STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515197	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT CRYSTAL SPRINGS	200 WHITMAN AVENUE PO BOX 1399

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=E	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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. Findings Included: a) Resident #30 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: --02/19/24-02/27/24 8 days --03/04/24-03/19/24 15 days --04/15/24-04/23/24 8 days --05/14/24-05/28/24 14 days --06/04/24-06/18/24 14 days --07/16/24-08/01/24 16 days --08/06/24-08/20/24 14 days --08/20/24-09/02/24 13 days --09/02/24-09/17/24 15 days	F 684	Action ADON performed a skin evaluation Residents #30, #76, #18, and #75. Resident At Risk All Residents have the potential to affected. Systematic Change DON or Designee will educate all Nurses on the importance of performing weekly skin evaluations per physician order. Quality Assurance DON or Designee will complete an initial audit all Residents to ensure weekly skin evaluations are being completed per physician order. Following the initial audit weekly will be completed for six months. DON or Designee will continue to code status of Residents per previously implemented Plan of Correction. The audits will be reported weekly the QAPI Committee for tracking recommendations for the first four weeks then monthly for a minimum six months. Additional audits will determined by the QAPI Committee.	01/06/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/13/2024

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT CRYSTAL SPRINGS	200 WHITMAN AVENUE PO BOX 1399

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

--09/30/24-10/14/24 15 days

On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.

b) Resident #76

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:

--02/05/24-02/13/24 8 days
--02/20/24-03/12/24 21 days
--04/01/24-04/09/24 8 days
--04/16/24-05/21/24 35 days
--05/21/24-06/04/24 14 days
--06/11/24-06/21/24 10 days
--07/19/24-07/29/24 10 days
--08/01/24-08/09/24 8 days
--08/30/24-09/13/24 14 days
--09/13/24-09/27/24 14 days
--09/27/24-10/10/24 13 days
--11/15/24-11/23/24 8 days

On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.

c) Resident #18

On 11/26/24 at 10:45 AM, a record review was completed for Resident #18. The review found the physician's order regarding weekly skin evaluations had not been followed. The following dates of the completed skin evaluations have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT CRYSTAL SPRINGS	200 WHITMAN AVENUE PO BOX 1399

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	greater than seven (7) days in between weekly skin evaluations: --05/21/24-05/30/24 9 days --08/21/24-08/30/24 9 days --10/14/24-10/28/24 14 days On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly. d) Resident #75 On 11/26/24 at 11:00 AM, a record review was completed for Resident #75. 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: --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 On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.			
F 656 SS=E	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans	F 656	Action	01/06/25

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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged		MDS Nurse reviewed and updated Plans for Residents #30, #76, #18 #75 to ensure all Residents had a Plan regarding weekly skin evaluations. Resident At Risk All Residents have the potential to affected. Systematic Change Administrator or Designee will educate all Nurse Managers on that all Residents should have a Care Plan related to weekly skin evaluations. Quality Assurance MDS Nurse will audit all Care Plans ensure that every Resident has a Plan related to weekly skin evaluations. The audit will occur randomly five per week for four-weeks then monthly. The audits will be reported weekly the QAPI Committee for tracking recommendations for the first four weeks then monthly for a minimum six months. Additional audits will determined by the QAPI Committee.	

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by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
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.

Findings Include:

a) Resident #30

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:

--02/19/24-02/27/24 8 days
--03/04/24-03/19/24 15 days
--04/15/24-04/23/24 8 days
--05/14/24-05/28/24 14 days
--06/04/24-06/18/24 14 days
--07/16/24-08/01/24 16 days
--08/06/24-08/20/24 14 days
--08/20/24-09/02/24 13 days
--09/02/24-09/17/24 15 days
--09/30/24-10/14/24 15 days

On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.

b) Resident #76

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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:

--02/05/24-02/13/24 8 days
--02/20/24-03/12/24 21 days
--04/01/24-04/09/24 8 days
--04/16/24-05/21/24 35 days
--05/21/24-06/04/24 14 days
--06/11/24-06/21/24 10 days
--07/19/24-07/29/24 10 days
--08/01/24-08/09/24 8 days
--08/30/24-09/13/24 14 days
--09/13/24-09/27/24 14 days
--09/27/24-10/10/24 13 days
--11/15/24-11/23/24 8 days

On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.

c) Resident #18

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:

--05/21/24-05/30/24 9 days
--08/21/24-08/30/24 9 days
--10/14/24-10/28/24 14 days

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	On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly. d) Resident #75 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: --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 On 11/26/24 at 1:15 PM, the Assistant Director of Nursing (ADON) #53 confirmed the skin evaluations were not being completed weekly.			
F 000 SS=E	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at Autumn Lake Healthcare at Crystal Springs from 11/25/24 - 11/26/24. The deficiencies cited are based on observations, interviews and record review as indicated. The facility's census on the first day of the survey was 82 residents.	F 000	Action MDS Nurse reviewed and updated Plans for Residents #30, #76, #18 #75 to ensure all Residents had a Plan regarding weekly skin evaluations. Resident At Risk All Residents have the potential to	01/06/25

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	Complaint: #29568- Unsubstantiated Complaint: #31430- Unsubstantiated Complaint: #33200- Sunstantiated- F684 and F756		affected. Systematic Change Administrator or Designee will educate all Nurse Managers on that all Residents should have a Care Plan related to weekly skin evaluations. Quality Assurance MDS Nurse will audit all Care Plans ensure that every Resident has a Plan related to weekly skin evaluations. The audit will occur randomly five per week for four-weeks then monthly. The audits will be reported weekly the QAPI Committee for tracking recommendations for the first four weeks then monthly for a minimum six months. Additional audits will determined by the QAPI Committee.	
F 842 SS=E	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted	F 842	Action POST forms were reviewed and updated for Residents #75, #30, #18. Resident At Risk All residents have the potential to affected. Systematic Change Administrator educated IDT Team POST forms must be completed signatures for preparer and cannot have white-out on the POST form. In the event that a Resident, Medical Power of Attorney or	01/06/25

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	professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches		Healthcare Surrogate prepares the POST form person's signature must be on the form. Quality Assurance DON or Designee will audit weekly to ensure that all POST forms are completed, contain no white-out and have a preparer's signature. Ongoing audits will be monthly x6 months. The audits will be reported to the Committee for tracking and recommendations for the first four weeks then monthly for a minimum six months. Additional audits will determined by the QAPI Committee.	

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legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
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.

Findings Included:

a) Resident #75

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.

On 11/25/24 at 3:30 PM, Social Worker (SW) #48 confirmed the POST form was incomplete.

b) Resident #30

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

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	physician's signature and the preparer's signature and date were left blank on the POST form. 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. c) Resident #18 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. On 11/25/24 at 3:30 PM, Social Worker (SW) #48 confirmed the POST form was incomplete.			
F 756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §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. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in	F 756	Action Medication Reviews were completed Resident #35. Resident At Risk All residents have the potential to be affected. Systematic Change Administrator educated DON and Managers on the requirements for Medication Reviews. Quality Assurance	01/06/25

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	paragraph (d) of this section for an unnecessary drug. (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 nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. . 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 Findings included: a) Resident #35 Record review on 11/25/24 at approximately		DON/Designee will audit weekly to ensure Medication Reviews are being completed and timely addressed. Ongoing audits will be monthly x6 months. The audits will be reported to the Committee for tracking and recommendations for the first four weeks then monthly for a minimum six months. Additional audits will determined by the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515197	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT CRYSTAL SPRINGS	200 WHITMAN AVENUE PO BOX 1399

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

12:30 PM revealed that Resident #35 was currently on the following medications:
Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth every morning and at bedtime for psychosis Order dated 07/18/24

Depakote Sprinkles Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium)
Give 125 mg by mouth three times a day for psychosis may mix in food such as pudding or ice cream.
Order dated 07/16/24.

Record review of the consultant pharmacist's recommendations for the period 02/09/24 to 11/11/24 revealed the following:

Consultant pharmacist review on 04/09/24:
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.

Per State and Federal guidelines:
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.

Record review revealed that the physician had been notified on 05/06/24, and no response to the recommendation had been received.

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

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indicating that the physician had responded to the consulting pharmacist's recommendation.

Consultant pharmacist review on 06/12/24:

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."

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.

The recommendation was faxed to the physician on 06/18/24. The physician had not responded to the pharmacist's recommendation.

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.

A review of the physician's documentation revealed no notes referring to the pharmacist's recommendation, and the Depakote prescription remained unchanged.

This citation refers to the following Federal guidelines related to pharmacist, and physician's

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	obligations: \'a7483.45(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. \'a7483.45(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. (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. (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			