STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	495190	A. BUILDING _____ B. WING _____	08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY 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 OEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 08/14/17 through 08/16/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. A complaint was investigated during the survey. The Life Safety Code survey/report will follow.

The census in this 90 certified bed facility was 79 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents #1 through #13, and #18) and 4 closed record reviews (Residents #14 through #17).

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.

F 225 SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225

483.12(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

1. Resident # 14 was assisted by center staff with a planned discharge back to the community on 5-19-17. The former Director of Nursing Clinical Services (DCS) investigation file was submitted to the surveyor involving a misappropriation of medication was inconclusive. The current DCS has not identified or been made aware of any drug diversions. Center administrative staff will be educated on the documentation process for an investigation and notifications to regulatory agencies.

9/2/17

LABORATORY OIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Q — Divisional Executive Director — 8/31/17

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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F 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225	CNA A has not been employed with the center since 8-10-17. Center staff will be educated on the verification process for criminal background checks eligibility in Long term care and verify certification and eligibility to work in Virginia prior to hire. 2. The unit managers and licensed nurses will review resident's physician orders and reconciled with the medicine in the medication cart. Human Resources staff will review new hire file for past 30 days to assess for documentation of criminal background check and current certification and eligibility to work in Virginia prior to hire.	9/21/17

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F 225	Continued From page 2 if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to report and investigate an allegation of abuse for 1 of 18 residents (Resident #14) and failed to ensure one of five employees (CNA A) was screened for a history of abuse, neglect or mistreating residents. 1. For Resident #14, the facility failed to report and investigate an allegation involving the misappropriation of medication. 2. For CNA A, the facility staff failed to ensure a criminal background check was obtained within 30 days of hire and failed to verify certification and eligibility to work in Virginia prior to hire. The findings included: 1. For Resident #14, the facility failed to report and investigate an allegation involving the misappropriation of medication. On 8/15/17, the Administrator and Director of Nursing (DON) were asked if they were aware of any drug diversions that had occurred in the facility, specifically in the month of May 2017. The DON stated that she had only been acting in the position since July 2017 and was not aware of a drug diversion. The Administrator stated that he had been at the facility since April 2017, but was not aware of a drug diversion. On 8/15/17 at 3:25 p.m., an interview was conducted with Licensed Practical Nurse A (LPN	F 225	3. The Center administrative staff and nursing staff will be re educated by DCS on the center's policy titled "Resident Abuse." The Executive Director as the abuse coordinator is responsible for ensuring that the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. The executive director and center receptionist will be trained to assist in the new hire process in the absence of the Human resource coordinator staff. 9/21/17	

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F 225	Continued From page 3	F 225		

A). LPN A was the staffing coordinator and had worked at the facility for many years. LPN A was asked if she was aware of any drug diversions that may have occurred in the facility. She stated yes, one incident had been investigated. When asked what the specific allegation included, LPN A stated that she could not remember. LPN A did know the name of the nurse involved, RN C. LPN A stated she had not been involved in completing the investigation. LPN A stated that the former DON had handled the investigation regarding RN C.

At the end of day meeting on 8/15/17, the Administrator and DON were notified that LPN A stated that there was a possible drug diversion investigated in May 2017. They were asked to provide the investigation. The investigation provided involved RN C and Resident #14.

RN C was not available for interview. She worked on an as needed basis. She last worked at the facility on 6/3/17.

Resident #14, a 58 year old, was admitted to the facility on 5/9/17. His diagnoses included aftercare for a left hip fracture, dementia, anxiety, depression, hypertension, Alzheimer's disease and cirrhosis. The 5 day Minimum Data Set assessment with an assessment reference date of 5/16/17 coded Resident #14 with severe cognitive impairment. He required extensive assistance with his activities of daily living.

