STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Suffolk	2580 Pruden Boulevard Suffolk, VA 23434

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 22218 Based on interviews, document review, and clinical record review facility staff failed to notify the medical provider and/or a responsible party for related to residents' medication regime for 2 of 35 sampled residents (Resident #100 & #206). 1. For Resident #100, facility staff failed to notify the physician when an anti-hypotensive medication was held. Resident #100 was admitted to the facility with diagnoses which included end stage renal disease with hemodialysis, diabetes mellitus, anemia, septicemia, peripheral vascular disease, deep vein thrombosis, orthostatic hypotension, and malnutrition. On the most recent Minimum Data Set assessment the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. Clinical record review revealed an order for Midodrine 5 milligrams 3 tabs oral every 6 hours. A nursing medication note dated 9/10/2024 18:00 indicated Not Administered: Other Comment: held due to BP of 140/71. The surveyor was unable to locate hold parameters for the medication in the clinical record. There was no documentation that the physician or another provider was notified that the medication was held. The surveyor discussed the concern with the Director of Nursing (DON) on 9/17/24. The DON stated that the physician did not want hold parameters for the medication. The nurse should have contacted the physician for instructions. The surveyor spoke with the medical director (MD) by phone on 9/18/2024. The medical director stated that there were no hold parameters on the order because the MD expected the medication to be administered as ordered. The MD expected to be contacted if the resident's condition was of concern to the nurse. The nurse had not contacted the MD about not administering the medication. Further review of the medication administration record revealed the medication was also held at 12:00 on 9/3, 4, 5, 9, and 10 with medication notes indicating resident unavailable. The physician was not notified of those holds. The administrator and DON were notified of the concern during a summary meeting on 9/18/2024. 21227 2. Resident #206's clinical documentation failed to contain evidence of the resident's responsible party being notified of changes in the resident's medications. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #206's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/25/23, was signed as completed on 7/27/23. Resident #206 was assessed as usually able to make self understood and as able to understand others. Resident #206 was assessed as having problems with both short-term memory and long-term memory. Resident #206 was assessed as being dependent on others for transfers, dressing, personal hygiene, and bathing. Resident #206's clinical record included evidence of multiple medications being discontinued on 7/18/23. These discontinued medications included, but were not limited to: potassium, multivitamin, metoprolol, Norvasc, ergocalciferol, iron, and cyanocobalamin. No documentation was found to explicitly indicate Resident #206's responsible party was notified of these medications being discontinued. On 9/17/24 at 4:11 p.m., Licensed Practical Nurse (LPN) #2 reported they found no documentation of Resident #206's responsible party being notified of the aforementioned discontinued medications. LPN #2 reported the hospice initiated the discontinuation of the medications therefore they would expect the hospice staff to have notified the resident's responsible party. LPN #2 confirmed a facility staff member would have had to enter the discontinue orders. The following information was found in a nursing note dated 7/18/23 at 5:15 p.m.: Call placed to Hospice spoke with (hospice nurse practitioner name omitted) orders obtained to discontinues [sic] scheduled medications, (due to) patient's inability to swallow at this time. Also discontinue weekly and monthly weights. No evidence of Resident #206's responsible party being notified of these medication discontinuation orders was included in this note. On 9/18/24 at 11:40 a.m., the facility's Regional Director of Clinical Services (RDCS) stated they would have expected the hospice staff to communicate these medication discontinuations with the resident's responsible party. The RDCS provided the surveyor with a hospice nursing note dated 7/19/23 at 11:26 a.m. This note included the following information: Upon arrival of RN, check in with facility nurse (name omitted) stating pt (patient) has continued to have shallow, increased respirations. Pt sleeping upon arrival and pt opens eyes when forehead is stroked. Closes eyes again. Pt on 2 (liters of oxygen) via (nasal cannula) continuously. Oral care provided with glycerin swabs. Pt HOH (hard of hearing) bilateral/ eyes do not track this RN voice when opened. (Vital signs) charted in (the electronic medical record). Facial grimacing with movement. Returns to baseline when peri care completed. (Last bowel movement) per staff was 7/18/23. Pt has not eaten more than a few bites since Sunday. Pt consumed nothing in past 24 hours per staff. Oral Medication [sic] reviewed and (discontinue) order received from (medical provider name omitted) 07/18/23 evening. Pt appears to be in no distress with eyes closed when visit ends. (Resident #206's adult child's identifying information deleted) contacted. This note does not detail what information was provided to Resident #206's adult child / responsible party. Resident #206's clinical record included an order, dated 7/25/23, for morphine 5 mg to be administered orally for shortness of breath. This medication was documented as being administered on 7/25/23 at 3:31 p.m. No nursing assessment documentation was found to detail the resident's clinical condition resulting in the need for the 7/25/23 morphine order. No documentation was found to indicate Resident #206's responsible party had been notified of the need to obtain a new order for morphine. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 2:06 p.m., LPN #2 stated that the resident's responsible party would be notified of a new medication order. LPN #2 reported the notification is usually found as a nursing progress note. LPN #2 reported they did not find documentation of Resident #206's responsible party being notified of the 7/25/23 provider order for morphine to be administered for shortness of breath. On 9/18/24 at 9:56 a.m., LPN #3 reported Resident #206's adult child was present when the 7/25/23 morphine order was obtained. LPN #3 stated the adult child was okay with the administration of the morphine. Resident #206's clinical record did not include documentation of a resident assessment related to the need to obtain the 7/25/23 morphine order; Resident #206's clinical record did not include documentation to indicate the Resident's responsible party was at the bedside and aware of the new morphine order. The following information was found in a facility policy titled Resident Change in Condition Policy (with a revised date of 6/27/24): The Physician / Provider and Resident / Family / Responsible Party will be notified when there has been: . A need to alter the resident's medical treatment, including a change in provider orders . On 9/18/24 at 1:06 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the absence of documentation to indicate Resident #206's responsible party had been notified of the aforementioned medication orders being either discontinued or initiated was discussed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team, and/or failed to involve the resident and/or resident representative in planning care, for 5 of 35 sampled residents. Resident #28, Resident #61, Resident #83, Resident #40, and Resident #206. The findings included: 1. For Resident #28, the facility staff failed to review the plan of care after the resident's comprehensive assessment on 3/21/24 and the facility staff failed to ensure the resident and/or resident representative, was provided the opportunity to participate in planning care at the facility. Resident #28's diagnosis list indicated diagnoses that included, but were not limited to, Emphysema, Hypertension, Glaucoma, Anxiety Disorder, Adult Failure to Thrive, Acute Respiratory Failure, Legal Blindness, Depression, Mild Cognitive Impairment, and Insomnia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/19/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating Resident #28 was cognitively intact. On 9/10/24 at 6:05 PM, surveyor interviewed Resident #28 and the resident informed surveyor he only remembers attending one care plan meeting since admission and could not recall receiving any care plan meeting invitations. A review of the clinical record did not reveal any invitations to care plan meetings for Resident #28 and there was no evidence of a care plan meeting being held for the ARD of 3/21/24. Surveyor requested evidence of resident and/or resident representative being invited to care plan meetings. On 9/13/24 at 9:03 AM, surveyor interviewed the social worker, and she informed surveyor there was no evidence of the resident and/or resident representative being invited to the care plan meeting for the 3/21/24 ARD or any evidence of a care plan meeting being held. On 9/18/24 at 9:33 AM, surveyor interviewed registered nurse #8 and she stated she was not able to locate any evidence of a care plan meeting being held for the 3/21/24 ARD. This concern was discussed at the end of day meeting on 9/17/24 at 5:28 PM, with the administrator, director of nursing, assistant administrator, and assistant director of nursing and again at the pre-exit meeting on 9/18/24 at 1:05 PM with the above-mentioned staff and the regional director of clinical services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received a facility policy titled, Comprehensive Care Planning Policy, that read in part, .H. A Facility Resident Care Plan coordinator .is responsible for .the Resident Care Plan Conference . M. The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation is presented to the resident at least five (5) days prior to the date of the conference .A copy of the letter is maintained for reference .S. The Resident Care Conference meets as scheduled .T. All Resident Care Plan participants sign .on each Plan of Care. The conference date is to be properly logged . Surveyor also requested and received a facility policy titled, Care Plan Invitation Letter Policy, that read in part, .The resident and the resident's Responsible Party or legal representative will be invited to attend each of the Interdisciplinary Care Planning Conferences .1 .will designate a staff member who will be responsible for completing the Care Planning invitations, for delivering the invitation to the resident prior to the conference date .2. Copies of the invitations .will be maintained as verification the invitations were sent .3. Ask the resident to sign a copy of the invitation letter and retain a copy as verification that the invitation was delivered to the resident .5. All attendees at the Care Planning Conference .will sign the Care Plan to verify their attendance. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24. 2. For Resident #61, the facility staff failed to review the plan of care after the resident's comprehensive assessment on 3/11/24 and the facility staff failed to ensure the resident and/or resident representative, was provided the opportunity to participate in planning care at the facility. Resident #61's diagnosis list indicated diagnoses that included, but were not limited to, Metabolic Encephalopathy, Chronic Obstructive Pulmonary Disease, Tremor, Cellulitis of Left Lower Limb, Peripheral Vascular Disease, Suicidal ideations, and Vascular Dementia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/20/24, assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. On 9/10/24 at 5:50 PM, surveyor interviewed Resident #61 and the resident informed surveyor she could not recall being invited to any care plan meetings. A review of the clinical record did not reveal any invitations to care plan meetings for Resident #61 and there was no evidence of a care plan meeting being held for the ARD of 3/11/24. Surveyor requested evidence of resident and/or resident representative being invited to care plan meetings. On 9/13/24 at 8:25 AM, the assistant administrator verified no care plan meeting invitations could be located for the comprehensive assessment date of 3/11/24. On 9/13/24 at 9:03 AM, surveyor interviewed the social worker, and she informed surveyor there was no evidence of the resident and/or resident representative being invited to the care plan meeting for the 3/21/24 ARD or any evidence of a care plan meeting being held. On 9/18/24 at 9:33 AM, surveyor interviewed registered nurse #8 and she stated she was not able to locate any evidence of a care plan meeting being held for the 3/11/24 ARD. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This concern was discussed at the end of day meeting on 9/17/24 at 5:28 PM, with the administrator, director of nursing, assistant administrator, and assistant director of nursing and again at the pre-exit meeting on 9/18/24 at 1:05 PM with the above-mentioned staff and the regional director of clinical services. Surveyor requested and received a facility policy titled, Comprehensive Care Planning Policy, that read in part, .H. A Facility Resident Care Plan coordinator .is responsible for .the Resident Care Plan Conference . M. The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation is presented to the resident at least five (5) days prior to the date of the conference .A copy of the letter is maintained for reference .S. The Resident Care Conference meets as scheduled .T. All Resident Care Plan participants sign .on each Plan of Care. The conference date is to be properly logged . Surveyor also requested and received a facility policy titled, Care Plan Invitation Letter Policy, that read in part, .The resident and the resident's Responsible Party or legal representative will be invited to attend each of the Interdisciplinary Care Planning Conferences .1 .will designate a staff member who will be responsible for completing the Care Planning invitations, for delivering the invitation to the resident prior to the conference date .2. Copies of the invitations .will be maintained as verification the invitations were sent .3. Ask the resident to sign a copy of the invitation letter and retain a copy as verification that the invitation was delivered to the resident .5. All attendees at the Care Planning Conference .will sign the Care Plan to verify their attendance. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24. 3. For Resident #83, the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's physical, mental, and psychosocial well-being. Resident #83's diagnosis list indicated diagnoses that included, but were not limited to, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Epilepsy, Personal history of transient ischemic attack (TIA), Unspecified convulsions, and Type 2 (two) diabetes mellitus. Resident #83 is on Hospice Services for end-of-life care. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/18/24 indicated in the review of Section C, Cognitive Patterns, that Resident #83 was severely impaired in cognitive decision-making with short & long-term memory problems and was coded as being rarely/never understood and rarely/never understands. Surveyor could not locate an initial activity assessment or any activity progress notes on the clinical record for Resident #83. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 12:52 PM, activity director provided surveyor with an activity care plan with a created date of 9/12/24, that read in part, Problem .has decreased orientation and limited orientation. Activities needed that she may observe and enjoyy [sic] .Goal .will positively respond to sensory thru [sic] next review period . Intervention .will be visited regularly by activity staff and volunteers thru [sic] next review period . Activity director stated she could not locate an initial activity assessment and stated she does not complete quarterly activity progress notes. She stated she was not sure what the activity policy stated about activity progress notes On 9/12/24 at 2:31 PM, activity director informed surveyor that she was on vacation at the time Resident #83 was admitted and was not sure what happened with the resident's initial activity assessment. She informed surveyor she had reviewed the activity policies and agreed she should have completed an activity progress note every ninety days. This concern was discussed at the end of day meeting on 9/17/24 at 5:28 PM, with the administrator, director of nursing, assistant administrator, and assistant director of nursing and again at the pre-exit meeting on 9/18/24 at 1:05 PM with the above-mentioned staff and the regional director of clinical services. Surveyor requested and received a facility policy titled, Life Enrichment Assessment and Documentation Policy, that read in part, .The Life Enrichment Department will complete ongoing assessments and documentation required by the MDS cycle for each resident in order to promote their physical, mental, and psychosocial well-being .5 .The Care Plan will be reviewed, updated, and rewritten quarterly and as needed . 7. The completed Life Enrichment Assessment will be part of the resident's medical record .9 .A Life Enrichment progress note needs to be written at minimal every quarter (every ninety days), including any time MDS documentation is completed . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24. 47299 4. For resident # 40, the facility staff failed to inform or include the residents responsible party in the care plan process, and failed to provide evidence that care plan conferences were being held. Resident # 40's care plan states resident has altered cognitive function related to a brief interview for mental status (BIMS) score of 3. This surveyor interviewed resident # 40's responsible party on 9/11/24 at 2:27 PM. They stated they had not been informed or invited to any care conferences lately and that they had only ever been invited to one that they attended via telephone. The clinical record was reviewed. This surveyor was unable to locate care plan invitations, or documentation of care plan conferences for the minimum data set (MDS) assessments dated 3/13/24 for a quarterly review, or 6/11/24 for an annual review. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 11:59 AM this surveyor interviewed the Social Worker about inviting the Responsible Party to care plan meetings. They stated that the resident and/or responsible party were sent invitations for each meeting and that meetings are held at least quarterly to coincide with the MDS assessments. They provided a care plan invitation dated 10/3/23 Which was already seen in the record. They stated, That's all I could come up with for resident # 40 except for the one that we are having next week. When asked if invitations are being sent, they stated, They are now, but I've only been here for two months, so I don't know about before. Surveyor asked if they knew whether or not meetings were being held prior to their arrival, I'm not sure. On 9/13/24 the Assistant Administrator provided care plan invitations for October 3, 2023, and June 20, 2023. For 2024 they provided a care plan invitation for 9/17/24. On 9/17/24 this surveyor interviewed the Assistant Administrator and the Social Worker at 09:40 AM. The social worker stated, the care plan invitation letters should have a signature. I take it to the resident, and I get a signature, even if it's just an x, and I scan it into the record. I also send an invitation to the responsible party and scan that in. Care plan meetings are held on Tuesdays every three months, or with a significant change. The meetings are held within 7 days of the ARD (assessment reference date). They stated that the actual meetings should be documented in the record and were able to provide documentation of all the 2023 meetings. This surveyor requested and received the policy entitled, Comprehensive Care Plan Policy with a revised date of 3/2/21. Under the heading Procedure, the policy read in part, I) A resident care plan conference is scheduled at least weekly. J) Residents scheduled for the Resident Care conference include: 1. New admissions who's MDS was completed within the previous 7 days. 2. Residents who have returned from the hospital in the past week. Their previous MDS and care plan must be reviewed and updated. 