STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Madison	Number One Autumn Court Madison, VA 22727

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of three errors occurred out of 31 opportunities for error due to residents not receiving their medication for two residents (Resident (R)19 and R84) out of six residents observed for medication administration. In addition, one of six residents (R27) received a partial dose of medication. The facility medication error rate was 9.68%. This failure had the potential to affect the accurate dosing of medication administered to the residents and for residents not to receive the full beneficial effects of the prescribed medications.Findings include:1. Observations during medication administration on 04/23/26 at 8:16 AM, revealed Registered Nurse (RN) 1 failed to administer R84's bumetanide (a medication used to treat excess fluid retention) 1 [one] milligram (mg) one tablet. Review of R84's Physician Orders, dated April 2026 and located under the Orders tab of the electronic medical record (EMR), indicated there was a physician's order for bumetanide 1 mg every day at 9:00AM. 2. Observations during medication administration on 04/23/26 at 8:55 AM revealed that RN2 failed to administer R19's Salon Pas 4% lidocaine adhesive patch (a pain-relieving patch). Review of R19's Physician Orders, dated April 2026 and located under the Orders tab in the EMR, indicated there was a physician's order for Salon Pas 4% lidocaine adhesive patch twice a day at 7:00AM-11:00 AM and 19:00-23:00 [7:00 PM to 11:00 PM]. 3. Observations during medication administration on 04/23/26 at 8:39 AM, revealed Licensed Practical Nurse/Unit Manager (LPNUM) administered R27's Geri-Kot 8.6 mg [a medication used to help you have a bowel movement] 1 [one] tablet. Review of R27's Physician Orders, dated April 2026 located under the Orders tab of the EMR, indicated there was a physician's order for Senna 8.6 mg 2 [two] tablets, twice a day at 7:00AM-11:00AM and 19:00-23:00 [7:00 PM to 11:00 PM]. During an interview on 04/23/24 at 3:15PM, RN1 stated I gave it [referring to the bumetanide], let's go look on the cart. RN1 went to medication cart with the Surveyor and was unable to find a medication card for bumetanide. Further research revealed the pharmacy had not delivered the medication. During an interview on 04/23/24 at 3:45 PM, RN2 stated We are out of the patches. I checked in both medication rooms and there weren't any here when I worked Sunday either. During an interview on 04/23/24 at 4:10 PM, LPNUM was asked about only giving one Geri-Kot (senna (continued on next page)

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

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	495244	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet) instead of two. LPNUM stated, I thought I did give two. During an interview on 04/23/26 at 4:30 PM, the Director of Nursing (DON) stated, staff should never mark medications as given when they weren't available, and that she should be made aware of missing medications so they can be gotten from the pharmacy. Review of the facility policy titled, Medication Shortages/Unavailable Medications, dated 12/01/07, last revision date 08/01/24, revealed, . 1. Upon discovery that Facility has an inadequate supply of medication to administer to a resident, Facility staff should immediately initiate action to obtain medication from pharmacy. If medication shortage is discovered at the time of medication administration, facility staff should immediately notify the pharmacy.