The investigation did not include any specifics of the allegation. The actual allegation and date of the allegation were not identified in the investigation. The investigation did not include a description of the allegation being investigated. It

4. The Executive Director and DCS during morning clinical meeting to conduct quality monitoring of 24 hour report for allegation of abuse. ED will conduct interviews of residents and staff for allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown and misappropriation of resident property that require investigation and notification to State and Federal agencies. The quality monitoring will be conducted by ED weeklyx4, bi weekly x2, and then monthly x1. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

9/21/17

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did not include witness statements or interviews. The investigation did include email correspondence between the former Director of Nursing (DON) and a staff member at Adult Protective Services (APS). The dates of the emails were 5/15/17 and 5/17/17. The emails identified RN C and Resident #14. According to the emails, APS intended to investigate the issue. The APS email also instructed that RN C not provide care to Resident #14.

The facility did not conduct their own investigation of the allegation. It appears that they referred the allegation to APS for them to complete the investigation. The facility did not report the allegation to the state agency. It is unclear whether RN C was suspended once the facility became aware of the allegation.

There was a copy of a page of Resident #14's May 2017 Medication Administration Record (MAR) in the investigation. The medication on this MAR was as needed lorazepam (Ativan) and pain assessment documentation.

Resident #14 did have an order for Ativan dated 5/9/17 that read Lorazepam tablet 1 milligram tablet as needed for agitation three times per day.

At the end of day meeting on 8/16/17, it was reviewed with the Administrator and Director of Nursing (DON) that the facility referred an allegation to APS for investigation and did not perform their own internal investigation and did not report the incident to the state agency.

The facility policy titled "Resident Abuse" read "Once an allegation is reported, the Executive Director, as the abuse coordinator, is responsible

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F 225	Continued From page 5	F 225		

for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred." The policy also read "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse." With regards to reporting, the policy read "Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken."

No other information was received from the facility.

Complaint deficiency

2. For CNA A (Certified Nursing Assistant A), the facility staff failed to ensure a criminal background check was obtained within 30 days of hire and failed to verify certification and eligibility to work in Virginia prior to hire.

On 8/15/2017 at 2:20 PM, the facility

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Administrator informed the surveyor that the facility did not have a Human Resources Director for a couple of weeks from the end of June 2017 to the middle of July 2017. The Administrator stated one of the five employee records selected for review, CNA A (Certified Nursing Assistant A), did not have a copy of a criminal background check prior to hire. The Administrator stated he and other facility staff members had searched but were unable to find the complete new hire record which would include the criminal background check.

On 8/15/2017 at 2:25 PM, five employee records were reviewed. Review revealed that one employee (Certified Nursing Assistant A) CNA A did not have a papers in a folder as did the other four employees. There were several papers paper clipped together which included new hire payroll information, withholding forms, pay rate with shift differential and other forms. There was no copy of a criminal background check performed prior to hire. Further review of the papers presented by the Administrator revealed no documentation of Certification to work in Virginia. There was a copy of registration to work in South Dakota that would expire in September 2018. There was no documentation of checking with the registry prior to hire.

On 8/15/2017 at 3:00 PM, the Department of Health Professions (DHP) was contacted. The representative at DHP stated CNAs do not have multistate privileges and the applicant would need to be certified in Virginia. She stated applicants to Virginia should follow the instructions on the DHP website.

Review of the DHP website revealed the following

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instructions:
"Out-of-State CNAs

A current CNA who met similar requirements in another jurisdiction may be approved for certification by endorsement; if approved, no further examination will be required. The Board of Nursing will determine whether examination will be required.

Endorsement applicants may fil (sic) out their applications online or call (804) 367-4569 for materials."

On 8/15/2017 at 4:00 PM, an interview was conducted with the new Human Resources Director (Employee A) who stated she had been employed at the facility since 7/17/2017. Employee A stated CNA A was hired on 7/6/2017 and that the CNA A's employee file should have been complete with a criminal background check and verification of eligibility to work in Virginia. Employee A also stated CNA A was hired to work on weekends only on the 3-11 shift. The surveyor requested copies of the payroll since CNA A's hire date on 7/6/2017 and the schedule for August 2017.