3. Residents who have had a significant condition change and MDS completed in the past week. 4. Residents who have had 90-day review assessments or an annual full assessment completed with the previous 7 days. M. The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented to the resident at least five days prior to the date of conference. A designated time of meeting is given to each resident. (Those residents who have been deemed legally incompetent or has documentation in their medical record as medically incompetent by their attending physician would be exempt from this procedure.) A copy of the letter is maintained for reference. N. The facility designee is responsible for mailing an original letter of requested participation to an appropriate family member or legal representative for all residents scheduled for review who have deemed legally incompetent or have been charted as being medically incompetent by their attending physician. The letter is mailed at least seven days prior to the date of conference. A copy of the letter is maintained for reference . O. The facility designees are responsible for proving the Coordinator copies of all said letters on the scheduled day of conference. The coordinator makes notations on the copies addressing the recipient's participating or nonparticipating status. On 9/17/24 at 5:15 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing and the Assistant Administrator. This concern was discussed. No further information was provided to the survey team prior to the exit conference. 21227 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The facility staff failed to review and/or revise Resident #206's care plan at the appropriate time intervals. The facility staff failed to include Resident #206's responsible party as part of the interdisciplinary team. Resident #206's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/25/23, was signed as completed on 7/27/23. Resident #206 was assessed as usually able to make self understood and as able to understand others. Resident #206 was assessed as having problems with both short-term memory and long-term memory. Resident #206 was assessed as being dependent on others for transfers, dressing, personal hygiene, and bathing. The following information was found in a facility policy titled Comprehensive Care Planning Policy (with a revision date of 3/2/21): - The Interdisciplinary Care Planning Team may consist of: . The resident, the resident's family and/or the resident's legal representative. - A Resident Care Plan conference is scheduled at least weekly. - Residents scheduled for the Resident Care conference include: . Residents who have had 90-day review assessments or an annual full assessment completed within the previous 7 days. - The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented to the resident at least five (5) days prior to the date of conference. A designated time of meeting is given to each resident. (Those residents who have been deemed legally incompetent or has documentation in their medical record, as medically incompetent by their attending physician would be exempt from this procedure.) A copy of the letter is maintained for reference. - The facility designee is responsible for mailing an original letter of requested participation to an appropriate family member or legal representative for all residents scheduled for review who have been deemed legally incompetent or have been charted as being medically incompetent by their attending physician. The letter is mailed at least seven (7) days prior to the date of conference. A copy of the letter is maintained for reference. The family may call the facility and request to change their time, and the facility will attempt to accommodate all times to the best of our ability. On 9/17/24 at 9:35 a.m., the Director of Social Services reported that a signature should be obtained on the form provided to the resident about the scheduled care plan meeting; this signed form should be scanned into the electronic clinical record. The Director of Social Services reported that a letter is sent to the responsible party about the scheduled care plan meeting; the Director of Social Services reported a copy of the letter should be scanned into the electronic clinical record. On 9/17/24 at 9:35 a.m., the Assistant Administrator reported the care plan meetings would occur every three (3) months or with a significant change in the resident's condition. Resident #206's clinical record indicated the resident had Minimum Data Set (MDS) assessments completed with the following ARD dates: - A quarterly assessment dated [DATE]; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An annual assessment dated [DATE]; - A quarterly assessment dated [DATE]; - A quarterly assessment dated [DATE]; - A quarterly assessment dated [DATE]; - A quarterly assessment dated [DATE]; - A quarterly assessment dated [DATE]; and - A significant change in condition assessment dated [DATE]. The facility staff provided the surveyor a copy of an invitation letter which indicated a care plan meeting was planned for 8/9/22 at 12:30 p.m. No documentation was provided to indicate who was given this letter. The facility staff provided the surveyor a copy of an invitation letter which indicated a care plan meeting was planned for 12/13/22 at 12:30 p.m. No documentation was provided to indicate who was given this letter. The facility staff provided the surveyor a social services note dated 6/13/23 which indicated the Social Worker had discussed Resident #206's change in condition care planning form with the resident's responsible party. (The change in condition MDS assessment had an assessment reference date of 5/23/23; no evidence was provided to indicate the responsible party had been included in a care plan meeting related to this MDS assessment.) No evidence was found by or provided to the surveyor to indicate Resident 206's responsible party was consistently invited to the resident's care plan meetings. On 9/17/24 at 11:31 a.m., the Assistant Administrator reported there were times when no evidence of Resident #206's responsible party being included in the care plan meeting was found. Resident #206's clinical record included documents titled (company name omitted) Care Plan Conference Summary. The facility staff provided the survey team with two (2) of these forms documented with effective dates of: 12/13/22 at 2:24 p.m. and 3/28/23 at 10:28 a.m.; both of these documents indicated that Resident #206's Resident Representative was invited to the care plan conference but chose not to participate. No care plan conference summaries were provided for Resident #206's following MDS assessments: - A quarterly assessment with an ARD date of 7/30/22; - An annual assessment with an ARD date of 9/2/22; - A quarterly assessment with an ARD date of 10/21/22; - A quarterly assessment with an ARD date of 12/21/22; - A quarterly assessment with an ARD date of 4/21/23; and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Autumn Care of Suffolk		STREET ADDRESS, CITY, STATE, ZIP CODE: 2580 Pruden Boulevard Suffolk, VA 23434	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A significant change in condition assessment with an ARD date of 5/23/23. Resident #206's care plan failed to address the resident's responsible party's request for morphine not to be administered to the resident. On 9/18/24 at 1:06 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the following care plan findings was discussed: (a) the failure to ensure care plan meetings were completed, (b) the failure to ensure the Resident #206's responsible party was consistently included in the care plan meetings, and (c) the failure of Resident #206's care plan to address Resident #206's responsible party's request for the resident not to be administered morphine.