

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Care of Mechanicsville		STREET ADDRESS, CITY, STATE, ZIP CODE  7600 Autumn Parkway Mechanicsville, VA 23116	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide notification to the physician of a residents refusal of treatment for one of 35 residents in the survey sample, Resident #359.</p> <p>The findings include:</p> <p>For Resident #359 (R359), the facility staff failed to evidence notification of the physician of R359's refusal of lab testing on 11/6/24 and 11/7/24.</p> <p>On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/29/24, the resident scored three on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions.</p> <p>The physician orders for R359 documented in part,</p> <ul style="list-style-type: none"> <li>- BMP (basic metabolic profile) and CBC (complete blood count); Special Instructions: BMP and CBC Once- One Time 23:00 (11:00 pm)- 07:00 (7:00am). Start Date: 11/06/2024. End Date: 11/06/2024.</li> <li>- BMP and CBC; Special Instructions: BMP and CBC Once- One Time 23:00 - 07:00. Start Date: 11/07/2024. End Date: 11/07/2024.</li> </ul> <p>The progress notes for R359 documented in part, 11/05/2024 14:51 (2:51 p.m.) New orders for Pyridium 100 mg (milligram) po (by mouth) BID (twice a day) for 3 days, Keflex 500 mg po every 8 hours for 5 days, and labs for BMP and CBC 11/6/24. RP (responsible party) [Name of RP] aware.</p> <p>The progress notes for R359 failed to evidence the BMP and CBC obtained, results of the BMP or CBC, documentation of refusal of the lab testing or notification of the physician of refusal of the lab testing ordered on 11/6/24 and 11/7/24.</p> <p>On 2/26/25 at 11:52 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the results of the BMP and CBC ordered above.</p> <p>On 2/26/25 at 1:02 p.m., ASM #1 provided laboratory patient log sheets dated 11/6/24 and 11/7/24 which documented R359 refusing the lab testing on both dates. The log sheets failed to evidence notification of the physician of the refusal.</p> <p>(continued on next page)</p>		

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/26/25 at 1:04 p.m., an interview was conducted with RN (registered nurse) #3 who stated that when there was an order for a lab test the nurse entered the order into the electronic medical record and into the laboratory system. She stated that the night shift staff printed out the lab orders for that night and gave them to the lab technician who came in six nights a week to draw labs. She stated that when a resident refused to have labs drawn the technician notified the nurse who let the physician, and the responsible party know and documented it in the progress notes. RN #3 stated that this was done because the physician had ordered the lab tests for a reason and needed to know that it had not been obtained.</p> <p>On 2/26/25 at approximately 2:45 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the vice president of operations were made aware of the findings.</p> <p>No further information was provided prior to exit.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. For Resident #79 (R79), the facility staff failed to provide physician prescribed adaptive eating equipment.</p> <p>On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/24, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.</p> <p>A review of R79's clinical record revealed a physician's order dated 9/10/24 that documented, Provide 2 handled cup with lid + straw and red foam to knife and fork for all meals as tolerated.</p> <p>On 2/25/25 at 9:00 a.m., R79 was observed sitting up in bed. A cup containing coffee was observed on the resident's overbed table. The cup had one handle and no lid. Spilled coffee was observed on the overbed table. R79's right hand was observed tremoring. The resident stated, I used to feed herself but now staff feed her because of her tremors. R79 stated, She cannot pick up the cup, so she uses a straw R79 stated she used to have a special cup, but it went missing, and she used to have red foam handles for utensils but does not have them anymore.</p> <p>On 2/25/25 at 12:50 p.m., R79 was observed sitting up in bed while a CNA (certified nursing assistant) was feeding her. The cup on R79's meal tray contained no handles and no red foam handles for R79's utensils were observed on the meal tray. R79's lunch meal tray ticket dated 2/25/25 documented, 2 handle cup wit [sic] lid; red foam build [sic] up utensils.</p> <p>On 2/25/25 at 2:56 p.m., an interview was conducted with OSM (other staff member) #3 (an occupational therapist who had previously treated R79). OSM #3 stated, That due to an ulnar drift (a hand dysfunction where the fingers bend towards the outer arm bone), R79 has difficulty grasping objects. OSM #3 stated, A two handled cup and red foam utensil handles are supposed to aid R79 with grasping objects more easily.</p> <p>On 2/25/25 at 3:38 p.m., an interview was conducted with CNA #1. CNA #1 stated, R79 can feed herself finger foods but must be fed other foods because her hands shake. CNA #1 stated, She was not aware of R79 requiring any adaptive eating equipment such as a special cup or red foam utensil handles, and she has not seen any adaptive eating equipment for R79 since she began employment in June 2024.</p> <p>On 2/25/25 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.</p> <p>No further information was presented prior to exit.</p> <p>Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide assistive devices for eating for one of 35 residents in the survey sample, Resident #75 (R75).</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>For Resident #75 (R75), the facility staff failed to provide built up eating utensils for the resident to use during meals.</p> <p>On the following dates and times, R75 was observed eating a meal. At each of these observations, the resident was attempting to use regular utensils to feed herself. At all observations, she abandoned using the utensils, and used her fingers to feed herself: 2/24/25 at 2:20 p.m., 2/25/24 at 9:05 a.m. and 1:18 p.m. On 2/25/25 at 1:18 p.m., R75 stated she had been seen by the occupational therapy staff, and they had given her eating utensils that were built up on the ends so she could more easily manipulate them. She stated she had lost the utensils, and it was her fault that she didn't have any adaptive utensils to use. She stated the staff had not attempted to give her additional adaptive eating equipment.</p> <p>A review of R75's tray meal ticket for the lunch meal on 2/25/25 at 1:18 p.m. revealed, in part: Lightweight spoon and fork when eating.</p> <p>A review of R75's occupational therapy Discharge summary dated [DATE] revealed, in part: Recommendations .foam built up on utensils for self-feeding.</p> <p>A review of R75's orders revealed the following order, dated 2/23/25: Lightweight spoon and fork when eating.</p> <p>A review of R75's comprehensive care plan, most recently updated on 2/4/25, revealed no information related to the resident's need for adaptive eating equipment.</p> <p>On 2/25/25 at 2:53 p.m., OSM (other staff member) #3, an occupational therapist, was interviewed. She stated occupational therapy had recently treated and discharged R75 with a recommendation for red, tubular foam build ups on her eating utensils. She stated: She had three of them. They were in her room. The CNAs (certified nursing assistants) are responsible for putting them on her eating utensils.</p> <p>On 2/25/25 at 3:32 p.m., CNA #2 was interviewed. She stated she is very familiar with R7 and is regularly assigned to care for her. She stated: [R75] is not supposed to have any specialized equipment for eating.</p> <p>A review of the facility policy, Adaptive (Assistive) Eating Devices, revealed, in part: Adaptive .eating devices are provided per physicians' order or as needed/requested .Individuals will be referred to the therapy department as needed for evaluation of noted eating difficulty(s) .Adaptive .devices will be provided per order .The dietary department is responsible for ensuring that adaptive devices are cleaned and sanitized after each use and the device is provided for each meal or snack as appropriate.</p> <p>On 2/25/25 at 4:10 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the assistant director of nursing, were informed of these concerns.</p> <p>No additional information was provided prior to exit.</p>		