STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. BUILDING _____ B. WING _____	C 02/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 2/20/18 through 2/21/18. One complaint was investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 114 certified bed facility was 103 at the time of the survey. The survey sample consisted of 1 current resident review and 1 closed record review (Resident #1and #2).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		3/28/18

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

Electronically Signed | 03/19/2018

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews, clinical record review, and facility document review, the facility staff failed to notify an emergency contact after a fall for 1 of 2 resident's in the survey sample, Resident #2. The facility staff failed to notify Resident #2's emergency contact on 1/17/2018 after the resident had encountered a second fall that day. The findings included: Resident #2 was a 93 year old admitted to the	F 580	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 580	Continued From page 2 facility on 5/29/2017 with diagnoses to include Atrial Fibrillation, Psychosis, and Repeated Falls. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date of (ARD) of 12/6/17. The Brief Interview for Mental Status (BIMS) was a 10 out of a possible 15 indicating the resident had some cognitive deficits but was capable of some daily decision making. Under Section J1800 Resident #2 was coded as having had falls since admission/or prior assessment, one fall with no injury and one fall with injury (not major). While reviewing a complaint on Resident #2 it was noted that the resident fell twice on 1/17/2018; however, the emergency contact was not made aware of the second fall that day from facility staff. The complainant was contacted by the surveyor on 2/20/18 at 2:00 P.M. and the above statement was verified. Resident #2's Progress Notes were reviewed for 1/17/18 and are documented in part, as follows: 1/17/2018 07:06 Resident found on floor lying face down. Alerted by CNA (Certified Nursing Assistant) when resident was screaming out for HELP. No new injuries found upon assessment. Will notify DCS (Director of Clinical Services) and hospice as well as MD (Medical Doctor) and RP (Responsible Party). 1/17/2018 14:30 (2:30 P.M.) Resident had an un-witnessed fall. Staff passed by room and she was on floor up under bed. Head to toe assessment done and no injuries noted. Resident is still restless.	F 580	1. Resident #2 no longer resides at the facility. 2. Quality review of residents identified as having a fall within the last 30 days for responsible party (RP) notification conducted by Director of Nursing/Designee utilizing the Morning Clinical Meeting Process Follow up based on findings. 3. Licensed Nurses re-educated by ADON/Designee on notification of family/responsible party. 4. DCS/designee to conduct Quality Improvement Monitoring of responsible party (RP) notification post fall utilizing the Morning Clinical Meeting Process 5 x/week x 4 weeks, weekly x 4 weeks, monthly and prn thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 580	Continued From page 3	F 580		

On 2/21/18 at 10:25 A.M. the above documentation was shared and reviewed with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Regional Director of Nursing. The Director of Nursing and the Assistant Director of Nursing stated that they had not been made aware of the Resident's second fall on 1/17/18. The Director of Nursing stated, "We don't have an incident report for the second fall only the first one." The facility was unable to provide any information to show that Resident #2's emergency contact or physician were notified about the second fall on 1/17/2018. The Regional Director of Nursing stated, "We should have notified the physician and the responsible party about the Resident's second fall."

The facility policy titled, "Family Notification" effective date 11/30/14 is documented in part, as follows:

Policy: It is the policy of The Company to: Keep families informed, keep families involved.

Procedure:
1. The family will be notified of any resident changes, i.e.:
b. Health problems through: telephone calls, or verbal exchange when family member is in the facility.

5. All significant family contact will be documented. This should include discussion of transfer, discharges, problems with care or roommate, significant changes in family support systems, etc.

On 2/21/18 at 2:30 P.M. a pre-exit conference was conducted with the Administrator, the

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F 580	Continued From page 4 Director of Nursing, the Assistant Director of Nursing and the Regional Director of Nursing where the above information was shared. Prior to exit no further information was provided.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews, clinical record review, and facility document review the facility staff failed to follow physician hospital discharge orders for 1 of 2 resident's in the survey sample, Resident #2. The facility staff failed to follow physician hospital discharge orders dated 12/13/17 regarding Resident #2's forehead staples to be removed on 12/20/17. The findings included: Resident #2 was a 93 year old admitted to the facility on 5/29/2017 and readmitted on 12/13/17 with diagnoses to include *(1) Atrial Fibrillation, *(2) Psychosis, and *(3) Repeated Falls. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date of	F 684	1. Resident #2 no longer resides at Consulate of Windsor. 2. Quality Review conducted by Interdisciplinary Team of residents with discharge orders within the last 30 days for accurate transcription. Follow up based on findings. 3. Licensed Nurses have been re-educated by ADON/Designee on process for accurate physician order transcription. 4. DCS/designee to conduct Quality Improvement Monitoring of discharge orders for accurate transcription utilizing Morning Clinical Meeting Process daily 5x/week x 4 weeks, weekly x 4 weeks, monthly and prn thereafter. Findings to be	3/28/18