Review of the Facility document, Resident Abuse Policies and Procedures, Effective 11/30/2014, Revision date 2/1/2017, revealed documentation the following under "Screening" section:
"Persons applying for employment the Company facility will be screened for a history of abuse, neglect, or mistreating residents to include:
Criminal Background check (VA specific; after hire, during orientation)
Abuse check with appropriate licensing board and

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F 225	Continued From page 8 registries, prior to hire. Sworn Disclosure Statement prior to hire. Verify license or registration prior to hire Any Additional State Specific Requirement will be compieted per regulation or statute." On 8/16/2017 at 9:20 AM, Employee A presented copies of the payroll for July and August 2017 and August 2017 schedule to the surveyor. Review of the two payroll periods of 7/19/2017 -8/16/2017 for CNA A revealed CNA A worked 7/20/2017, 7/24/2017, 7/29/2017, 7/30/2017, 8/3/2017, 8/7/2017, 8/12/2017 and 8/13/2017. Review of the August 2017 schedule revealed CNA A was scheduled to work 8/3/2017, 8/7/2017, 8/12/2017, 8/13/2017, 8/17/2017, 8/21/2017, 8/26/2017, 8/27/2017 and 8/31/2017. During the end of day debriefing on 8/16/2017 at 10:30 AM, the facility Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to	F 226		

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F 226	Continued From page 9 investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to implement the abuse prevention policy for 1 of 18 residents (Resident #14) and failed for one of five employees, Certified Nursing Assistant A (CNA A), hired on 7/6/2017 to implement and operationalize their Abuse policies and procedures for screening persons applying for employment for a history of abuse, neglect or mistreating residents. 1. For Resident #14, the facility failed to report and investigate an allegation involving the misappropriation of medication.	F 226	1. Resident #14 was assisted by center staff with a planned discharge back to the community on 5/19/2017. Director of Clinical Services (DCS) and Registered Nurse C are no longer employed with the center. Certified Nursing Assistant A as of 8/10/2017 is no longer employed with the center. 2. Unit Managers and Licensed Nursing Staff to conduct quality reviews of physician orders and reconcile with medicine in the medication cart. Human Resource Coordinator to conduct quality reviews of new hires in the past thirty (30) days for criminal background check and verification of eligibility to work in Virginia. Follow up based on findings.	9/21/17 9/21/17

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2. For CNA A (Certified Nursing Assistant A), the facility staff failed to obtain a criminal background check and failed to verify certification and eligibility to work in Virginia prior to hire.

The findings included:

1. For Resident #14, the facility failed to report and investigate an allegation involving the misappropriation of medication.

On 8/15/17, the Administrator and Director of Nursing (DON) were asked if they were aware of any drug diversions that had occurred in the facility, specifically in the month of May 2017. The DON stated that she had only been acting in the position since July 2017 and was not aware of a drug diversion. The Administrator stated that he had been at the facility since April 2017, but was not aware of a drug diversion.

On 8/15/17 at 3:25 p.m., an interview was conducted with Licensed Practical Nurse A (LPN A). LPN A was the staffing coordinator and had worked at the facility for many years. LPN A was asked if she was aware of any drug diversions that may have occurred in the facility. She stated yes, one incident had been investigated. When asked what the specific allegation included, LPN A stated that she could not remember. LPN A did know the name of the nurse involved, RN C. LPN A stated she had not been involved in completing the investigation. LPN A stated that the former DON had handled the investigation regarding RN C.

At the end of day meeting on 8/15/17, the Administrator and DON were notified that LPN A

3. Human Resource Coordinator (HRC), Nursing Administration (Unit Manager, MDS Coordinator) Executive Director and Licensed Nurses re-educated by DCS /designee on implementation of the abuse prevention policy.