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34307 Based on staff interview, clinical record review, and facility document review the facility staff failed to follow physician's orders for the administration of medications for 5 of 35 residents, Resident #33, Resident #207, Resident #100, Resident #357, and Resident #20. The findings included: 1. For Resident #33 the facility staff failed to administer the medication gabapentin per the physician's orders. Resident #33's face sheet listed diagnoses which included but not limited to hypertension and chronic pain syndrome. Resident #33's most recent minimum data set with an assessment reference date of 07/02/24 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive status. This indicates that the resident is moderately cognitively impaired. Resident #33's comprehensive care plan was reviewed and contained a care plan for Pain: Resident has potential for pain r/t (related to) generalized discomfort. Interventions for this care plan include Administer pharmacological interventions as indicated per physician and monitor the effectiveness. Resident #33's clinical record was reviewed and contained a physician's order summary which read in part gabapentin-Schedule V capsule; 100 mg; amt: 1 capsule; oral. Twice a day, and gabapentin-Schedule V capsule; 300 mg; amt: 1 capsule; oral. Special instructions: 1 cap by mouth every day related to chronic pain syndrome. Resident #33's electronic medication administration record for the month of August 2024 was reviewed and contained entries as above. The entry for gabapentin 100 mg was not administered on 08/23, 08/25, or 08/26 for the am dose and not administered on 08/20, 08/21, 08/23, 08/24 or 08/25 for the pm dose. Reasons given for each of these missed doses were documented as drug/item unavailable, on order, and waiting for arrival. Surveyor spoke with the director of nursing (DON) on 09/12/24 regarding resident #33's medications. DON stated that resident has refused medications at times, and that it should be documented, if refused. Surveyor pointed out that medication was documented as not available. Surveyor requested and was provided with a list of medications available in the facility's emergency medications supply. This list contained gabapentin 100 mg and gabapentin 300 mg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and was provided with a facility policy entitled Medication Shortages/Unavailable Medications which read in part, 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. 2. If a medication is unavailable during normal pharmacy hours: 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 3. If a medication is unavailable is discovered after normal Pharmacy hours: 3.1 A Facility nurse should obtain the ordered medication from the Emergency Medication Supply. The concern on not administering medications as ordered by the physician was discussed with the administrator, administrator-in-training, DON, and regional director of clinical services on 09/12/24 at 5:25 pm. No further information was provided prior to exit. 28169 2. For Resident #207, facility staff failed to administer Gabapentin per provider orders. Resident #207's admission record listed diagnoses which included but not limited to sepsis and right leg pain. The minimum data set assessment with an assessment reference date of 01/29/24 coded the resident's brief interview for mental status a 15 out of 15 (in Section C - cognitive patterns) which indicated the resident was cognitively intact. The clinical record contained a provider order for gabapentin oral capsule 300mg; give 2 capsules by mouth one time a day for nerve pain and give 3 capsules by mouth at bedtime for nerve pain. Resident #207's medication administration record (MAR) for February 2024 was reviewed. On 02/07/24 for the morning and evening doses, on 02/08/24 for the evening dose, and on 02/11/24 for the evening dose, the MAR documentation indicated the resident's gabapentin was not administered. Staff documented a numerical code for these four (4) doses: 1. 02/07/24 9:00 a.m. dose - Code 19 was documented (19 = other/see nurses notes). The registered nurse documented awaiting pharmacy. That nurse no longer worked at the facility. A registered nurse unit manager (RN-UM) was interviewed on 09/17/24. The RN-UM had written a witness statement about retrieving two (2) Gabapentin 300mg capsules from the facility's Omnicell for Resident #207. The statement was dated 02/09/24 but read the doses were for 02/07/24. During the interview, the RN-UM could not be sure which date she retrieved the medication from the Omnicell. The nurse stated she did not administer the medication; she retrieved the medication for another nurse but could not recall which nurse. The RN-UM stated it takes two (2) nurses to retrieve a narcotic from the Omnicell. 2. 02/07/24 9:00 p.m. dose - Code 19 was documented (19 = other/see nurses notes). The licensed practical nurse (LPN) documented on order. The assistant director of nursing (ADON) provided a statement the LPN gave to the ADON via phone on 09/13/24. The statement read the LPN learned in report the medication was on order therefore did not need to be reordered. The statement read the evening dose had been retrieved from the Omnicell. The surveyor was unable to interview this nurse who worked for an agency company. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. 02/08/24 9:00 p.m. dose - Code 16 was documented (16 = hold/see note). A different LPN, who no longer worked at the facility according to the ADON, wrote 2/7/2024 2/8/2024 2/8/2024 Reordered GABAPENTIN (C5) 300MG CAPSULE. The ADON acknowledged this dose was not given and no hold order was found. 4. 