AUTUMN C	ARE OF CHESAPEAK	E		CHE	SAPEAKE, VA 23320			
		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF	RECTION	(X5) COMPLETION	
(X4) ID PREFIX TAG	(EACH DEEICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	2000	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE	
F 658	Continued From pag	je 17	F	658				
, 555	not available. When	asked why they were						
	documented as have	ing been given, LPN #6 said,						
	she was nervous.							
	A Committee of the Comm							
	Another review of th	e clinical record revealed that						
	LPN #6 had not doo	cumented that the medications						
	were not administer	ed, nor had it been indicated vas made aware of the						
	medications not bei	ng available						
	medications not be	ng available.						
	Review of the STAT	box (emergency medication						
	supply) contents lis	ting revealed the Lasix was						
	available in the STA	AT box and could have been						
	retrieved to provide	to the Resident.						
	On 12/6/23 at 9:12	AM, an interview was						
1	conducted with LPI	N #6. LPN #6 was asked to						
	explain the process	s if a medication is not						
	available LPN #6	said, if a medication is not						
	available, she wou	ld check the emergency supply						
	box (STAT box) an	d see if the medication was						
	available to be obt	ained/retrieved there and if not						
	would call the pha	rmacy and doctor. When ss had been followed for						
	Resident #85 she	indicated it had not been done.						
1	The facility admini	stration was asked to provide a						
	copy of their facilit	y policy regarding medication						
	administration. The	ne facility submitted an undated						
	document titled, "	Preparing for Medication						
	Administration".	Excerpts from this document ons Administered: Initial						
	read, Medicali	of the MAR immediately after						
	administration of	the medication. Medication						
	Availability: If a m	edication is not administered						
	because the med	ication is not available, make						
	every effort to loc	ate the medication. If the						
	medication canno	ot be located, check the interim						
	or emergency kit	for the medication so that				16 41 41-	n sheet Page 18	

STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		<u>91</u>
		495256	B. WING	B. WING		l .	С	
	PROVIDER OR SUPPLIER N CARE OF CHESAPEAKE		·	7	STREET ADDRESS, CITY, STATE, ZIP CODE 15 ARGYLL ST CHESAPEAKE, VA 23320	1 12	2/08/2023	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D RE COMPLETI		J
F 65	medication pass can be unavailable medication protocol. Contact the delivery of the medicate On 12/6/23, in the later administration was man observations and confictippincott standards of According to the "Lippin Practice, Eighth Edition for Departure from Star on page 18. The list into, "failure to administer in a timely fashion, or to omitted doses appropriate On 12/8/23, the facility of survey team with evider received disciplinary act suspended pending an interestination."	pe completed. Document in appropriately per facility pharmacy and arrange for ition. If afternoon, the facility de aware of the above remed the facility follows in ursing practice. In cott Manual of Nursing in ", "Common Legal Claims indards of Care" were listed cluded, but was not limited in medications properly and in report and administer ately". Administrator provided the ince that LPN #6 had ition on 12/7/23 and was investigation. Additionally.	F	658				
F 677 SS=D	to LPN #6 regarding me following them being ma findings. No further information w ADL Care Provided for D	ade aware of the above as received.	F 67	7				
55=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resident out activities of daily livin services to maintain good personal and oral hygien This REQUIREMENT is by: Based on observation, F	ng receives the necessary d nutrition, grooming, and ne; not met as evidenced						

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDI	NG		С	
		495256	B. WING			12/0	08/2023
	ROVIDER OR SUPPLIER	,		71	REET ADDRESS, CITY, STATE, ZIP CODE 5 ARGYLL ST HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	interview, and clinical staff failed to respon ADL (activity of daily Resident (Resident Residents). The findings include For Resident #48, the respond to the Resident and a half to respond to the Resident #48 was obtained bell. The surveyor respond to the responding profusely of the surveyor who had been waiting the surveyor who had been waiting getting washed up, this happens frequently she said she has we because some peoplell. During the above of observed sitting at the computer and were observed on Review of Resident that according to the standard respondent to the standard respondent to the standard respondent to the standard respondent respo	al record review, the facility d to a Resident's request for reliving) assistance for one #48) in a survey sample of 55 d: d: de facility staff failed to dent ringing the tap bell for an equest assistance to eximately 10:05-10:10 AM, abserved to be ringing her tap emained on the unit making and noted no staff entered sident. Throughout this time, inging the bell. At 0 AM, Resident #48 began on the bell. AM, Resident #48 was asked at she needed and reported and for staff to assist her with The Resident reported that ently that people don't come. Waited as long as 3 hours upple say they didn't hear the observations, LPN #6 was the nursing station working on various other staff members	F	677	timely for ADL assistance for 1 resident (#48), facility immedia ensured that affected resident received ADL care 2. 100% of residents have the potential to be affected. Facilic conducted interviews on 100% cognitive residents to address bell response times. 3. 100% of all staff educated bell response time, routine rouprocedures, and ensuring call are within reach during routine by DON and Administrator 4. The Facility Administrator designee will conduct weekly of call light response times x5 for 12 weeks. Results of the abe submitted to QAPI commit review and recommendation. 5. Compliance Date 1/19/2026	ty of all call on call le call unding bells care r audits weekly udit will tee for	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495256	B. WING			C	
AUTUMN	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			71	TREET ADDRESS, CITY, STATE, ZIP CODE 15 ARGYLL ST HESAPEAKE, VA 23320	<u> 12</u>	2/08/2023
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ξ .ΤΕ	(X5) COMPLETION DATE
F 684 SS=D SS=D SS=D SS=D SS=D SS=D SS=D SS=	titled, "Resident Community Light Policy". This polity respond to call lights polity of call lights polity administration was made findings. No further information of Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a function of the call the ca	e her daily ADL's. ed of the facility's policy nunication System and Call cy read, " 3. Staff will romptly". //6/23, the facility's de aware of the above was provided. elamental principle that and care provided to an the comprehensive nt, the facility must ensure eatment and care in sional standards of ansive person-centered ents' choices. Is not met as evidenced staff interview and clinical sy staff failed to maintain re care was in sident's care plan, for two and #72), in a survey	F 6				