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F 226	Continued From page 11 stated that there was a possible drug diversion investigated in May 2017. They were asked to provide the investigation. The investigation provided involved RN C and Resident #14. RN C was not available for interview. She worked on an as needed basis. She last worked at the facility on 6/3/17. Resident #14, a 58 year old, was admitted to the facility on 5/9/17. His diagnoses included aftercare for a left hip fracture, dementia, anxiety, depression, hypertension, Alzheimer's disease and cirrhosis. The 5 day Minimum Data Set assessment with an assessment reference date of 5/16/17 coded Resident #14 with severe cognitive impairment. He required extensive assistance with his activities of daily living. The investigation did not include any specifics of the allegation. The actual allegation and date of the allegation were not identified in the investigation. The investigation did not include a description of the allegation being investigated. It did not include witness statements or interviews. The investigation did include email correspondence between the former Director of Nursing (DON) and a staff member at Adult Protective Services (APS). The dates of the emails were 5/15/17 and 5/17/17. The emails identified RN C and Resident #14. According to the emails, APS intended to investigate the issue. The APS email also instructed that RN C not provide care to Resident #14. The facility did not conduct their own investigation of the allegation. It appears that they referred the allegation to APS for them to complete the investigation. The facility did not report the	F 226	4. Unit Managers/ ADCS or designee during Morning Clinical meeting to conduct quality monitoring of new physician orders daily 5 x week for 1 month, then weekly x 2 months then monthly. Quality monitoring schedule modified based on findings. The HRC to conduct quality monitoring for criminal background check and verification of eligibility to work in Virginia prior to new hire starting orientation. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings 9/21/17	

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allegation to the state agency. It is unclear whether RN C was suspended once the facility became aware of the allegation.

There was a copy of a page of Resident #14's May 2017 Medication Administration Record (MAR) in the investigation. The medication on this MAR was as needed lorazepam (Ativan) and pain assessment documentation.

Resident #14 did have an order for Ativan dated 5/9/17 that read Lorazepam tablet 1 milligram tablet as needed for agitation three times per day.

At the end of day meeting on 8/16/17, it was reviewed with the Administrator and DON that the facility referred an allegation to APS for investigation and did not perform their own internal investigation and did not report the incident to the state agency.

The facility policy titled "Resident Abuse" read "Once an allegation is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred." The policy also read "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse." With regards to reporting, the policy read "Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken."

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Complaint Deficiency
2. For CNA A (Certified Nursing Assistant A), the facility staff failed to obtain a criminal background check and failed to verify certification and eligibility to work in Virginia prior to hire.

On 8/15/2017 at 2:20 PM, the facility Administrator informed the surveyor that the facility did not have a Human Resources Director for a couple of weeks from the end of June 2017 to the middle of July 2017. The Administrator stated one of the five employee records selected for review, CNA A (Certified Nursing Assistant A), did not have a copy of a criminal background check prior to hire. The Administrator stated he and other facility staff members had searched but were unable to find the complete new hire record which would include the criminal background check.

On 8/15/2017 at 2:25 PM, five employee records were reviewed. Review revealed that one employee (Certified Nursing Assistant A) CNA A did not have papers in a folder as did the other four employees. There were several papers paper clipped together which included new hire payroll information, withholding forms, pay rate with shift differential and other forms. There was no copy of a criminal background check performed prior to hire. Further review of the papers presented by the Administrator revealed no documentation of Certification to work in Virginia. There was a copy of registration to work in South Dakota that would expire in September 2018. There was no documentation of checking with the registry prior to hire.

On 8/15/2017 at 3:00 PM, the Department of

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Health Professions (DHP) was contacted. The representative at DHP stated CNAs do not have multistate privileges and the applicant would need to be certified in Virginia. She stated applicants to Virginia should follow the instructions on the DHP website.

Review of the DHP website revealed the following instructions:
"Out-of-State CNAs

A current CNA who met similar requirements in another jurisdiction may be approved for certification by endorsement; if approved, no further examination will be required. The Board of Nursing will determine whether examination will be required.

Endorsement applicants may fil (sic) out their applications online or call (804) 367-4569 for materials."

