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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure one of 24 residents was clinically appropriate for self-administration of medications, Resident #87. The findings included: For Resident #87 the facility staff failed to complete a self-administration of medications assessment. Resident #87's face sheet listed diagnoses which included but not limited to stiff-man syndrome, other pulmonary embolism without cor pulmonale, and chronic obstructive pulmonary disease. 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 clinical record was reviewed and contained a physician's order summary which read in part, albuterol sulfate HFA aerosol inhaler; 90 mcg/actuation; amt: 2 puffs; inhalation. Special instructions: May keep at bedside. Twice a day 9:00, 21:00. This order listed a start date of 07/30/24. Resident #87's clinical record was reviewed, and surveyor could not locate a self-administration of medications assessment. Surveyor spoke with the director of nursing (DON) on 09/12/24 at 2:30 pm regarding Resident #87's self-administration of medications assessment. DON provided surveyor with a copy of a Self-administration of medications form dated 09/12/24 and stated to surveyor that the order for medications at bedside was just entered on 09/11/24. Surveyor pointed out the albuterol order, and that it was dated 07/30/34. Surveyor requested and was provided with a facility policy entitled Self-Administration of Medications which read in part, 2. Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not completing the self-administration of medications assessment 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.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 22218 Facility staff failed to ensure that residents and/or resident representative had the opportunity to develop an Advanced Directive for 19 of 24 residents reviewed. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives. Facility policy does not meet requirement for advance planning, affecting all residents including a number of residents in the survey sample. During record review, surveyors noted difficulty locating documentation concerning advance care planning in resident records. Since the facility had changed clinical record software during calendar year 2024, surveyors asked staff for advance care planning documentation for 24 residents in the survey sample. Surveyors received a policy titled Advance Care Planning Meeting Protocol with revision date 10/1/2023. The policy stated under Purpose: It is the policy of this facility that Advance Care Planning is conducted on each patient's admission to the facility. The patient will meet wit the appropriate member of the healthcare team to ensure their preferences; (Living Wills, Medical [NAME] of Attorney, etc.) are recorded in their medical record and further used in the patient's plan of care. Advance Care Planning assists to ensure that family, friends, and caregivers are all familiar with a patient's wishes regarding the care they wish to receive, especially re;dated to end of life care as each patient will have different preferences based on personal values and beliefs. Under Procedure: 1-[Summary] an appropriate staff member will discuss advance care planning 3-5 days fro admission 2- [verbatim] Information regarding Advance Directives is provided to the resident and family by the facility during the meeting. 3- [verbatim] Resident/representative will be given opportunity to discuss their goals for care including their preference for Advance Care Planning. 4-[summary] legal documents will be obtained and placed in the clinical record 5- [verbatim] Results of the Advanced Care planning will be communicated to the resident's care providers and documented in the clinical record. The surveyor interviewed by phone the Social Service Director, who is responsible for the Advance Care Planning process in the facility. The social service director stated the facility used a form titled Advance Care Planning Tracking form to document resident wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/17, surveyors requested the tracking forms for 24 residents in the final survey sample. All were admitted to the facility prior to the start of the survey on 9/11/2024 and should have already had an Advance Care Planning meeting. Of the 24, thirteen residents had a tracking form on record, while eleven did not. There was no record of a care planning discussion with the eleven who did not have forms (Residents 18, 22, 24, 28, 30, 32, 48, 77, 87, 90, 100). None of the thirteen tracking forms document written information provided to the resident or resident's representative as required by the regulation. None of the residents is documented to have chosen DNI (do not intubate), DNH (do not hospitalize), Living Will, No artificial feeding, POST(Physician Orders for Life-Sustaining Treatment/MOLST/POST end of life instructions, No artificial feeding, other care limiting orders, or any type of Durable Power of Attorney. The only options documented as chosen by residents were Full Code and Do not Resuscitate. Surveyors determined the facility did not have a procedure that met regulatory requirements for provision of written information about formulating advance care plans and providing a meaningful opportunity to formulate those plans and put them into practice. The administrator and Director of Nursing were notified of the ongoing system failure during a summary meeting on the final day of the survey.