PRINTED: 01/02/2024 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	A. BUILDING			
		495256	B. WING			12/0	8/2023
	ROVIDER OR SUPPLIER	E	·	71	REET ADDRESS, CITY, STATE, ZIP CODE 5 ARGYLL ST HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FOLL		ID PREF TAG	9,0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	providing water at the On 12/6/23 at approvere made in Reside #54 was noted to have bedside which was 3 observed that on the noted a 1000 cc fluid. On 12/6/23 at approvided by the pitcher in his room, approximately 960 conted and another of liquid was noted. A fluid restriction. On 12/7/23 at 8:23 in Resident #54's rowater pitcher on the full of ice water. A the bedside table, medications where provided beverages water pitcher and of 1000 cc fluid restriction. Review of both Residents were no restriction. Reside "1000ml fluid restriction. The pitches "1000ml fluid restriction. Reside "1000ml fluid restriction. Reside "1000ml fluid restriction. The pitches "1000ml fluid restriction. Reside "1000ml fluid restriction. The pitches "1000ml fluid restriction. Reside "1000ml fluid restriction. The pitches "1000ml fluid restricti	e bedside. ximately 10 AM, observations ent #54's room. Resident ove a water pitcher at the 3/4 full of ice water. It was e wall behind the bed, a sign of restriction. ximately 10:21 AM, nade of Resident #72's room. The was a full water which contained oc., a 120-cc cup of juice was out with approx. 120 cc of sign above bed says 1000 cc AM, observations were made one. He was noted to have a cover bed table which was 3/4 canned 12-ounce diet coke on Resident #54 also receives water is provided and is so with meals. By having the other fluids at the bedside, the other fluids at the bedside, the other have a second of the compliant with the fluid on a fluid restriction. Seation in the care plan that the n-compliant with the fluid on the properties of the compliant with the fluid on the compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-compliant with the fluid on the care plan that the n-care plan that the n-ca	F	684	F 684 1. Facility failed to maintain fluir restriction for 2 residents (#54 a #72), affected resident immedia had pitchers removed from bed 2. 100% of residents with fluid restrictions have the potential trestrictions orders and careplar audited to ensure accuracy, by or designee. 3. 100% of all staff have been educated regarding the facility and procedure for residents wirestrictions by nursing home administrator. 100% of all food service staff educated on providuids per order for residents will fluid restrictions by dietician. In nursing staff educated on providuids per order for residents with fluir restriction for visualization of interventions in place x 5 weel 12 weeks. Results of the audit submitted to QAPI committee review and recommendation 5. Compliance Date 1/19/2024	and ately liside. o be h fluid ns DON policy th fluid ith 00% of riding ith d kly for the will be for	

ı	STATEMEN	IT OF DEFICIENCIES	(X4) PROMPERIOR				OMB NO. 0938-0391		
		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		LE CONSTRUCTION		TE SURVEY MPLETED	
			495256	B. WING	i		١.	С	
		PROVIDER OR SUPPLIER N CARE OF CHESAPEAKE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320	<u> 1</u>	2/08/2023	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E JTE	(X5) COMPLETION DATE	
		Resident #72's physici Fluid restriction Dietary Lunch=240cc, dinner=AM=120cc, PM=120cc every shift". On 12/7/23 at approximinterview was conducted asked about the two Rorestrictions, she confirm restrictions. When ask being at the bedside armaintained the fluid reswas not sure and perhathere just as facility profon 12/7/23, in the late administration was madifindings. No further information was ree of Accident Hazard CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure	an order read, "1000ml y Breakfast=240cc, 240cc Total=720ml Nursing to NOC=40cc Total=280ml should be a sidents being on fluid and they were both on fluid and they were both on fluid asked how they striction, LPN #6 said, she aps the water pitcher was stocol. afternoon, the facility are aware of the above striction was provided. As/Supervision/Devices that - and ent receives adequate are devices to prevent and as evidenced assident interview, staff are taken interview, staff are facility staff failed to	F 68	684				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			SURVEY LETED
		495256	B. WING			12/	08/2023
	ROVIDER OR SUPPLIER CARE OF CHESAPEAK	E	•	71	REET ADDRESS, CITY, STATE, ZIP CODE 5 ARGYLL ST HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	300000	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	hazards on one of formal hazards included to secure medications as afe environment, 1a. On 12/5/23 at an observations were of Multiple Residents of Counter medications included: a. Resident #42 has at bedside. b. Resident #54 has on the bedside table on the bedside and bathroom. d. Resident #77 has at the bedside and bathroom. d. Resident #51 has and a bottle of Sambedside table. The prescription label, we resident #394. Per interview with CNA expired on 11/10/2 e. Resident #78 has prescription label afreeze at the bedsiapproximately 1 P was made of Resident was still noted to be conducted with LF medications must	d: Inursing unit, the facility failed as and chemicals to maintain free of accident hazards. pproximately 12:00 PM, conducted of the 100 unit. were noted to have over the at the bedside. They d hair growth pills/supplement d Nutririte-800 multivitamins e. d refresh lubricating eye drops hemorrhoid cream in the a Sarna lotion had a which indicated it belonged to be the clinical record and an aft, Resident #394 had 3. ad refresh eye drops with a and a container of roll-on bio ide. On 12/6/23, at M, an additional observation dent #78's room. The bio freeze	F	689	1. Facility failed to maintain a senvironment, free of accident on one of four resident care un including secure medications and chemicals. All medications and chemical bottle immediately refrom unit and secured. 2. 100% of residents have the potential to be affected. All environmental services staff on chemical spray bottle label 12/6/23. 100% audit conducte ensure appropriate medication storage by the DON or design 100% of residents rooms and unsecure medications and cle chemicals. 3. 100% of all licensed nurses educated on proper medication storage completed by DON or designee, 100% of interdiscip team educated on facility rour and reporting procedure for a or chemicals not stored proped. Interdisciplinary team will caudits within facility to ensure medication or chemicals with resident rooms 5 x weekly for weeks. Results of the audit was submitted to QAPI committee review and recommendation. 5. Compliance Date: 1/19/20	ducated ing on id to nee. ited for eaning on idinary inding ny meds erly. conduct en o in rate for in rate in o in o in rate in o in	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		495256	B. WING	<u> </u>	С	
NAME OF	PROVIDER OR SUPPLIER	400200	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		12/08/2023
