

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Crystal Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Whitman Avenue Elkins, WV 26241	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and staff interview, the facility failed to implement the care plan intervention of weekly skin evaluations for Resident #30, #76, #18 and #75. This was true for four (4) of five (5) residents reviewed during the survey process. Resident Identifiers: #30, #76, #18 and #75. Facility Census: 82.</p> <p>Findings Include:</p> <p>a) Resident #30</p> <p>On 11/26/24 at 10:00 AM, a record review was completed for Resident #30. The review found the care plan had not been implemented regarding weekly skin evaluations. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <p>--02/19/24-02/27/24 8 days</p> <p>--03/04/24-03/19/24 15 days</p> <p>--04/15/24-04/23/24 8 days</p> <p>--05/14/24-05/28/24 14 days</p> <p>--06/04/24-06/18/24 14 days</p> <p>--07/16/24-08/01/24 16 days</p> <p>--08/06/24-08/20/24 14 days</p> <p>--08/20/24-09/02/24 13 days</p> <p>--09/02/24-09/17/24 15 days</p> <p>--09/30/24-10/14/24 15 days</p> <p>On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b) Resident #76</p> <p>On 11/26/24 at 10:30 AM, a record review was completed for Resident #76. The review found the care plan had not been implemented regarding weekly skin evaluations. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <p>--02/05/24-02/13/24 8 days</p> <p>--02/20/24-03/12/24 21 days</p> <p>--04/01/24-04/09/24 8 days</p> <p>--04/16/24-05/21/24 35 days</p> <p>--05/21/24-06/04/24 14 days</p> <p>--06/11/24-06/21/24 10 days</p> <p>--07/19/24-07/29/24 10 days</p> <p>--08/01/24-08/09/24 8 days</p> <p>--08/30/24-09/13/24 14 days</p> <p>--09/13/24-09/27/24 14 days</p> <p>--09/27/24-10/10/24 13 days</p> <p>--11/15/24-11/23/24 8 days</p> <p>On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.</p> <p>c) Resident #18</p> <p>On 11/26/24 at 10:45 AM, a record review was completed for Resident #18. The review found the care plan had not been implemented regarding weekly skin evaluations. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <p>--05/21/24-05/30/24 9 days</p> <p>--08/21/24-08/30/24 9 days</p> <p>--10/14/24-10/28/24 14 days</p> <p>On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d) Resident #75</p> <p>On 11/26/24 at 11:00 AM, a record review was completed for Resident #75. The review found the care plan had not been implemented regarding weekly skin evaluations. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <ul style="list-style-type: none"> --03/14/24-03/28/24 14 days --03/28/24-04/16/24 19 days --04/18/24-05/02/24 14 days --05/16/24-05/30/24 14 days --06/12/24-06/20/24 8 days --06/27/24-07/26/24 29 days --08/29/24-09/06/24 8 days --09/12/24-10/10/24 28 days --10/10/24-10/31/24 21 days <p>On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.</p>

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview the facility failed to honor code status for one (1) of 23 residents reviewed. This is cited as past non compliance due to the facility's correction of the problem prior to the surveyors arrival at the facility. Resident identifier: #83. Facility census: 82.</p> <p>Findings included:</p> <p>a) Resident #83</p> <p>At approximately 11:00 AM on [DATE], a review of a facility reported incident was conducted. During the review it was noted Resident #83 had passed away at the facility on [DATE] and the facility failed to administer CPR, despite the resident being a full code status.</p> <p>According to a summary report provided by the Administrator and Director of Nursing (DON), Resident #83 had an order to Do Not Resuscitate (DNR) until [DATE], when the code status was changed on [DATE] at a hospital for a surgical procedure.</p> <p>The resident was admitted to the facility on [DATE] with orders from the hospital as a full code, meaning CPR was to be initiated if needed. However, the hospital sent a POST form stating the resident was a DNR , even though the status had been changed. It was determined Unit Manager (UM) #94 queued orders in the computer system and told the admitting nurse to activate those orders and she would verify the accuracy of said orders upon arrival to the facility the morning of [DATE].