On 8/15/2017 at 4:00 PM, an interview was conducted with the new Human Resources Director (Employee A) who stated she had been employed at the facility since 7/17/2017. Employee A stated CNA A was hired on 7/6/2017 and that the CNA A's employee file should have been complete with a criminal background check and verification of eligibility to work in Virginia. Employee A also stated CNA A was hired to work on weekends only on the 3-11 shift. The surveyor requested copies of the payroll since CNA A's hire date on 7/6/2017 and the schedule for August 2017.

Review of the Facility document, Resident Abuse Policies and Procedures, Effective 11/30/2014,

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Revision date 2/1/2017, revealed documentation the following under "Screening" section:
"Persons applying for employment the Company facility will be screened for a history of abuse, neglect, or mistreating residents to include:
Criminal Background check (VA specific; after hire, during orientation)
Abuse check with appropriate licensing board and registries, prior to hire.
Sworn Disclosure Statement prior to hire.
Verify license or registration prior to hire
Any Additional State Specific Requirement will be completed per regulation or statute."

On 8/16/2017 at 9:20 AM, Employee A presented copies of the payroll for July and August 2017 and August 2017 schedule to the surveyor.

Review of the two payroll periods of 7/19/2017 -8/16/2017 for CNA A revealed CNA A worked 7/20/2017, 7/24/2017, 7/29/2017, 7/30/2017, 8/3/2017, 8/7/2017, 8/12/2017 and 8/13/2017.

Review of the August 2017 schedule revealed CNA A was scheduled to work 8/3/2017, 8/7/2017, 8/12/2017, 8/13/2017, 8/17/2017, 8/21/2017, 8/26/2017, 8/27/2017 and 8/31/2017.

During the end of day debriefing on 8/16/2017 at 10:30 AM, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	

(a)(1) A facility must treat and care for each resident in a manner and in an environment that

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promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to provide a dignified living experience for two Residents (Resident #11, and #12) in a survey sample of 18 Residents.

1. RN (registered nurse) A administered all morning medications to Resident #11 in the communal activities room with 7 other Residents watching the administration.

2. For Resident #12 the facility staff allowed a used urinal container to remain on the over-bed table, and allowed him to sit in a wheelchair with a large urine stain on the front of his sweat pants.

The findings included:

1. Resident #11, was initially admitted to the facility 3-10-17. Diagnoses included falls dysphagia, Alzheimer's dementia, anemia, and heart disease.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-12-17 was coded as a quarterly assessment. The Resident was coded as having severe cognitive impairment. Resident #11 was coded as requiring set up or limited assistance of one staff member with the exception of toileting, and bathing, for which extensive assistance was required. Resident #11 was coded as being always incontinent of bowel, and frequently

1. Licensed Nurse RN A to be re educated on appropriate location for medication administration when resident # 1 and or other residents not in privacy of room. Resident # 12 continues to require extensive assistance with toileting by staff. The administration of medication to resident # 12 by licensed nurses does not include the resident's urinal on the over bed table. Resident # 12 continues to be self mobile in wheel chair throughout the center. Resident # 12 has been re-evaluated for a toileting plan. Nursing staff has been assisting resident # 12 with toileting needs as indicated .