AUTUM	N CARE OF CHESAPEAKE			715 ARGYLL ST CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	asked if medications or rooms, LPN #5 said, "in room, but it is based interview for mental stascore over a certain the Being a nursing home medications in the room where families are non what we ask, so if we fand notify the DON (Dimanager. Following the above in #5 accompanied the stand #77's room. LPN #5 accompanied the stand #77's room to servations and remon hemorrhoid cream from LPN #5 also removed to Resident #78's room but #5 went on to say that the Resident #78 and her fain. The surveyor explained in the that the items were eashave been removed by The facility provided an "Medication Storage". Endocument read, "Proper standard of practice Medication carts and call when unattended".	ran be kept in the Resident They should not keep meds d on their BIMS (brief atus) score. They must ing, to even be considered. though we don't keep ms. We have had people decomplaint and go against find something we take it rector of Nursing) and unit terview with LPN #5, LPN driveyors to Resident #78 #5 confirmed the ved the eye drops and for Resident #77's room. The eye drops from fut left the bio freeze. LPN they have difficulty with family with bringing items for the the titems were for the servation and did not fut's personal items be fitems. LPN #5 agreed filly identified and should facility staff. fundated document titled, fixcerpts from this for medication storage is a fedication Carts: for binets should be locked	F 68			
	1b. On 12/5/23 at appro- following was observed	ximately 12:30 PM, the on the 100 unit.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495256	B. WING			12/08	3/2023	
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKI		715 ARGYLL ST CHESAPEAKE, VA 23320		ESAPEAKE, VA 23320			
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F 689	Resident #85 had a bedside. In Resident in her room, there we chemical that was grano label. On 12/05/23 at 02:10 conducted with Other housekeeper. The hall chemicals are to of the housekeeping then proceeded to so the cart lock was brought in the proceeded to so the cart lock was brought in the many get to them, and it conducted with the Director (Other Emphottle with the clear be in his office. Who chemicals in the Repercent no". When have a label, he said that's not normal for the 100 unit they wander and self-prowhen asked if they CNA #2 said yes. A review was cond "Hazard Communic Excerpts from the pattern of the pattern	bottle of Lysol spray at her it #17's bathroom, which was as a spray bottle of cleaning reen in color. The bottle had O PM, an interview was er Employee #2, who was a housekeeper explained that be kept in the locked portion of cart. Other Employee #2, how the two surveyors that beken so she was not able to of why chemicals must be the said, "because patients can an be dangerous". PM, an interview was Maintenance/Housekeeping bloyee #3). The unlabeled hing chemicals was noted to then asked if it is ok to leave tesident's room, he said, "100 asked if the bottle was to id, "Yes that is an OSHA issue,	F	689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	AUTUMN	PROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CO 715 ARGYLL ST CHESAPEAKE, VA 23320	ODE	12	/08/2023	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE ACTI	ON SHOULD BE HE APPROPRIAT	E	(X5) COMPLETIO DATE	N
	SS=E	workplace. Applying a to containers The En following safe work in rules". On 12/6/23, in the late Administrator was made findings. No further information on RN 8 Hrs/7 days/Wk, FCFR(s): 483.35(b)(1)-(3) §483.35(b) (Registered of §483.35(b)(1) Except where the services of least 8 consecutive hour services of nursing on a service of nursing on the PBJ) Staffing Data Reports of the PBJ) Staffing Data Reports of the PBJ Staffing Data Reports of the Registered Nurse of the least eight consecutive wenty-four hour period, in the service of the period, in the service of the period of the period of the period of the service of the service of the service of the period o	a HIMS label (if necessary) inployee is responsible for: methods and safety afternoon, the facility le aware of the above was provided. ull Time DON B) nurse then waived under his section, the facility of a registered nurse for at rs a day, 7 days a week. Then waived under his section, the facility ered nurse to serve as the full time basis. for of nursing may serve when the facility has an y of 60 or fewer residents. In not met as evidenced Payroll Based Journal ort, review of the actual urse staff, and staff off failed to ensure they (RN) providing services whours within each	F 72	589				
	a tv	it least eight consecutive	hours within each						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION C 12/08/2023 B. WING 495256 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 ARGYLL ST **AUTUMN CARE OF CHESAPEAKE** CHESAPEAKE, VA 23320 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 727 F 727 Continued From page 27 F 727 1. Facility failed to provide required 8 consecutive RN hours for 18 days The Fiscal Year Quarter 4 2023 (July 1 over last year September 30) PBJ Staffing Data Report 2. 100% of residents have the triggered for four or more days within the quarter potential to be affected, A 100% audit with no RN hours. A review of eleven months of was completed for last 30 days to actual nurse staffing from January 2023 through ensure that 8 hours of consecutive November 2023 revealed the facility was without RN hours are provided each day. an RN on duty eight consecutive hours on 3. 100% of nursing leadership and 2/12/23, 2/18/23 2/19/23, 3/4/23, 3/11/23, scheduler educated on requirement 3/19/23, 4/29/23, 7/9/23, 7/22/23, 7/23/23, 9/3/23, to ensure 8 hours of RN coverage in 9/9/23, 9/16/23, 9/30/23, 10/1/23, 10/14/23, the facility each day by the nursing 10/15/23, 11/23/23. home administrator. 4. Administrator or designee will On 12/7/23 at approximately 4:45 PM an interview was conducted with Licensed Practical conduct audit on RN coverage scheduled for each day of the week Nurse (LPN) #11. LPN #11 stated a great deal of and will confirm 8 hours of effort is expended to obtain RN coverage for the consecutive RN hours scheduled weekends and holidays but it is very challenging daily for 12 weeks. and occasionally they are not successful in meeting the requirement to have an RN on duty 5. Compliance Date 1/19/2024. for eight consecutive hours every twenty-four hours. LPN #11 also stated many times the RN is scheduled, but calls out therefore the facility is without the supervision of the RN. The review also identified that many days in which RN coverage was not available it was because an RN had not been scheduled to work for eight consecutive hours within each twenty-four hour period Since a lack of RN coverage was identified for four or more days in quarters two and four, and already for quarter one which will end 1/1/2024, random days without RN coverage were reviewed for the potential for more than minimal harm due to the facility's RN staffing failure. The review