</p> <p>The admitting nurse activated the orders, including the order entered for DNR by UM #94. However, UM #94 did not verify the status of the orders when she arrived to the facility on [DATE] and stated she assumed the order from the hospital for a full code was wrong and did not verify it for that reason. The DNR order was signed by the facility physician.</p> <p>On [DATE], Resident #83 was found to have no pulse or respirations and CPR was not attempted and Emergency Services were called and the resident was pronounced dead.</p> <p>As a result of the investigation by the facility, UM #94 was suspended and later terminated due to failing to verify the orders.</p> <p>At approximately 12:30 PM on [DATE], an interview was conducted with the Administrator and DON. During the interview, both stated CPR should have been performed on Resident #83. The Administrator stated the admitting nurse had it in writing from a group nurse chat stating UM #94 told her to activate the orders she had queued and she would verify the accuracy the following morning. Regarding the conflicting orders on the discharge summary from the hospital and the POST form for Resident #83, both stated orders should have been pulled from the discharge summary, however, they should have been verified due to them being conflicting. Neither the hospital or wife was contacted to verify. The Administrator stated the facility was unaware Resident #83 should have received CPR until a nurse contacted his wife on [DATE] to inform her of his passing at the facility. The Administrator stated UM #94 inserted her opinion for what the doctors and wife wanted regarding Resident #83's code status.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility plan of correction is as follows:</p> <p>Facility performed a facility wide audit of resident code statuses, POST forms, and CPR certification for all residents.</p> <p>All nurses were educated on verifying code statuses, accuracy of orders if orders are conflicting.</p> <p>Audits completed by the DON to ensure all admissions were completed and code status was verified. DON performed random audits of ten (10) percent of resident population to ensure code status and POST forms.</p> <p>CPR drills were conducted twice per month, and will continue for six (6) months.</p> <p>DON will conduct monthly audits, and upon hire, to ensure all nursing CPR certifications are up to date. Audits will last six (6) months.</p> <p>All audit results will be reported to QAPI for review.</p> <p>The correction occurred on [DATE].</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and staff interview, the facility failed to follow physician's orders regarding weekly skin evaluations for four (4) of five (5) residents reviewed for quality of care. Resident #30, #76, #18 and #75 were affected by this. Resident identifiers: #30, #76, #18, and #75. Facility Census: 82.</p> <p>Findings Included:</p> <p>a) Resident #30</p> <p>On 11/26/24 at 10:00 AM, a record review was completed for Resident #30. The review found the physician's order regarding weekly skin evaluations had not been followed. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <p>--02/19/24-02/27/24 8 days</p> <p>--03/04/24-03/19/24 15 days</p> <p>--04/15/24-04/23/24 8 days</p> <p>--05/14/24-05/28/24 14 days</p> <p>--06/04/24-06/18/24 14 days</p> <p>--07/16/24-08/01/24 16 days</p> <p>--08/06/24-08/20/24 14 days</p> <p>--08/20/24-09/02/24 13 days</p> <p>--09/02/24-09/17/24 15 days</p> <p>--09/30/24-10/14/24 15 days</p> <p>On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.</p> <p>b) Resident #76</p> <p>On 11/26/24 at 10:30 AM, a record review was completed for Resident #76. The review found the physician's order had not been followed regarding weekly skin evaluations. The following dates of the completed skin evaluations have greater than seven (7) days in between weekly skin evaluations:</p> <p>--02/05/24-02/13/24 8 days</p> <p>--02/20/24-03/12/24 21 days</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>.</p> <p>Based on a complaint investigation conducted from 11/25/24 through 11/26/24. Record review, and interview, revealed that the facility failed to ensure that the physician reviewed and documented a response, to the irregularities noted by the consultant pharmacist. This was true for one (1) of six (6) resident records surveyed. Resident Identifier: #35. Facility census:82</p> <p>Findings included:</p> <p>a) Resident #35</p> <p>Record review on 11/25/24 at approximately 12:30 PM revealed that Resident #35 was currently on the following medications:</p> <p>Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth every morning and at bedtime for psychosis Order dated 07/18/24</p> <p>Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium)</p> <p>Give 125 mg by mouth three times a day for psychosis may mix in food such as pudding or ice cream.