02/11/24 9:00 p.m. dose - Code 16 was documented (16 = hold/see note). Another LPN, who no longer worked at the facility according to the ADON, wrote Administered last dosage. reordered, called Pharmacy and was informed medication will be delivered 02/12/24. There was no hold order found. The facility's Omni Inventory (medication dispensing system) list of medications was reviewed. The list included Gabapentin 300mg capsules. This surveyor called the facility's pharmacy and spoke with the general manager, who is a pharmacist, on 09/17/24 at 3:30p.m. After reviewing information regarding Resident #207, the pharmacist listed this information: 01/25/24 - Dispensed 60 Gabapentin pills 01/25/24 - Omnicell, 3 pills possibly 02/07/24 - No Omnicell codes given 02/08/24 - No Omnicell codes given 02/09/24 - Omnicell code given for 2 pills 02/11/24 - No Omnicell codes given 02/12/24 - Dispensed 90 Gabapentin pills Regarding the 60 pills dispensed on 01/25/24, if 5 pills/day were administered as ordered, the 60 pills would have been depleted by 02/05/24. The pharmacy did not have evidence of providing Omnicell codes for 02/07/24, 02/08/24, or 02/11/24. The codes are required to obtain Gabapentin from the Omnicell. The surveyor requested Resident #207's Medication Administration Audit Report. For the four doses over 02/07/24, 02/08/24, and 02/11/24, the audit report showed an administration time. After reviewing a different audit report for medications refused by another resident, those medications that were refused showed an administration time. The administration time on the audit report indicated staff had inserted documentation; it did not indicate the medication was administered. On 09/17/24 at 5:00 p.m., this surveyor with another surveyor spoke with the DON and ADON in the ADON's office. The surveyors informed the nurses it was apparent the administration time on the medication administration audit report did not indicate the medication was given and received. It indicated staff inserted documentation for that time/dose which could be any code to include the 12=refused, 16=hold/see note, and 19=other/see nurse's notes or other possible codes. Both the DON and the ADON verbalized understanding and did not provide further information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/17/24 at 5:28 p.m. the administrator, assistant administrator, DON, and ADON were informed of the concern regarding Resident #207 not receiving Gabapentin for 4 doses over 3 days (02/07/24 a.m. & p.m., 02/08/24 p.m., and 02/11/24 p.m.) This surveyor explained the Omnicare pharmacist reported there was no evidence Omnicell codes were provided for retrieval of Gabapentin on 02/07/24, 02/08/24, or 02/11/24. The facility administration denied questions or comments. No further information was provided prior to the exit conference. 22218 3. For Resident #100, staff failed to administer an anti-hypotensive medication as ordered. Resident #100 was admitted to the facility with diagnoses which included end stage renal disease with hemodialysis, diabetes mellitus, anemia, septicemia, peripheral vascular disease, deep vein thrombosis, orthostatic hypotension, and malnutrition. On the most recent Minimum Data Set assessment the resident scored15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. Clinical record review revealed an order for midodrine 5 milligrams 3 tabs oral every 6 hours. A nursing medication note dated 9/10/2024 18:00 indicated Not Administered: Other Comment: held due to BP of 140/71. The surveyor was unable to locate hold parameters for the medication in the clinical record. There was no documentation that the physician or another provider was notified that the medication was held. The surveyor discussed the concern with the Director of Nursing (DON) on 9/17/24. The DON stated that the physician did not want hold parameters for the medication. The nurse should have contacted the physician for instructions. The surveyor spoke with the medical director (MD) by phone on 9/18/2024. The medical director stated that there were no hold parameters on the order because the MD expected the medication to be administered as ordered. The MD expected to be contacted if the resident's condition was of concern to the nurse. The nurse had not contacted the MD about not administering the medication. Further review of the medication administration record revealed the medication was also held at 12:00 on 9/3, 4, 5, 9, and 10 with medication notes indicating resident unavailable. The physician was not notified of those holds. The administrator and DON were notified of the concern during a summary meeting on 9/18/2024. 42353 4. For Resident #20, the facility staff failed to follow the medical provider orders for notification of blood sugar levels less than 100 (one hundred). Resident #20's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 (two) diabetes mellitus, Muscle weakness (generalized), Hyperlipidemia, Encounter for orthopedic aftercare following surgical amputation, Schizophrenia, Schizoaffective disorder, and Phantom limb syndrome with pain. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/30/24, assigned the resident a brief interview for mental status (BIMS) summary score of 10 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #20's medical provider orders included an order dated 6/14/24 for Humulin (insulin pen) that read in part, .Monitor blood sugar via finger stick. Hold and call MD (medical doctor) if BS (blood sugar) less than 100 . Surveyor reviewed Resident #20's August 2024 and September 2024 MAR (medication administration record) and observed documentation of resident's BS being less than 100 and no evidence could be located in the clinical record that the medical provider was notified as indicated in the order on the following dates: 8/7/24-LOW 8/26-24-BS 87 8/27/24-BS 80 8/28/24-BS 65 8/29/24-BS 98 9/2/24-BS 77 9/4/24-BS 94 9/5/24-Low BS 9/7/24-Low BS On 9/13/24 at 8:39 AM, regional director of clinical services informed surveyor that no documentation could be located that the medical provider was notified. The comprehensive care plan read in part, .Problem .Resident is at risk for unstable blood glucose related to diabetes .Goal .Resident will remain free of symptoms and complications of .hypoglycemia (low blood sugar) . Approach .Call MD for BS equal to or less than 100 . These concerns were discussed at the end of day meeting on 9/17/24 at 5:28 PM with the administrator, director of nursing, assistant administrator, and assistant director of nursing and again at the pre-exit meeting on 9/18/24 at 1:05 PM with the above-mentioned staff and the regional director of clinical services. Surveyor requested and received a facility policy titled, Physician/Provider Orders, that read in part, .3. The nurse shall document .the orders were confirmed . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24. 49622 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #20, the facility staff failed to follow the medical provider orders for notification of blood sugar levels less than 100 (one hundred). Resident #20's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 (two) diabetes mellitus, Muscle weakness (generalized), Hyperlipidemia, Encounter for orthopedic aftercare following surgical amputation, Schizophrenia, Schizoaffective disorder, and Phantom limb syndrome with pain. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/30/24, assigned the resident a brief interview for mental status (BIMS) summary score of 10 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of Resident #20's medical provider orders included an order dated 6/14/24 for Humulin (insulin pen) that read in part, .Monitor blood sugar via finger stick. Hold and call MD (medical doctor) if BS (blood sugar) less than 100 . Surveyor reviewed Resident #20's August 2024 and September 2024 MAR (medication administration record) and observed documentation of resident's BS being less than 100 and no evidence could be located in the clinical record that the medical provider was notified as indicated in the order on the following dates: 8/7/24-LOW 8/26-24-BS 87 8/27/24-BS 80 8/28/24-BS 65 8/29/24-BS 98 9/2/24-BS 77 9/4/24-BS 94 9/5/24-Low BS 9/7/24-Low BS On 9/13/24 at 8:39 AM, regional director of clinical services informed surveyor that no documentation could be located that the medical provider was notified. The comprehensive care plan read in part, .Problem .Resident is at risk for unstable blood glucose related to diabetes .Goal .Resident will remain free of symptoms and complications of .hypoglycemia (low blood sugar) . Approach .Call MD for BS equal to or less than 100 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These concerns were discussed at the end of day meeting on 9/17/24 at 5:28 PM with the administrator, director of nursing, assistant administrator, and assistant director of nursing and again at the pre-exit meeting on 9/18/24 at 1:05 PM with the above-mentioned staff and the regional director of clinical services. Surveyor requested and received a facility policy titled, Physician/Provider Orders, that read in part, .3. The nurse shall document .the orders were confirmed . No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 3 of 35 residents was free of significant medication errors, Resident #33, Resident #87, and Resident #206. The findings included: 1. For Resident #33 the facility staff held the blood pressure medication amlodipine without a hold order. Resident #33's face sheet listed diagnoses which included but not limited to hypertension and chronic pain syndrome. Resident #33's most recent minimum data set with an assessment reference date of 07/02/24 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive status. This indicates that the resident is moderately cognitively impaired. Resident #33's clinical record was reviewed and contained a physician's order summary which read in part, amlodipine tablet; 2.5 mg; amt: 1 tab; Oral. Special Instructions: Give 2.5 mg by mouth one time a day related to essential hypertension. Resident #33's electronic medication administration record for month of August 2024 was reviewed and contained an entry as above. This entry was not initialed as administered on 08/04/24, 08/17/24 and 08/19/24. Reasons for not administering were given as bp (blood pressure) 101/58, held for hypotension; BP 97/65, and d/t (due to) low BP. Surveyor spoke with the director of nursing on 09/12/24 at 11:40 am regarding Resident #33's amlodipine. DON stated the order did not contain parameters. Surveyor requested and was provided with a facility policy entitled General Dose Preparation and Medication Administration which read in part, 3. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.1 Verify each time a medication is administered that its is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. 3.2 Confirm that the MAR (medication administration record) reflects the most recent order. The concern of holding the resident's medications without a physician's order was discussed with the administrator, administrator-in-training, DON, and regional director of clinical services on 09/12/24 at 5:25 pm. No further information was provided prior to exit. 2. For Resident #87 the facility staff failed to administer the medications Xarelto and Lasix (furosemide) per the physician's orders. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #87's face sheet listed diagnoses which included but not limited to stiff-man syndrome, other pulmonary embolism without cor pulmonale, and localized edema. Resident #87's most recent minimum data set with an assessment reference date of 07/27/24 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #87's comprehensive care plan was reviewed and contained care plans for Resident is prescribed anticoagulant therapy and Resident receives diuretic medication R/T (related to) pedal edema. Interventions for these care plans included Administer anticoagulant and Administer diuretic. Resident #87's clinical record was reviewed and contained a physician's order summary which read in part, furosemide tablet; 40 mg; amt: 40 mg; oral. Once a day and Xarelto tablet; 20 mg; amt: 1 tablet; oral. Special Instructions: Give 1 tablet by mouth one time a day related to personal history of pulmonary embolism. Resident #87's electronic medication administration record for the month of July 2024 was reviewed and contained entries as above. The entry for furosemide was marked as not administered on 07/03/24 and 07/05/24, with a reason of not available. The entry for Xarelto was marked as not administered on 07/03/24, with a reason of not available. Surveyor requested and was provided with a list of medications available in the facility's emergency medication supply. This list included furosemide 20 mg tablets, and Xarelto 10 mg tablets. The concern on not administering Resident #87's medications was discussed with the administrator, administrator-in-training, DON, and regional director of clinical services on 09/12/24 at 5:25 pm. No further information was provided prior to exit. 21227 3. The facility staff failed to act on a medical provider's order to discontinue Resident #206's morphine (this medication was ordered on an as needed bases). This resulted in the resident continuing to receive the morphine after the medical provider gave the discontinue order. Resident #206's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/25/23, was signed as completed on 7/27/23. Resident #206 was assessed as usually able to make self understood and as able to understand others. Resident #206 was assessed as having problems with both short-term memory and long-term memory. Resident #206 was assessed as being dependent on others for transfers, dressing, personal hygiene, and bathing. The following VERBAL ORDER was found in Resident #206's clinical record (dated 7/7/23 at 2:14 p.m.): Discontinue: effective 7/7/23 - morphine 20 mg/ml oral concentrate; Administer 0.25 milliliter(s) orally every 4 hours as needed for severe pain; Prn - read back and confirmed . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #206's Medication Administration Record (MAR) for July 2023 indicated the aforementioned 'discontinue' order was not implemented. Resident #206 continued to receive doses of morphine on the following dates and times: (1) 7/15/23 at 7:00 p.m., (2) 7/17/23 at 8:20 p.m., (3) 7/18/23 at 5:32 a.m., (4) 7/19/23 at 8:17 a.m., and (5) 7/19/23 at 1:31 p.m. On 9/17/24, the Director of Nursing (DON) and Assistant DON (ADON), reported the aforementioned 7/7/23 order to discontinue the morphine had not been implemented. On 9/18/24 at 11:54 a.m., the Regional Director of Clinical Services (RDCS) reported that it is not known when the 7/7/23 order to discontinue Resident #206's morphine was provided to the facility; the RDCS reported the form was uploaded into the electronic record on 7/18/23. On 9/18/24 at 1:06 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of facility staff to implement Resident #206's morphine discontinue order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Autumn Care of Suffolk		STREET ADDRESS, CITY, STATE, ZIP CODE 2580 Pruden Boulevard Suffolk, VA 23434	