9/2-1/17

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F 241	Continued From page 17 incontinent of bladder. Resident #11 was observed during medication pour and pass administration on 8-15-17 at 8:35 a.m. The Resident was sitting in a wheel chair, alert, and in the communal activities room with 7 other Residents. The communal activities room was located on the main facility hallway, and was lined with windows having a view into the hallway. The hallway was full of residents, staff, and visitors moving freely up and down the hallway. RN A approached her and stated to the Resident that she was going to give her the medications. No opportunity was given to allow the Resident to return to her room, or another secluded location to receive her medications out of the public view. The Resident was not asked if she wished to take her medications at that location, or at that time. RN A prepared the medications in the hallway, at the medication cart, then proceeded into the activity room and administered the medications with the other residents watching. At the end of medication pour and pass observations, RN A was interviewed, RN A stated that she had been nervous and "should not have given the medications there." "Fundamentals of Nursing, 7 th Edition, Potter-Perry, page 475," provides guidance, "A sense of dignity includes a person's positive self-regard, an ability to invest in and gain strength from one's own meaning in life, feeling valued by others, and how one is treated by caregivers. Nurses promote a client's self esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience...When caring for a client's bodily	F 241	2. Quality reviews of randomly selected licensed nursing staff medication administration to residents was completed to ensure resident's dignity is respected in regards to appropriate location and a clean over bed table. Quality reviews were conducted of resident's who move freely in the center for receiving appropriate toileting needs. 3. The licensed nursing staff re-educated by DCS/ADCS/ Unit Manager on maintaining resident's dignity during medication administration and monitoring residents for timely incontinence care. Nursing staff re-educated by DCS/ADCS/ Unit Manager on providing timely incontinence care and appropriate placement of resident's urinal and emptying urinals.	9/22/17 9/22/17

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F 241	Continued From page 18	F 241	4. ADCS/Unit managers to conduct random	9/21/17

functions, show patience and respect, especially after the client becomes dependent."

The administrator, DON (director of nursing) were informed of the failure of RN A to treat Resident #11 with dignity, at the end of day debrief on 8-15-17 at 4:00 p.m.

2. For Resident #12 the facility staff allowed a used urinal container to remain on the over-bed table, and allowed him to sit in a wheelchair with a large urine stain on the front of his sweat pants.

Resident #12, a 77 year old male, was admitted to the facility on 7/28/2014. His diagnoses included chronic kidney disease contractures, dementia, anemia, pituitary cancer, high cholesterol, depression, diabetes, hypertension, reflux, anemia, benign prostate hypertrophy, and congestive heart failure.

Resident #12's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/22/2017 was coded as a quarterly assessment. Resident 12 had a BIMS (Brief Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. He was totally dependent on the assistance of 1-2 persons for his activities of daily living and was coded as frequently incontinent of bowel and occasionally incontinent of bladder.

medication administration observation of licensed nurses for appropriate medication pass location and cleanliness of over bed table weekly x 4 then monthly. ADCS/Unit Managers/Designee to conduct quality reviews weekly x 4 for observation of residents clothing needing attention due to toileting need, then bi-weekly x 2, then monthly. Quality monitoring schedule to be modified based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

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Resident #12 was initially observed on 8/15/2017 at 8:00 AM during the medication pass review with RN (Registered Nurse) A. Resident #12 was lying in bed with an over-bed table across the bed and in front of the Resident. On the table was a water pitcher for drinking water and directly beside the drinking water was a urinal half filled with urine. The table had splashes of liquid on it which were still wet, and it was unknown if the liquid was urine or drinking water. The Resident was not able to pick up the pitcher or use the urinal without assistance.

At 9:00 AM at the conclusion of the medication pass, Resident #12's room was revisited with RN A, and the condition was found unchanged. RN A's attention was directed to the co-mingling of the drinking water and the urinal, and the wet spots on the table. She stated "that is not ok". She removed the urinal from the table, emptied it, and hung it on the bed railing. She then cleaned the table. RN A was asked how the urinal got placed on the over-bed table, and she stated that she did not know.

Resident #12 was again observed on 8/15/2017 at 11:30 AM. He was sitting in a wheelchair just inside the main entrance to the facility facing the entry door. He had on gray sweat pants with a large incontinence stain on the front. He was again observed on 8/15/2017 at 1:00 PM and it was unchanged. At 3:15 PM on 8/15/2017 he was in the same position with the wet pants. He was asked how he was feeling and did he know that he was wet. He stated that he knew. Employee C, Social Services Director, noticed the conversation and wheeled Resident #12 away stating "Let's get you cleaned up".