</p> <p>Order dated 07/16/24.</p> <p>Record review of the consultant pharmacist's recommendations for the period 02/09/24 to 11/11/24 revealed the following:</p> <p>Consultant pharmacist review on 04/09/24:</p> <p>The Consulting pharmacist suggested discontinuing PRN use of Seroquel for agitation/wound changes. Suggested considering the use of a medication from a different therapeutic class such as a short acting Benzodiazepine for PRN use with a 14 day stop.</p> <p>Per State and Federal guidelines:</p> <p>PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed, unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>Record review revealed that the physician had been notified on 05/06/24, and no response to the recommendation had been received.</p> <p>During an interview with the Director of Nursing (DON) on 11/26/24 at approximately 2:00 PM, the DON confirmed that there were no records indicating that the physician had responded to the consulting pharmacist's recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Consultant pharmacist review on 06/12/24:</p> <p>The Consulting Pharmacist noted this resident has been taking Depakote DR 125 MG TID since 06/23 without a Gradual Dose Reduction (GDR). Could we attempt a dose reduction at this time to perhaps 125 MG BID to verify the resident is on the lowest possible dose? If not, please indicate response.</p> <p>Federal guidelines state that psychopharmacological drugs should have an attempt at a GDR twice per year for the first year in two (2) different quarters with one (1) month between attempts, then annually thereafter, when used to manage behavior, stabilize mood, or treat psych disorder.</p> <p>The recommendation was faxed to the physician on 06/18/24. The physician had not responded to the pharmacist's recommendation.</p> <p>During the interview with the DON on 11/26/24 at approximately 2:00 PM, the DON stated that though the physician had not responded to the recommendation, the physician had come into the facility and performed a complete history and physical, and medication review of Resident #35, on 06/24/24 at approximately 7:00 AM.</p> <p>A review of the physician's documentation revealed no notes referring to the pharmacist's recommendation, and the Depakote prescription remained unchanged.</p> <p>This citation refers to the following Federal guidelines related to pharmacist, and physician's obligations:</p> <p>&sect;483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>&sect;483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of a</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interview, the facility failed to provide an accurate and complete medical record for Resident #75, #30 and #18. This was true for three (3) of five (5) residents reviewed during the survey process. Resident Identifiers: #30, #75 and #18. Facility Census: 82.</p> <p>Findings Included:</p> <p>a) Resident #75</p> <p>On 11/25/24 at 1:00 PM, a record review was completed for Resident #75. The review found the Physician Orders for Scope of Treatment (POST) form was incomplete. The preparer's signature and date were left blank.</p> <p>On 11/25/24 at 3:30 PM, Social Worker (SW) #48 confirmed the POST form was incomplete.</p> <p>b) Resident #30</p> <p>On 11/25/24 at 1:15 PM, a record review was completed for Resident #30. The review found white correction fluid on the area of the physician's signature and the preparer's signature and date were left blank on the POST form.</p> <p>On 11/25/24 at 3:30 PM, Social Worker (SW) #48 confirmed the POST form was incomplete and white correction fluid was used on the area of the physician's signature.</p> <p>c) Resident #18</p> <p>On 11/25/24 at 1:30 PM, a record review was completed for Resident #18. The review found the POST form was incomplete in section B which lists the medical intervention choices; section C which lists the medically administered fluids and nutrition; and, the preparer's signature and date were left blank.</p> <p>On 11/25/24 at 3:30 PM, Social Worker (SW) #48 confirmed the POST form was incomplete.</p>		