failured to identify specific services could not be provided when an RN was not available for eight consecutive hours within each twenty-four hour

PRINTED: 01/02/2024

STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION			O. 0938-0391 E SURVEY
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F 72	7 Continued From page period.	28	F 7	27			
F 755 SS=D	interview was conducted Director of Nursing and Consultants. The DON noncompliance but offer information regarding a compliant with RN staff voiced no concerns reginformation. Pharmacy Srvcs/Proce CFR(s): 483.45(a)(b)(1)	acknowledged the ered no additional a strategy to become fing and the facility's team garding the above dures/Pharmacist/Records)-(3)	F 75	55			
	drugs and biologicals to them under an agreeme §483.70(g). The facility personnel to administer	e routine and emergency its residents, or obtain ent described in may permit unlicensed					
	§483.45(a) Procedures. pharmaceutical services that assure the accurate dispensing, and adminis biologicals) to meet the	(including procedures acquiring, receiving, tering of all drugs and					
	§483.45(b) Service Cons must employ or obtain the pharmacist who-	sultation. The facility se services of a licensed					
	§483.45(b)(1) Provides of aspects of the provision of the facility.	consultation on all of pharmacy services in					
	§483.45(b)(2) Establishe	s a system of records of					

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) F 755 Continued From page 29 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and \$483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically recorded. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to three (3) of 55 residents in the survey sample (Resident #69, #26, #35) and during a medication pass on one of four units (100 unit). The findings include: 1. Resident #69's medication Janumet was not available for administration resulting in five missed doses of the medication. Resident #69's medication and dysphagia. The minimum data set (MDS) dated 11/6/23 assessed R66 as cognitively intact. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 2. Something Table Appropriate 2. PROVIDERS PLAN TO CORRECTION 2. PROVIDERS PLAN TO CORRECTIO	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			SONE THE STORY	(3) DATE S COMPL	URVEY ETED
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AUTUMN CARE OF CHESAPEAKE CHEAPEAKE, VA 23320 CHEAPEACA AND AND AND AND AND AND AND AND AND AN	NAME OF PE	ROVIDER OR SUPPLIER			CONT.			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULTORY OR LSC IDENTIFYING INFORMATION) TAG			-					
F 755 Continued From page 29 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and S483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to three (3) of 55 residents in the survey sample (Resident #69's medication Janumet was not available for administration resulting in five missed doses of the medication. Resident #69's medication Janumet was not available for administration record review, the facility with diagnoses that included diabetes, cerebral infrarction, dysarthria, hypertension, protein-calorie mainutrition and dysphagia. The minimum data set (MDS) dated 11/6/23 assessed R69 as cognitively intact. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication or Sunday and procedure on protein-calorie mainutrition and dysphagia. The minimum data set (MDS) dated 11/6/23 assessed R69 as cognitively intact. PREFIX TAG RAPICAL CORRECTIVE ACTIONS MOLIDAS CROSS AREFERENCE TO THE APPROPRIATE DEACH STAGE TO THE APPROPRIATE DEACH STAGE TO THE APPROPRIATE DEACH STAGE TO THE MEDICAL	AUTUMN	CARE OF CHESAPEAK	E		С			
Continued From page 29 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications were available for administration to three (3) of 55 residents in the survey sample (Resident #69, #26, #85) and during a medication pass on one of four units (100 unit). The findings include: 1. Resident #69's medication Janumet was not available for administration resulting in five missed doses of the medication. Resident #69 (R69) was admitted to the facility with diagnoses that included diabetes, cerebral infarction, dysarthria, hypertension, protein-calorie malnutrition and dysphagia. The minimum data set (MDS) dated 11/6/23 assessed R69 as cognitively intact. Resident #69's clinical record documented a physician's order dated 8/9/23 for the medication 1. Facility failed to provide medication or three residents #69 discharged on 7/30/22, resident #85 given liquid iron from house stock and peridox ordered through pharmacy and given on 12/7/23. LPN responsible for residents #26 and #85 educated on 12/7/23 and medications. 2. 100% of residents have the potential to be affected, 100% audit completed of all medication ordered in stock and available by DON or designee. 3. 100% of all licensed nursing staff educated regarding medication availability, utilization of stat box, and process to follow when medication is unavailable. 4. DON or designee will conduct audits weekly for 12 weeks of all medication carts to ensure medication availability. Results of the audit will be submitted to QAPI committee for review and recommendation. 5. Compliance date 1/19/2024.	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	2000	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
Janumet 50-1000 mg (milligrams) one tablet by mouth two times per day for type 2 diabetes. A physician's order was documented on 11/2/23 for Janumet 50-1000 mg two times per day via gastric tube for management of type 2 diabetes. Resident #69's medication administration record	F 755	receipt and dispositic sufficient detail to en reconciliation; and §483.45(b)(3) Deternorder and that an act is maintained and portion order and that an act is maintained and portion order and that an act is maintained and portion order and that an act is maintained and portion order or an act interview, facility do record review, facility do record review, the famedications were at three (3) of 55 resid (Resident #69, #26, pass on one of four The findings included 1. Resident #69's mavailable for adminimissed doses of the Resident #69 (R69 with diagnoses that infarction, dysarthriprotein-calorie maliminimum data set in R69 as cognitively Resident #69's climphysician's order of Janumet 50-1000 mouth two times pophysician's order of Janumet 50-1000 gastric tube for maintain that is a sufficient with the sufficient reconstitution of the population	mines that drug records are in able an accurate mines that drug records are in account of all controlled drugs eriodically reconciled. It is not met as evidenced acility staff failed to ensure vailable for administration to lents in the survey sample #85) and during a medication units (100 unit). Example: medication Janumet was not instration resulting in five the medication. In was admitted to the facility the included diabetes, cerebral in instration and dysphagia. The (MDS) dated 11/6/23 assessed intact. Mical record documented a lated 8/9/23 for the medication may (milligrams) one tablet by the reday for type 2 diabetes. A was documented on 11/2/23 for may two times per day via an agement of type 2 diabetes.	F	755	1. Facility failed to provide medication ordered for three residents (#69, #26, and #85) resident Resident #69 discharged 7/30/22, resident #26 was given both medications that day and resident #85 given liquid iron fron house stock and peridox ordered through pharmacy and given on 12/7/23. LPN responsible for residents #26 and #85 educated 12/7/23 on medication administrated and policy and procedure on unavailable medications. 2. 100% of residents have the potential to be affected, 100% aucompleted of all medication orde in stock and available by DON or designee. 3. 100% of all licensed nursing seducated regarding medication availability, utilization of stat box process to follow when medication available. 4. DON or designee will conduct audits weekly for 12 weeks of all medication carts to ensure medication availability. Results of audit will be submitted to QAPI committee for review and recommendation.	on ation udit ered r staff a, and on is	

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	(MAR) documented the Janumet was not admin 9:00 a.m. and 5:00 p.m administered on 9/7/23 MAR documented the administered on 12/2/2 12/3/23 at 9:00 a.m. A nursing note dated 9. Janumet was not admin was not available from practitioner's note dated "missed JanumetPe given for 2 days" An documented regarding MD [physician] awaiting and a note on 12/3/23 c per MD until received from the company of the missed doses stated she sometimes e timely deliveries from the stated she usually order when there were five or card. LPN #1 stated she medications before and medications before and medications had not be stated she was not sure not available on 9/6/23, \$12/3/23. On 12/6/23 at 10:30 a.m. #2) was interviewed abo Janumet. LPN #2 stated sent a 14-day supply of the pharmacy requested	e 9:00 a.m. dose of nistered on 9/6/23 and the n. doses were not b. The December 2023 Janumet was not 13 at 9:00 p.m. and on 16/23 documented R69's nistered because the drug the pharmacy. A nurse of 9/10/23 documented, er nurse, Janumet not ursing note dated 12/2/23 the Janumet, "hold per pharmacy to deliver" Hocumented, "On hold om pharmacy" 1, the licensed practical or R69 was interviewed at of Janumet. LPN #1 experienced problems with the pharmacy. LPN #1 et refills on medicines less doses on the supply the had reordered three days later, the en delivered. LPN #1 why the Janumet was 9/7/23, 12/2/23 or, the unit manager (LPN the pharmacy usually the Janumet and at times	F 7	55				

NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE AUTUMN CARE OF CHESAPEAKE (ACH) DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREETX TAG FROM 11/2/23 as 1:54 p.m., the unit manager (LPN #2) was interviewed about R69's unavailable Janumet. LPH #2 stated the Janumet was not sure why it was not available on 12/2/23. On 12/6/23 at 1:54 p.m., the unit manager (LPN #2) stated in refills several days in advance of running out. On 12/7/23 at 3:04 p.m., the director of nursing (DON) was interviewed about R69's unavailable Janumet. The DON stated regarding the pharmacy deliveries, "We have problems at times." The DON stated fregarding the pharmacy deliveries, "We have problems at times." The DON stated nurses entered refill orders from the computer and were expected to reorder medicines at least two days in advance of running out to allow time for delivery. On 12/7/23 at 5:55 p.m., the facility's consultant pharmacist (other staff #1) was interviewed about R69's unavailable Janumet doses. The pharmacist stated R69's insurance "did not like the medicine." The pharmacist stated S69's insurance "did not like the medicines" the pharmacist stated R69's insurance "did not like the medicines". The pharmacist stated S99 insurance "did not like the medicines" at least two days upply was provided and other times a 14-day supply was provided and other times a 7-day supply was sprovided and other times a 7-day supply was provided and other times a 7-day supply was sprovided and other times a 7-day supply was sprovided and other times a 7-day supply was provided and other times a 7-day supply was sprovided and other times a 7-day supply was sprovided and other times a 7-day supply was provided and other times a 7-day supply was provided and other times a 7-day supply was provided and other times a 7-day supply was	STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE S COMPL	ETED	
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LPN #2 stated the Janumet was most recently reordered on 11/22/23 so she was not sure why it was not available on 12/2/23. On 12/6/23 at 1:54 p.m., the unit manager (LPN #2) was interviewed again about R69's unavailable Janumet. LPN #2 stated the Janumet was not stocked in the back-up supply, so it had to be delivered from the pharmacy. LPN #2 stated nurses were expected to order medication refills several days in advance of running out. On 12/7/23 at 3:04 p.m., the director of nursing (DON) was interviewed about R69's unavailable Janumet. The DON stated regarding the pharmacy deliveries, "We have problems at times." The DON stated hanumet was not part of the back-up inventory. The DON stated nurses entered refill orders from the computer and were expected to reorder medicines at least two days in advance of running out to allow time for delivery. On 12/7/23 at 5:55 p.m., the facility's consultant pharmacist (other staff #1) was interviewed about R69's unavailable Janumet doses. The pharmacist stated R69's insurance "did not like the medicine." The pharmacist stated sometimes a 14-day supply was provided and other times a 7-day supply was provid	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE	
alternate medication had been considered since there had been problems with keeping the Janumet in stock at the facility. The facility's policy titled Medication Storage	F 755	LPN #2 stated the Jareordered on 11/22/2 was not available on On 12/6/23 at 1:54 p #2) was interviewed unavailable Janumet Janumet was not sto so it had to be delived #2 stated nurses we medication refills serunning out. On 12/7/23 at 3:04 p (DON) was interview Janumet. The DON pharmacy deliveries times." The DON st part of the back-up in urses entered refill and were expected two days in advance for delivery. On 12/7/23 at 5:55 pharmacist (other s R69's unavailable J pharmacist stated F the medicine." The a 14-day supply was spharmacist stated of the back-up inventoral ternate medication there had been pro Janumet in stock ar	anumet was most recently 23 so she was not sure why it 12/2/23. 2.m., the unit manager (LPN again about R69's t. LPN #2 stated the ocked in the back-up supply, ared from the pharmacy. LPN are expected to order overal days in advance of 2.m., the director of nursing ared about R69's unavailable a stated regarding the acted the Janumet was not anventory. The DON stated a orders from the computer are of running out to allow time p.m., the facility's consultant anumet doses. The acted and other times a anent to the facility. The alanumet had not been setup in any, and he was not sure if an an had been considered since blems with keeping the at the facility.	F	755				

STATEME	NT OF DEFICIENCIES	(X1) PROMPERIOUS (SEC.)	T	_		OMB N	NO. 0938-0391
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	F PROVIDER OR SUPPLIER IN CARE OF CHESAPEAKE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320	1	2/06/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E NTE	(X5) COMPLETION DATE
F 75	"Medication is availal orders" The facility's Medication Storage and Pathway (CMS for 200 "Medications should administered as orderer-Prompt re-ordering -P medications - Prompt repharmacy if issue with This finding was review and director of nursing 12/8/23 at 9:35 a.m. with provided regarding the 2. For Resident #26, thensure that medications administration. On 12/6/23 at 8:16 AM, prepare and administer #26. LPN #6 administer #26. LPN #6 administer Coenzyme Q10 Capsul 12.5 MG (Carvedilol), P Solution 0.12 % (Chlorh (Mouth-Throat), and boo supplement). Following the administration on the conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted to the conducted to reconcile the noted that LPN #6 had conducted to the conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted with Resident to reconcile the noted that LPN #6 had conducted to reconci	able for all active resident is training protocol titled and Labeling Critical Element (189) documented, be always available to be ad by following these steps: rompt receiving of notification to provider or medication order" Inved with the administrator during a meeting on the no further information unavailable medication. The facility staff failed to be swere available for LPN #6 was observed to medications to Resident and the medications, and the medications, are 100 MG, Coreg Tablet eridex Mouth/Throat decider Mouth/Throat decider (a nutritional content of the administration). It was documented that Lasix desemide) and MiraLAX alene Glycol 3350) were der were.	F	755			

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION	СОМ	E SURVEY PLETED
		495256	B. WING	1200000		12	/08/2023
	ROVIDER OR SUPPLIER	E		715 AF	T ADDRESS, CITY, STATE, ZIP CODE RGYLL ST SAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	2007	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 755	On 12/6/23 at 9:12 A conducted with LPN about the medication been given during the administration that we surveyors. LPN #6 MiraLAX had not been documented as having she was nervous. Another review of the LPN #6 had not documented as having the medicated that aware of the state available in the STA retrieved to provide 3. For Resident #85 ensure that two menadministration as of the medications to Resident #85 was given a medications to Resident #85 was given. The iron sumedication cart had therefore was not a Peridex mouth solution.	M, an interview was #6. LPN #6 was asked hs documented as having he 8:16 AM, medication was observed by two confirmed that Lasix and hen given because they were hasked why they were hing been given, LPN #6 said, he clinical record revealed that humented that the medications hor administration, nor had it he physician was made hations not being available. Those (emergency medication hing revealed the Lasix was hat box and could have been	F	755			