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to screen for a mental disorder and/or intellectual disability prior to admission for 2 of 24 sampled residents. Resident #20 and Resident #61. The findings include: 1. For Resident #20, the facility staff failed to obtain a Level I Screening for Mental Illness, Intellectual Disability (ID), or Related Conditions, to determine if the resident had or may have had a MD (Mental Disorder), ID, or related condition prior to admission. 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. On 9/11/24, during review of the clinical record, surveyor could not locate a PASARR (Preadmission Screening and Resident Review) on Resident #20's clinical record. Surveyor requested evidence of a completed PASARR on 9/11/24 at 5:16 PM at the end of day meeting with the administrator, director of nursing, regional director of clinical services and assistant administrator. On 9/12/24 at 10:46 AM, surveyor was provided with a PASARR form dated 9/11/24 for Resident #20. On 9/12/24 at 11:00 AM, surveyor interviewed the social worker-other staff #2 (OS#2), who informed surveyor the PASARR was completed on 9/11/24, as she had only been employed at the facility for two months and she was unable to locate a PASARR for Resident #20's admission several months ago, so she completed the PASARR yesterday (9/11/2024). This concern was discussed at the end of day meeting on 9/12/24 at 5:23 PM with the administrator, director of nursing, and regional director of clinical services and again at the end of day meeting on 9/17/24 with the above-mentioned facility staff and the assistant director of nursing, and assistant administrator. This concern was also discussed at the pre-exit meeting on 9/18/24 at 1:05 PM with the administrator, director of nursing, assistant administrator, assistant director of nursing, and regional director of clinical services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested a facility policy for PASARR, but was informed a facility policy could not be located and was provided with a document titled, Preadmission Screening and Resident Review (PASRR) Technical Assistance for States, that read in part, .Federal law mandates that Medicaid-certified nursing facilities (NF) may not admit an applicant with serious mental illness (MI), mental retardation (MR), or a related condition, unless the individual is properly screened .States are required to have a PASRR program in order to screen all NF applicants .The state uses the evaluation to determine, prior to admission, whether NF placement is appropriate .screens generally consist of forms completed by hospital discharge planners, community health nurses, or others . 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 obtain a Level I Screening for Mental Illness, Intellectual Disability (ID), or Related Conditions, to determine if the resident had or may have had a MD (Mental Disorder), ID, or related condition prior to admission. Resident #61's diagnosis list indicated diagnoses, which included, but not limited to, Metabolic encephalopathy, Chronic obstructive pulmonary disease, Personal history of transient ischemic attack (TIA), and cerebral infarction, 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 9/11/24, during review of the clinical record, surveyor could not locate a PASARR (Preadmission Screening and Resident Review) on Resident #61's clinical record. Surveyor requested evidence of a completed PASARR on 9/12/24 at 5:23 PM at the end of day meeting with the administrator, director of nursing, and regional director of clinical services. On 9/13/24 at 8:20 AM, surveyor was informed by the assistant administrator that a PASARR could not be located for Resident #61. 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 with the above-mentioned facility staff and the regional director of clinical services at the pre-exit meeting on 9/18/24 at 1:05 PM. Surveyor requested a facility policy for PASARR, but was informed a facility policy could not be located and was provided with a document titled, Preadmission Screening and Resident Review (PASRR) Technical Assistance for States, that read in part, .Federal law mandates that Medicaid-certified nursing facilities (NF) may not admit an applicant with serious mental illness (MI), mental retardation (MR), or a related condition, unless the individual is properly screened .States are required to have a PASRR program in order to screen all NF applicants .The state uses the evaluation to determine, prior to admission, whether NF placement is appropriate .screens generally consist of forms completed by hospital discharge planners, community health nurses, or others . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to develop and/or implement a person-centered, comprehensive, activity care plan for 1 of 24 sampled residents, Resident #83. The findings included: For Resident #83 the facility staff failed to develop and implement a comprehensive person-centered activity care plan to include measurable objectives and timeframes to meet the resident's mental and psychosocial needs and include the resident's goals, desired outcomes, and preferences for activities. 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. A review of the clinical record and comprehensive care plan on 9/11/24, produced no evidence of a person-centered, activity care plan for Resident #83. On 9/12/24 at 11:50 AM, during an interview with the activity director, surveyor requested evidence of an activity care plan for Resident #83. 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 . 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, .5. Each resident's Life Enrichment Care Plan .should reflect his/her individual needs .6 .Life Enrichment Care Plan will identify if a resident is capable of pursuing leisure without intervention from the community . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled Comprehensive Care Planning Policy, which read in part, .An interdisciplinary plan of care will be established for every resident .A. The facility must develop a comprehensive Person Centered Care Plan for each resident that includes measurable objectives and timetables to meet the resident's .mental and psychosocial needs . 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 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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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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(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	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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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide an ongoing, person-centered activity program to support resident choice, interests and physical, mental, and psychosocial well-being for 1 of 24 sampled residents, Resident #83. The findings included: For Resident #83, the facility staff failed to provide an ongoing, person-centered, activity program to support resident choice, interests, and 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. A review of the clinical record and comprehensive care plan on 9/11/24, produced no evidence of a person-centered, activity care plan, initial activity assessment, or any evidence of activity progress notes for Resident #83. On 9/12/24 at 11:50 AM, during an interview with the activity director, surveyor inquired what activities were being provided for Resident #83 and she responded that resident is provided with in-room activities with activity staff and volunteers. She stated she did not have a schedule of one-to-one visits, but activity staff take the activity cart around three times per week. Surveyor requested the activity care plan, activity participation records for July, August, September 2024, activity assessments, and activity progress notes for Resident #83. On 9/12/24 at 12:52 PM, activity director provided surveyor with hand-written activity participation records and 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. A review of the hand-written activity participation records indicated resident was visited for Cozy Corner activity on the following dates: 7/23/24 8/4/24 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/13/24 8/20/24 9/3/24 The activity director stated this was the only activity participation documentation that she could find, but they (activity staff) visit resident every day. 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 also stated that, Cozy Cart is a sensory program, and the activity staff play music for that program. This concern was discussed at the end of day meeting on 9/12/24 at 5:23 PM, and at the end of day meeting on 9/17/24 at 5:28 PM, with the regional director of clinical services, administrator, director of nursing, assistant director of nursing, and assistant administrator. Surveyor requested and received a facility policy titled, Life Enrichment Programming Policy, that read in part, .An ongoing resident-centered Life Enrichment Program, based on comprehensive assessments and care plans, will be provided .This program will be designed to meet the interests .and abilities of each resident including as their physical; mental; emotional; social; spiritual; psychosocial and leisure needs . No further information was presented to the survey team prior to exit on 9/18/24.

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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	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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Autumn Care of Suffolk	2580 Pruden Boulevard Suffolk, VA 23434

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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)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to maintain an accurate accounting of narcotics for one of 24 residents, Resident #18. The findings included: For Resident #18 the facility staff failed to report and/or account for missing doses of the medication morphine sulfate. Resident #18's face sheet listed diagnoses which included but not limited to Alzheimer's disease and pain. Resident #18's most recent minimum data set with an assessment reference date of 06/29/24 coded the resident as having both short- and long-term memory problems. Resident #18's clinical record was reviewed and contained a physician's order summary which read in part, morphine concentrate-Schedule II solution; 100 mg/5 ml (20 mg/ml); amt: 0.25 ml; oral. Special Instructions: Take 0.25 ml (5mg) by mouth every hour as needed for mild pain or shortness of breath. This order was discontinued on 04/22/24. Resident #18's electronic medication administration records for the months of July-December 2023 and January-April 2024 were reviewed and contained an entry as above. This entry was last initialed as being administered on 07/13/23. Resident #18's clinical record was reviewed and contained a Controlled Medication Utilization Record dated 07/09/23 indicating 30 ml of the medication, morphine sulfate, was received on this date. The record indicated the resident received five 0.25 ml doses between 07/10/23 and 07/13/23 for a total of 1.25 ml administered. This left a total of 28.75 ml on 07/13/23. The next entry on the control utilization form was dated 11/19/23, and read actual count and indicated an amount of 25.75 ml, a discrepancy of 3 ml. The next entry on the control form was dated 01/02/24 and read actual count and indicated an amount of 24.25 ml, a discrepancy of 1.5 ml from the previous amount. The control form contained