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47299 Based on staff interview, clinical record review, and facility document review the facility staff failed to obtain lab testing as ordered by the medical provider for 2 of 35 sampled residents. (Resident #51 and #357). The findings included: 1. For resident # 51 the facility failed to obtain a hemoglobin A1C (HgbA1c) ordered by the primary care provider. Resident # 51's diagnoses included type II diabetes mellitus. During a review of the clinical record on 9/12/24, an order to obtain a HgbA1c on 9/2/24 was noted. This surveyor was not able to locate results in the clinical record. The Medication Administration Record (MAR) was reviewed. The order was on the MAR and scheduled for 9/2/24, the order had not been signed off as done. On 09/12/24 04:04 PM this surveyor interviewed Registered Nurse (RN) # 2. They stated, the lab was not done. The physician has been notified and it is scheduled to be done tomorrow. They stated they did not know how the order was missed, I don't know, it was just missed. HgbA1c is a blood test that measures average blood sugar levels over the past two to three months. It is used to diagnose diabetes and to monitor how well people with diabetes are managing their blood sugar levels. On 9/17/24 Surveyor requested to see the results of the HgbA1c done on 9/13/24. The results were provided, along with an updated order to obtain the lab that was entered on 9/12/24, and were within normal limits at 4.4. On 09/17/24 05:14 PM The survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Assistant Administrator and Regional Director of Clinical Services. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference. 42353 2. For Resident #357, the facility staff failed to obtain a complete blood count (CBC) with differential blood test as ordered by the medical provider. Resident #357's diagnosis list indicated diagnoses, which included, but not limited to Acute on Chronic Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anemia, and Type 2 Diabetes Mellitus. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimum data set (MDS) with an assessment reference date (ARD) of 4/29/24 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. A review of Resident #357's clinical record revealed a medical provider order dated 5/07/24 to obtain a CBC with differential on 5/08/24. Resident #357 was seen by the nurse practitioner (NP) on 5/07/24, the progress note read in part .Given h/o [history of] recurrent falls will obtain .CBC . Surveyor reviewed Resident #357's clinical record and was unable to locate CBC results for 5/08/24. On 9/17/24 at 5:27 PM, surveyor informed the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing that Resident #357's clinical record failed to show evidence of a CBC being obtained as ordered on 5/08/24. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/18/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. Building B. Wing	09/18/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 21227 Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure communication with hospice staff allowed for the timely implementation of resident orders for one (1) of 35 sampled residents (Resident #206). The findings include: The facility staff failed to ensure communication with hospice allowed for the prompt implementation of an order to discontinue Resident #206's oral morphine. Resident #206's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/25/23, was signed as completed on 7/27/23. Resident #206 was assessed as usually able to make self understood and as able to understand others. Resident #206 was assessed as having problems with both short-term memory and long-term memory. Resident #206 was assessed as being dependent on others for transfers, dressing, personal hygiene, and bathing. The following VERBAL ORDER was found in Resident #206's clinical record (dated 7/7/23 at 2:14 p.m.): Discontinue: effective 7/7/23 - morphine 20 mg/ml oral concentrate; Administer 0.25 milliliter(s) orally every 4 hours as needed for severe pain; Prn - read back and confirmed . This order was given by the hospice provider. Resident #206's Medication Administration Record (MAR) for July 2023 indicated the aforementioned 'discontinue' order was not implemented. Resident #206 continued to receive doses of morphine on the following dates and times: (1) 7/15/23 at 7:00 p.m., (2) 7/17/23 at 8:20 p.m., (3) 7/18/23 at 5:32 a.m., (4) 7/19/23 at 8:17 a.m., and (5) 7/19/23 at 1:31 p.m. On 9/17/24, the Director of Nursing (DON) and Assistant DON (ADON), reported the aforementioned 7/7/23 order to discontinue the morphine had not been implemented. On 9/18/24 at 11:54 a.m., the Regional Director of Clinical Services (RDCS) reported that it is not known when the 7/7/23 order to discontinue Resident #206's morphine was provided to the facility; the RDCS reported the form was uploaded into the electronic record on 7/18/23. The following information was found in a facility policy titled Hospice Care Policy (with a revision date of 5/24/23): - This community provides hospice services through collaboration with a Medicare certified hospice agency when ordered by the resident's physician. - The hospice services and those providing them will meet professional standards and be provided timely. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The community will designate a team member with a clinical background to work with the hospice representative[s] to coordinate the care provided to the community's residents by the hospice staff and the community staff. This coordinator must practice within their scope of practice and be able to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The coordinator will be responsible for the following: . Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. The following information was found in a hospice Medical Social Worker Visit Note dated 7/7/23 at 12:00 noon: Spoke with (resident's adult child's name omitted) who reports (they) went to see (Resident #206) and was not able to talk with (them). (Adult child) reports (they) told the nurse 2 weeks ago to stop giving (the resident) the morphine and only use the tramadol. MSW encouraged (adult child's name omitted) to call and speak with the Hospice nurse to find out what happened to (their) request to stop the morphine. On 9/18/24 at 1:06 p.m., the survey team met with the facility's Administrator, Assistant Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of the facility staff and hospice staff to communicate in a manner that ensured Resident #206's medical provider order to discontinue morphine was implemented.