	STATEMENT	OF DEFICIENCIES	0/4) ========				OWR M	IO. 0938-039	91
		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			495256	B. WING				С	
ľ	NAME OF I	PROVIDER OR SUPPLIER			_		1 12	2/08/2023	
		CARE OF CHESAPEAKE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ξ .TE	(X5) COMPLETION DATE	
		to administer medicative take measures to obtain the provider that the mavailable for administration on 12/6/23 at approximate record review was conchart. This review reverse physician had been not being available nor the to obtain/order the need on 12/6/23 at 9:12 AM/conducted with LPN #6 explain the process if a available. LPN #6 said available, she would chox (STAT box) and seed available to be obtained would call the pharmace asked if this process had Resident #85, she indicative to the indication. The facility administration. The facility administration. The facility policy administration. The facility policy administration of the medication of the medication cannot be lower effort to locate the medication pass can be unavailable medications.	in the medications or notify redications were not redications were not redications. Inately 9 AM, a clinical ducted of Resident #85's realed no indication that the tified of the medication not pharmacy being contacted ded medications. In an interview was redication is not reck the emergency supply redication is not redication was redication was redication was redication. When red been followed for redication redication. Medication redication. Medication redication. Medication redication. Medication redication. If the redication redication redication. If the redication so that	F	755				
	1.1	Ourtact the pri	armacy and arrange for		1			- 1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495256	B. WING			1 1	2/08/2023	
	CARE OF CHESAPEAK	I.	,	715	EET ADDRESS, CITY, STATE, ZIP CODE ARGYLL ST SAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO T	ULD BE	(X5) COMPLETION DATE	
F 755	administration was nobservations. On 12/8/23, the facil survey team with evireceived disciplinary suspended pending the facility administrato LPN #6 regarding		F	755				
F 759 SS=E	CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensure the second of th	Error Rts 5 Prcnt or More) on Errors. sure that its- ation error rates are not 5	F	759				
	by: Based on observat record review, and facility staff failed to rate was less than 8 errors in 26 opportu							
	On 12/6/23 at 8:16	AM, LPN #6 was observed to ister medications to Resident						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY
			A. BOILD	ING _			C
		495256	B. WING			1:	2/08/2023
	CARE OF CHESAPEAKE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 115 ARGYLL ST CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Resident #85. During the medication LPN #6 prepared their Resident #26 with 4 m Capsule 100 MG, Cord (Carvedilol), Peridex M % (Chlorhexidine Gluctoboost (a nutritional superiority of the conducted to reconcile noted that LPN #6 had Oral Tablet 20 MG (Furnal Packet 17 GM (Polyett administered when neinoted that LPN #6 about the medications been given during the 8 administration that was surveyors. LPN #6 cord Miral AX had not been not available. When as documented as having she was nervous. Another review of the collections and the physician was medications not being at Review of the STAT bostsupply) contents listing	administration observation, medications and provided dedications, Coenzyme Q10 eg Tablet 12.5 MG Mouth/Throat Solution 0.12 conate (Mouth-Throat), and oplement). ration a record review was a the administration. It was a documented that Lasix rosemide), and MiraLAX hylene Glycol 3350) were ther were given. , an interview was 6. LPN #6 was asked documented as having 8:16 AM, medication a observed by two infirmed that Lasix and given because they were sked why they were been given, LPN #6 said, linical record revealed that ented that the medications nor had it been indicated made aware of the available. It (emergency medication revealed the Lasix was box and could have been	F	759	F 759 1. Upon med pass observations during annual inspection, the fact failed to ensure a med pass errorate of less than 5%. 2. 100% of residents have the potential to be affected, 100% of license nurses will receive a Medication Administration Competency by the Director of Nursing and/or designee to ensuaccurate medication administration 3. 100% of all licensed nurses we educated on the 5 Rights of Medication Administration and the facility Medication Administration protocol by the Director of Nursing 4. Director of Nursing or designe conduct 5 Observational Medicate Administration Competency's perweek for 12 weeks. All aggregate findings will be submitted to the Committee for review and recommendation. 5. Compliance date 1/19/2024.	re on. ill be ng e will tion	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495256	B. WING			12/0	8/2023	
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 759	On 12/6/23 at 8:22 A during the preparatio medications to Resid Resident #85 was giver 2 medications, Peridex Mouth/Throagiven. The iron suppredication cart had a therefore was not admouth solution was remedication cart. LPN #6 then continue administration and mouth administer medication cart. LPN #6 then continue administer medication was remedication and mouth administer medication and mouth administer medication was remedications were not to see if the provider order to provide. On 12/6/23 at approvider order to provide. On 12/6/23 at approvider order to provide and the pharmacy being available and the pharmacy being needed medications On 12/6/23 at 9:12 A conducted with LPN explain the process available. LPN #6 savailable, she would box (STAT box) and available to be obtain	M, LPN #6 was observed in and administration of ent #85. It was noted that were 9 medications. There is a liquid iron supplement and it Solution that were not element that was in the expired November 2023, and ministered and the Peridex not available in the element that was in the expired November 2023, and ministered and the Peridex not available in the element that was in the element that was in the expired November 2023, and ministered and the Peridex not available in the element that was in the element available in the element available in the element in the provider that the element in the elem	F	759				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495256	B. WING _		C 12/08/2023	
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320	1 12	100/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	asked if this process here asked if this process here acopy of their facility possible administration. The factor administration. The factor administration. The factor administration. Excerded, " Medications appropriate book of the administration of the new Availability: If a medication because the medication every effort to locate the medication cannot be or emergency kit for the medication pass can be unavailable medication protocol. Contact the industry of the medication of the medication protocol. Contact the industry of the medication protocol. Contact the industry of the medication was man observations. On 12/6/23, in the lateral administration was man observations. On 12/8/23, the facility survey team with evidence in the facility administration and the facility administration to LPN #6 regarding medications.	and been followed for icated it had not been done. Ition was asked to provide a plicy regarding medication acility submitted an undated aring for Medication rpts from this document Administered: Initial e MAR immediately after medication. Medication ation is not administered on is not available, make me medication. If the located, check the interim medication so that me emedication so that me emedication so that me employed per facility pharmacy and arrange for medication. In afternoon, the facility de aware of the above Administrator provided the ence that LPN #6 had control of the control of the addition and provided education edication administration and aware of the above	F7	759		
	Label/Store Drugs and CFR(s): 483.45(g)(h)(1	Biologicals	F 76	51		

CENTER	S FUR WEDICARE &	MEDICAID SERVICES			and the second s	C.11.D 110	. 0000 0001	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						C	CONTROL ACTION CONTROL	
		495256	B. WING	_		12/0	08/2023	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
AUTUMN	CARE OF CHESAPEAKE			1905	15 ARGYLL ST			
					CHESAPEAKE, VA 23320		200	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Continued From page §483.45(g) Labeling or Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h) Storage of §483.45(h)(1) In according Federal laws, the fact biologicals in locked temperature controls personnel to have according to the Comprehensive In Control Act of 1976 a locked, permanently storage of controlled the Comprehensive In Control Act of 1976 a lockage drug distributed quantity stored is minuted by: Based on observation documentation revieensure medications location, accessible residents: Residents	of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and illity must store all drugs and compartments under proper and permit only authorized is to the keys. Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can of the facility staff failed to were stored in a secured to designated staff for 7 of 55 for Resident #77, Resident #51 the survey sample.		761		er ints ind ed idents udit e or		
	The facility staff facility staff facility staff. Hydrocortisone crea	m 1 percent (%) was stored						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	à é	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495256	B. WING _			C 12/08/2023	
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 761	staff only. Resident # facility on 11/30/22. Dincluded but not limite disorder. Resident #7's Minimum protocol) a quarterly a Assessment Reference under cognitive status Interview for Mental S as independent for deand reasonable. During the initial tour capproximately 1:59 p.r #7's overbed table was hydrocortisone cream applied the cream to a arms, upper back, and stated the cream dries skin from itching. She cream had been in her A review of Resident # Medication Administrative aled the following External Cream 1 %, a topically every 4 hours starting on 11/14/23. An interview was cond Manager on 12/08/23 a she removed the hydrostarting on 11/10/19/25.	accessible to designated 7 was admitted to the biagnosis for Resident #7 d to major depressive In Data Set (an assessment ssessment with an e Date (ARD) of 09/14/23, was not coded on the Brief tatus (BIMS) but was coded cisions being consistent In the facility on 12/05/23 at m., observed on Resident s an open tube of 1%. The resident stated rash located to her upper ander her breast. She up the rash and stops her stated the hydrocortisone room for a while. It is December 2023, tion Record (MAR) order: Hydrocortisone apply to chest, and arms as needed for itching ucted with the Unit at 10:07 a.m. She stated bocortisone cream out of the stated the cream at ock cream and should	F 7	61			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71, 50125			С	
		495256	B. WING			12/0	08/2023
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			7	STREET ADDRESS, CITY, STATE, ZIP CODE 115 ARGYLL ST CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Nursing (DON) on 12 stated Resident #7 has assessment complete pass. She stated Redepression and with a who cannot self-admit She stated Resident should have been sto and applied by the number of the should have been sto and applied by the number of the should have been sto and applied by the number of the should have been sto and applied by the number of the should have been sto and applied by the number of the should have been sto and applied by the number of the should have been sto and applied by the number of the should have been stored as practice. Definitions: -Major depression is when feelings of sadd frustration get in the should have been stored as welling, itching, and conditions. It works the substances in the sk redness, and itching (https://medlineplus.go.) 2. On the 100 unit, the sk redness is the sk redness.	ducted with the Director of /08/23 at 11:15 a.m., who ad a self-administration ed this morning and did not sident #7 has a diagnosis of a diagnosis of depression inister your own medication. #7's hydrocortisone cream ored in the medication cart urse. The definition of 12/08/23 at 1:30 p.m., who above findings. No further ided prior to exit. The document titled Medication torage is a standard of a mood disorder. It occurs ness, loss, anger, or way of your life over a long or changes how your body The document of various skin by activating natural	F	761			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10. 00.000.000.000.000	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	B. WING		С
NAME OF PROVIDER OR SUPPLIER]	STREET ADDRESS, CITY, STATE, ZIP CODE	12/08/2023
AUTUMN CARE OF CHESAPEAKE			715 ARGYLL ST CHESAPEAKE, VA 23320	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
with LPN #6, during m LPN #6 was preparing #85. When LPN #6 re the medication cart, si disposable medicine of bottle. She noted that 2023. Upon identificated discarded the poured bottle in the bottom dr. During the above observations are to be medications are to be medication cart and dinot given to Residents. Resident #85's orders administration record or revealed that Resident 11/4/23, that read, "Fe (Ferrous Sulfate) Give day for Supplement". administration record medication had been so given/administered the #6 was asked if the exigiven, she stated she cother supply to administration above observation. The medication storage was	M, observations were made nedication administration. If medications for Resident etrieved the liquid iron from the poured the dose into a cup and then checked the state iron expired November tion of this, LPN #6 medication and placed the awer of the medication cart. Ervation, LPN #6 was stated that expired removed from the scarded to ensure they are stated that expired removed from the scarded to ensure they are stated that expired removed from the scarded to ensure they are stated that the signed off as being to 5 days prior. When LPN pired medication was didn't know but had no ster at this time. In undated document titled,	F	761	