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F 684	Continued From page 5 (ARD) of 12/6/17. The Brief Interview for Mental Status (BIMS) was a 10 out of a possible 15 indicating the resident had some cognitive deficits but was capable of some daily decision making. Under Section J1800 Resident #2 was coded as having had falls since admission/or prior assessment, one fall with no injury and one fall with injury (not major). Resident #2's Progress Note dated 12/13/17 at 18:46 P.M. (6:46) was reviewed and is documented in part, as follows: Note Text: Resident arrived via medical transport. RP (Responsible Party) at bedside during admission. Orders verified with LTC (long term care) on call. Resident only alert to self. Resident has bruising to left forehead, left arm, right are, cyst noted to left hand, sutures noted to midline forehead extending into hairline. Resident #2's Hospital Discharge Summary dated 12/13/17 at 11:18 A.M. was reviewed and is documented in part, as follows: Physical Exam on Discharge: HEENT (head, eyes, ears, nose and throat): forehead lac. (laceration) with staples well approximated, bruising to left eye. Discharge Orders: Wound Care As Follows: Cleanse staples to the forehead with soap and water. Pat dry. Staples to be removed in 7 days-12/20/17. While reviewing a complaint on Resident #2 it was noted that the Complainant had to request for the facility staff to remove the forehead staples on 12/25/17 because that had become	F 684	reviewed at monthly QAPI Committee meeting. Monitoring schedule modified based on findings.	

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F 684	Continued From page 6	F 684		

embedded in her skin and that they should have been removed on 12/20/17. The Complainant was contacted by the surveyor on 2/20/18 at 2:00 P.M. and the above statement was verified.

Resident #2's December Treatment Administration Records for December 2017 were reviewed and no order/entry was identified for the physician ordered forehead staple order to be completed on 12/20/17.

Resident #2's Progress Note dated 12/25/17 at 13:40 P.M. (1:40) was reviewed and is documented in part, as follows:

RN (Registered Nurse) removed resident staples X 5 from forehead due for removal after 12/20/17. Resident tolerated without complaint. Wound is closed with scab present.

Resident #2's Physician Order dated 12/25/17 was reviewed and is documented in part, as follows:

Order Date: 12/25/17 13:32 P.M. (1:32) Remove staples to forehead after 12/20/17.

On 2/21/18 at 10:25 A.M. the above documentation was shared and reviewed with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Regional Director of Nursing. The Director of Nursing and the Assistant Director of Nursing both acknowledged that the Hospital Discharge Summary indicated that Resident #2's forehead staples were to have been removed on 12/20/17. The Director Of Nursing stated, "We just overlooked the order on the transfer summary."

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F 684	Continued From page 7	F 684		

The facility policy titled, "Physician Orders" revision date: 8/22/17 was reviewed and is documented in part, as follows:

Procedure:
ADMISSION ORDERS: Information received from the referring facility or agency to be reviewed and transcribed to the admission physician order form or electronic equivalent. The attending physician reviews and confirms the orders.

ROUTINE ORDERS:
The order is transcribed to all appropriate areas (MAR (Medication Administration Record), TAR (Treatment Administration Record), etc) or electronic equivalent.

On 2/21/18 at 2:30 P.M. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Director of Nursing where the above information was shared. Prior to exit no further information was provided.

*(1) Atrial Fibrillation: a cardiac arrhythmia characterized by disorganized electrical activity in the atria accompanied by an irregular ventricular response that is usually rapid.

*(2) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thought and makes incorrect references about external reality, even in the face of contrary evidence.

The above definitions are derived from Mosby's

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F 684	Continued From page 8 Dictionary of Medicine, Nursing, and Health Professions 8th Edition. THIS IS A COMPLAINT DEFICIENCY	F 684		