entries dated 01/11/24, 01/19/24, 02/09/24, 02/23/24, 03/29/24, 04/03/24 and 04/17/24. Each entry indicated a corrected count and stated either spillage or leaking. The corrected counts ranged from 0.25 ml to 3 ml each count. The final count on the control utilization form indicated 16 ml remaining, for a total of 12.75 ml unaccounted for. Surveyor spoke with the director of nursing (DON) on 09/11/24 at 9:30 am regarding the discrepancies on Resident #18's Controlled Medication Utilization Record. DON stated this form is not the narcotics count sheet, but an administration record. Surveyor asked DON how often narcotics should be counted, and DON responded, They should be counting morphine every day. Surveyor asked DON what should be done if the count is not correct, and DON stated they should be notified of incorrect narcotics counts. Surveyor asked the DON if anyone had notified them of the incorrect counts for Resident #18, and DON stated they had not. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with the DON again on 09/11/24 at 12 pm regarding the discrepancies in the controlled medications count. Surveyor asked DON if nurses' work 8- or 12-hour shifts, and DON stated they work 12 hours shifts. Surveyor again asked DON how often narcotics should be counted, and DON stated, they should count narcs every shift. Surveyor requested and was provided with a facility policy entitled Inventory Control of Controlled Substances which read in part, 1. With respect to Schedule II controlled substances: 1.1 Facility should maintain separate individual controlled substance records on all Schedule II medications and any medication with a potential for abuse or diversion in the form of declining inventory using the 'Controlled Substances Declining Inventory Record' .1.3 Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document results on a 'Controlled Substance Count Verification/Shift Count Sheet.' 4. Facility staff should ensure that its staff IMMEDIATELY reports suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation, and timely follow-up in accordance with Facility policy and Applicable Law. Surveyor requested and was provided with a facility policy entitled Missing Medication Policy which read in part, Any medication[s] identified as missing will be promptly investigated. 1. When a medication is identified as missing the issue is to be immediately communicated to the supervisor on duty, who will notify the Director of Nursing. 4. If, after the efforts above, a missing medication cannot be accounted for, the following steps should occur: Notify the Regional Director of Clinical Services for guidance. If the medication missing is a controlled substance, the local law enforcement is to be notified and the community must follow the steps of the state's regulations for long-term care and pharmacy regarding missing/diverted medications (discuss with your consulting pharmacist). If the medication missing is a controlled substance, work with both law enforcement and your consulting pharmacist to determine further investigational steps which might be necessary. Surveyor spoke with unit manager on 09/12/24 at 1:15 pm regarding narcotics counts, Unit manager stated the staff counts narcotics between shifts, and anytime another nurse takes over a cart. Surveyor asked unit manager what happens if they find a discrepancy in the count, and unit manager stated, they immediately do a re-count, and if it's still off, they notify the DON. Surveyor requested the Controlled Substance Count Verification/Shift Count Sheets for Resident #18's morphine sulfate from July 2023 until medication was discontinued in April 2024 on 09/11/24. DON stated they would look for them, but as of 11:00 am on 09/13/24, they had not been provided. The concern on not maintaining an accurate accounting of narcotics 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.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on staff interview, clinical record review and facility document review, the facility staff failed to review and/or act upon pharmacist recommendations for 3 of 24 residents, Resident #4, #51, #48. The findings included: 1. For resident # 4, the facility staff failed to review and act upon a pharmacy recommendation to complete an AIMS (abnormal involuntary movement scale) assessment for two months. Resident # 4's diagnoses included but were not limited to major depressive disorder, anxiety, bipolar disorder, and dementia with behavior disturbance. The minimum data set (MDS) assessment with an assessment reference date of 8/12/24 assigned the resident a brief interview for mental status (BIMS) score of 6 indicating they had a moderate cognitive impairment. The Medication Administration Record (MAR) for resident # 4 was reviewed. Resident had an order for Quetiapine (an antipsychotic) 25 mg every 12 hours for bipolar disorder. The clinical record was reviewed. A pharmacy consultation report dated 9/13/23 read in part, .receives Quetiapine 25 mg q (every) 12 hours for bipolar disorder, which may cause involuntary movements including tardive dyskenisia (TD), but and Abnormal Involuntary Movement scale (AIMS), dyskinesia identification system: condensed user scale (Discus), or other appropriate assessment was not documented in the medical record within the previous 6 months. The most recent AIMS is from 11/15/22 and was 3. Please monitor for involuntary movements now and at least every 6 months per facility protocol. It is recommended that monitoring frequency increase following dose adjustments adjustments. If voluntary movements are present, it is recommended that a risk/benefit assessment be completed and Quetiapine Fumarate be considered for discontinuation. This surveyor was unable to find the AIMS assessment in the clinical record. On 9/13/24 9:00 AM the Regional Director of Clinical Services was interviewed. They provided an AIMS for resident # 4 that was dated 11/8/23. They were unable to state why the AIMS was done nearly 2 months after the recommendation. The policy entitled, Medication Regimen Review with a revision date of 6/1/24 was requested and reviewed. The facility read in part, 9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. On 9/18/24 this surveyor interviewed the Director of Nursing. When asked what the expectation would be for a recommendation that read now and every six months they stated, I would expect it to be done now, not two months later. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For resident # 51 the facility staff failed to review and act upon a pharmacy recommendation dated 10/18/23. which read in part, .receives clopidogrel and a CYP2C19 inhibitor (a liver enzyme that metabolizes many medications), Omeprazole which may significantly reduce the effectiveness of clopidogrel (prevents blood clots). Please discontinue Omeprazole and, if appropriate, initiate alternative therapy with or Famotidine. A second pharmacy recommendation dated 2/14/24 read under the heading Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED.*** .has received a PPI Omeprazole 40 mg twice daily since 2-23-23 for GERD Recommendation: in the absence of an indication requiring twice daily PPI therapy (e.g., nocturnal symptoms, [NAME]-[NAME] syndrome), please change to pantoprazole 20 mg once daily since also taking clopidogrel. Omeprazole which may significantly reduce the effectiveness of clopidogrel. The Regional Director of Clinical Services provided an order that was dated 3/2/24 which indicated the Omeprazole was discontinued at that time. This surveyor requested and reviewed the policy entitled, 9.1 Medication Regimen Review with a revision date of 6/1/24. The policy read in part, 9. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR. 11. When the consultant pharmacist identifies an time-sensitive medication related concern during the MRR that requires immediate action, the consultant pharmacist will notify the nurse and request the facility contact the attending physician/prescriber to communicate the issue and obtain direction or new orders. 13. The attending physician/prescriber should address the consultant pharmacists recommendation no later that their next scheduled visit to the facility to assess the resident per facility policy and state or federal regulations. The survey team met with the Administrator, Assistant Administrator, Director of Nursing Regional Nurse Consultant and the Assistant Director of Nursing on 9/18/24 at 1:06 PM and this concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference. 28169 3. For Resident #48, facility staff failed to ensure pharmacy recommendations for AIMS (Abnormal Involuntary Movement Scale) assessments were completed every six (6) months. Resident #48's facesheet listed diagnoses to include but not limited to, schizoaffective disorder, anxiety disorder, dementia psychotic disturbance, mood disturbance, anxiety and bipolar disorder. The minimum data set assessment with an assessment reference date of 07/19/24 coded the resident's brief interview for mental status score a 03 out of 15 (in Section C - cognitive patterns) which indicated a severe cognitive impairment. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacy recommendation dated 07/11/24 read Resident #48 received Risperidone which may cause involuntary movements including tardive dyskinesia (TD), but an AIMS was last completed 10/13/23 and was 0 (zero). The pharmacist's recommendation read to monitor for involuntary movements now and at least every 6 months or per facility protocol. The rationale for the recommendation read that early detection of involuntary movements can allow for discontinuation of medication and prevent potentially irreversible TD. Resident #48's provider orders included but were not limited to: Risperdal (risperidone) solution 1mg/ml; 1mg at bedtime and Risperdal (risperidone) solution 1mg/ml; 0.5mg in the morning. Risperdal is an antipsychotic medication. On 09/12/24, this surveyor requested Resident #48's pharmacy recommendations (medication regimen review - MRR) for the four (4) months out of the last 12 months of pharmacy reviews. On 09/16/24 the director of nursing provided an AIMS document dated 01/13/24 and 09/14/24. There was no AIMS provided for six (6) months after the 01/13/24 document which would have been in July 2024, the month of the pharmacy recommendation. The AIMS completed on 09/14/24 was eight (8) months from the previous AIMS and completed after this surveyor asked about the AIMS documentation. The director of nursing (DON) was interviewed on 09/17/24 and stated she did not know why the AIMS was not completed in July but that would have been her expectation. The DON did not report facility policy indicated a different AIMS time-period. On 09/17/24 at 5:28 p.m., the administrator, assistant administrator, DON and assistant director of nursing were informed of the AIMS completion not being every six (6) months as recommended by the pharmacist's review. No further information was provided prior to the exit conference.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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)

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 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.

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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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.