FORM APPROVED
OMB NO. 0938-0391

PRINTED: 01/02/2024

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495256	B. WING			12/0	8/2023	
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 15 ARGYLL ST CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(Kellylette	(X5) COMPLETION DATE	
F 761	standard of practice Discontinued and/or be removed from me No further information 3. On the 100 unit of failed to ensure medilocked compartment personnel had access On 12/5/23 at approxobservations were completed with the counter medications included: a. Resident #42 had at bedside. b. Resident #54 had on the bedside table 2 once a day, and redialysis and has been concerned at the bedside and health toom. d. Resident #51 had and a bottle of Sarrabedside table. The sprescription label, will resident #394. Per	per medication storage is a . Medication Carts: expired medications should dication carts". In was provided. Ithe facility, the facility staff factions were stored in a and only authorized s. Itimately 12:00 PM, producted of the 100 unit. ere noted to have over the at the bedside. They The Resident said he takes aports he got them from a taking them about a year. Iteresh lubricating eye drops emorrhoid cream in the a tube of hydrocolloid cream a anti-itch cream on the Sarna lotion had a hich indicated it belonged to the clinical record and an #1, Resident #394 had	F	761				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495256	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	455250	J D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/08/2023
AUTUMN	CARE OF CHESAPEAKE		715 ARGYLL ST CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	e. Resident #78 had merescription label and freeze at the bedside. approximately 1 PM, a was made of Resident was still noted to be at the conducted with LPN # medications must be kenedication cart or merescribed in rooms, LPN #5 said, "in room, but it is based interview for mental state score over a certain the Being a nursing home medications in the room where families are non what we ask, so if we find notify the DON (Dimanager. Following the above in #5 accompanied the stand #77's room. LPN #5 also removed to the servations and remorphoid cream from LPN #5 also removed to the servation what we say that Resident #78 and her find. The surveyor explain easily identified upon or require that the Reside inspected to locate the	efresh eye drops with a a container of roll-on bio On 12/6/23, at an additional observation at #78's room. The bio freeze at the bedside. PM, an interview was 5. LPN #5 stated that all tept locked in the dication room. When an be kept in the Resident They should not keep meds at on their BIMS (brief atus) score. They have to ing, to even be considered. Though we don't keep ms. We have had people accomplaint and go against find something we take it irrector of Nursing) and unit the terview with LPN #5, LPN curveyors to Resident #78 #5 confirmed the eye drops and an Resident #77's room. The eye drops from the eye d	F 7	61		

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405050	B. WING	_		0	
	ROVIDER OR SUPPLIER	495256	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/0	08/2023
AUTUMN	CARE OF CHESAPEARI	= 8		С	HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	"Self-Administration of from the policy read, unable to self-adminimedication will be he resident can be reas: Interdisciplinary Tear the bedside must be The facility provided "Medication Storage document read, "Prostandard of practice. Medication carts and when unattended". On 12/6/23, in the la	sted of the facility policy titled, of Medication". Excerpts " 6. When a resident is ster medications, the eld by the nurses until the sessed by the m. 7 Medication(s) kept at kept in a locked drawer". an undated document titled, ". Excerpts from this per medication storage is a Medication Carts: It cabinets should be locked the afternoon, the facility ade aware of the above		761			
<i>a</i>	qualified professional service to be provide must have that serving person or agency or arrangement describute. Act or an agreement (2) of this section. §483.70(g)(2) Arran section 1861(w) of the pertaining to service resources must speassumes responsible.	facility does not employ a all person to furnish a specific ed by the facility, the facility ce furnished to residents by a utside the facility under an oed in section 1861(w) of the t described in paragraph (g) gements as described in he Act or agreements es furnished by outside cify in writing that the facility					

Event ID: SU2D11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		495256	B. WING			12	/08/2023
Second Contraction and Contraction	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		715 ARGYLL ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	standards and princip professionals providin and (ii) The timeliness of the This REQUIREMENT by: Based on family interclinical record review, ensure transportation for 1 resident's dental sample of 55 residents. The findings included: Resident #1 was origin on 11/29/13. The currecerebral palsy. The quarterly revised I assessment with an as (ARD) of 09/07/23 cod having the ability to co for Mental Status (BIM coded for long and sho as well as severely improved making. In section "GC resident was coded as for eating, oral hygiene bathing. The person centered company of the person centered company in the person ce	des that apply to g services in such a facility; and services. Is not met as evidenced wiew, staff interviews and the facility staff failed to arrangements were made appointment in a survey (Resident #1). Interview and the facility and diagnoses included winimum Data Set (MDS) are sessment reference date and the resident as not an another term memory problems are term memory problems are term memory problems are term memory problems are plan created on the diagnoses included are plan created on the diagnose and the resident was autrition and hydration and leeding in the oral cavity. Some of the less the staff would use to as to assess oral cavity for	F	840	F 840 1. Facility failed to provide transportation services for 1 reside (# 1), facility immediately ensured resident had transportation sched 2. 100% of residents have the potential to be affected. 100% of current residents with appointment for the next two weeks scheduled audited to ensure transportation available. 3. 100% of nursing leadership, Scheduler educated on process to scheduler educated on process to schedule transportation. 4. Nursing home administrator to upcoming weekly appointments to ensure transportation in place for weeks. Results of the weekly inspections be submitted to the QAPI committed for review and recommendation. 5. Compliance Date 1/19/2024.	d duled. Ints Docial audit D 12 will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		TIPLE ((X3) DATE SURVEY COMPLETED		
	A STATE OF THE STA		A. BUILD				;
		495256	B. WING			12/0	8/2023
	ROVIDER OR SUPPLIER CARE OF CHESAPEAKE			71	REET ADDRESS, CITY, STATE, ZIP CODE 5 ARGYLL ST HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	256	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 840	inflammation, bleedir assist/provide mouth to dental services (8/ On 12/06/23 at approte the initial tour Reside bed in a supine posit times and making so was observed near the concerning Resident Resident #1, has a losaid that he has men worker (SW) and nur. The family member a concerned that the rebothering her, but be pain may not be comstaff. On 12/08/23 at approinterview was condu (OSM) #6. OSM #6 resident could receiv (MAP) adjustment to said that Resident # adjustment. She was transported via whee that she would check An interview was con Nursing (DON) and (Regional Clinical Napproximately 2:10 preceiving transports The DON said that the	ag, swelling or rashes, care as needed and referral 03/21). Eximately 11:00 a.m., during and #1 was observed lying in ion, appeared restless at unds. A specialty wheel chair ne resident's bed. Eximately 12:32 p.m., a at to Family Member (FM) #1 #1. FM #1 said that but of dental cavities. FM #1 attioned this to the social se at care plan meetings. Also said that he was resident's teeth could be recause she is non-verbal, amunicated to the facility eximately 12:50 p.m. an acted with Other Staff Member was asked by the surveyor if the a Medicaid Advantage Plus areceive dental services. She is then ask if resident could be elichair transport. She said	F	840			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495256			С	
NAME OF PROVIDER OR SURRUER		493236	B. WING	0.70.5.7. 1.20.5.1.	12/08/2023	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 840	office. The following nurses' RN #1 on 12/07/23 at	notes were received from 3:40 p.m., "A call made to	F 8	40		
	Message left was regated Medicaid service]. A cut to Dental Services offithe above insurance. If from the Dental Service do accept Medicaid an accommodate patient's	gery (DDS) at 2:45 p.m., arding if they take [Name of all was placed at 3:20 p.m., ce to ask if they accepted Received a returned call less office at 3:25 p.m. They ad their VA Beach office can sepecialty wheelchair in the scheduled for 1/05/24 at				
F 919 SS=F	Consultant. An opportu	nared with the of Nursing and Corporate unity was offered to the t additional information, but on was provided.	F 9 [.]	19		
	residents to call for state communication system	equately equipped to allow ff assistance through a				
	by: Based on observation,	d bathing facilities. is not met as evidenced				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second		CONSTRUCTION	(X3) DATE :	
AND PLAN OF	CORRECTION	DENTI TOATION NOMBER.	A, BUILDI	NG _			,
			D MINIO			40"	
		495256	B. WING			12/0	08/2023
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF CHESAPEAK	E			IS ARGYLL ST		
ACTOMIN	07 II (II 07 07 1			С	HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	200240	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 919	system for Residents	maintain a Resident call s to call for staff assistance,	F	919	F 919 1. Facility failed to have manual bells in each resident's bathroo	m in 3	
	The findings included				out of 4 units, facility immediate placed manual call bells in all affected bathrooms. 100% of residents had the potential to be	9	
		there was a Resident call			affected, 100% of bathrooms at	laitea	
		oms and showers to allow			to ensure that manual call bells placed in bathrooms without		
		staff assistance, if needed.			functioning call lights by Nursin	a	
					home administrator or designed	hts by Nursing or or designee for	
	On 12/5/23, during a	in initial tour of the facility it			units 100 and 200.		
		ree of the Resident care a functional call bell system.			2. 100% of all staff educated or		
		noted to have hand bells			maintaining manual call bells in	all	
		e bedside. There was no			bathrooms and resident rooms		
		Resident bathrooms, many of			facility operating on emergency	Call	
	which also contained	d showers.			bell system. 3. Nursing home effectively rep	laced	
	toileted and showers independently witho assistance from staf call for assistance if #54 said, "I have no	erviews conducted sident #54 reported that the ed in his room's bathroom ut any supervision or ff. When asked how he would he needed help, Resident way to call other than yell, in broken for months because			all manual call bells with fully functioning electrical system or units on 1/5/24. Maintenance Director to do weekly audit for weeks on 15 randomly selected rooms and/or bathrooms to ensproper functioning of new systems. Compliance Date 1/19/2024.	12 d sure em.	
	staff assistance. Whelp how she would	ted that she toileted without hen asked, if she needed notify the facility staff? The to leave the door cracked so hear me".					
	conducted with LPN Resident #54 is "ver	AM, an interview was I #6. LPN #6 confirmed that ry independent" and does ithout any staff assistance.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			91
		IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С		
495256			B. WING		12/08/2023		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	.700/2023	_
AUTUMN	CARE OF CHESAPEAKE			715 ARGYLL ST			
(X4) ID	SUMMADV OTA	TELES		CHESAPEAKE, VA 23320			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)) RE COMPLETION		
	Continued From page 50 LPN #6 also confirmed that Resident #77 can toilet herself without staff assistance. On 9/28/23, an inspection was conducted at this facility and at that time the facility reported their call bell system would be functioning withing 8 weeks. During that inspection, the facility provided a document from the VSC Fire & Security Company dated 09/28/23. The read in part: After hours of troubleshooting, we have discovered in multiple places the existing wiring is "burned" and multiple location with inoperative stations. It is recommended to replace the entire system with a new nurse call system. After contacting (name of company) there is enough materials to get started and can support with on time delivers as this system replacement progresses. The plan is to replace all the existing system including wire and will work on and complete one (1) 20 room/unit pod at a time. The intention is to complete each unit/pod within a two (2) week period or within 8 weeks for the entire facility. On the afternoon of 12/7/23, an interview was conducted with the facility Administrator. The Administrator reported that the facility had a		F 919				
	Administrator reported the lightning strike in July 20 their call bell system for	nat the facility had a 123, that had disabled					
i i	had contracted with an o in the process of having	utside company who was to re-wire and install a					1
(new system. They had one of the call bell system on noted to be operational.	completed the installation one unit, and it was					
r	eported that due to the f	acility having a COVID					
C	outbreak the contractors	didn't work for two					
V	veeks in November, which	ch delayed the					
ti	nstallation as well as the he fire monitoring systen	fact that they prioritized n before the call bell					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE				715 ARG	ADDRESS, CITY, STATE, ZIP CODE SYLL ST PEAKE, VA 23320	12/08/2023 DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 919	Review of the facility Communication Sys was conducted. The of the facility to prov communicating with installed in each res areas". During the interview on 12/7/23, the abov the Residents on th any means to call for and shower if needs confirmed these obs shared that each sh that a call bell is in hour a staff member identify if any hand heard. The Admini- this walk through de entering a Residen On the morning of Administrator state concerns shared the	repolicy titled, "Resident tem and Call Light Policy" a policy read, "It is the policy ide residents with a means of staff. A call system is ident room and toilet/bath with the facility Administrator we concerns were shared that ree nursing units did not have or assistance in the bathroom ed. The Administrator servations. The administrator if the nurses check to ensure polace at the bedside and every r is to walk to hallway to bells and/or tap bells are strator further confirmed that pesn't include physically the room. 12/8/23, the facility did that in response to the lee day prior, they had procured and hand bells to place one in well.	F	919				