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F 241	Continued From page 20 On 8/15/2017 at 3:30 PM Administration A, Facility Administrator and Administration B, Director of Nursing were informed of both observations. They had no comment. Administration was informed of the findings on 8/16/2017 at 11:00 AM.	F 241		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and family	F 252	1. Resident # 10 and Resident # 9 continue to receive assistance from nursing staff to address toileting needs. 9/21/17 2. Quality review rounds have been conducted on James and Memory Care Units to determine, residents who require assistance with toileting needs by staff. Follow up based on findings. 9/21/17	

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F 252	Continued From page 21 interview, the facility failed to ensure a clean, homelike environment for 2 of 3 units (James and the Memory unit). Pervasive and sustained odors were evident on the James and the Memory Care units. The findings included: On 8/14/17 at 2:10 PM, during the facility tour, the James unit near the nurse's station, had a strong fecal odor. On 8/14/17 at 2:15 PM, Resident #10's room into the hallway had a strong urine odor. LPN (licensed practical nurse) B (unit manager) stated, "We just changed him." On 8/14/17 at 3:25 PM, the James unit continued to have a strong fecal odor. Resident #10's room also continued to have a strong urine/body odor that permeated into the hallway. The odors had not dissipated. On 8/14/2017 at 3:45 PM, an interview was conducted with a family member for Resident # 9 who resided on the Colonial Unit. The family member stated she had no concerns about the care of her family member but the facility "smells bad." She stated, "it will make people think their loved ones aren't being changed regularly or maybe urine is on the floor and not being cleaned up." She also stated the facility "didn't used to smell bad and they need to do something about this odor. It is terrible." The family member stated she had noticed the smell of urine a lot recently." She stated she often smelled a strong odor of urine in the halls on the James Unit as she walked to visit her family member on the Colonial	F 252	3. Licensed Nurses and CNA's re-educated by ADCS/Unit Managers/Designee regarding providing timely incontinence care to residents. 4. Unit Managers/ADCS or designee to conduct quality monitoring of residents for the absence of pervasive and sustained incontinent odors daily x 5 for 1 month, weekly x 4, then monthly. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	9/21/17 9/21/17

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F 252	Continued From page 22 Unit. She stated she could smell urine odor on the Colonial Unit too sometimes. On 8/15/17 at 8:40 AM, the strong odors on the James and Memory Care unit had disappeared. However, observation of Resident #12 revealed the resident sat in urine soaked pants at the entrance door of the facility for a prolonged period (See Tag 241). On 8/15/17 at 3:30 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 252		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure the professional standards of practice for medication and treatment administration were performed for two Residents (Resident's #11, and #7) in a survey sample of 18 Residents. 1. For Resident #11, the facility staff failed to administer 500 mg (milligrams) of Vitamin C during medication pour and pass observations. 2. For Resident #7, the facility staff failed to clarify	F 281	1. Resident # 11 has been receiving Vitamin C 500 mg administered by licensed nurses as ordered by physician. Resident # 7 physician order for use of a wheel chair arm support was clarified on 8/15/2017 and care plan updated. Wheelchair arm support in place per physician order.	9/21/17

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a physician's order for the use of a wheelchair arm support.

The findings included:

1. Resident #11, was initially admitted to the facility 3-10-17. Diagnoses included falls dysphagia, Alzheimer's dementia, anemia, and heart disease.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-12-17 was coded as a quarterly assessment. The Resident was coded as having severe cognitive impairment. Resident #11 was coded as requiring set up or limited assistance of one staff member with the exception of toileting, and bathing for which extensive assistance was required. Resident #11 was coded as always being incontinent of bowel, and frequently incontinent of bladder.

Resident #11 was observed during medication pour and pass administration on 8-15-17 at 8:35 a.m. The Resident was sitting in a wheel chair, alert, and in the communal activities room with 7 other Residents. RN A approached her and stated to the Resident that she was going to give her the medications. RN A prepared the medications in the hallway, at the medication cart, then proceeded into the activity room to administer the medications. Among those 7 medications which were administered, was the below physician's order:

Vitamin C tablet give 500 mg (milligrams) by mouth one time a day.

RN A opened a bulk dose bottle of 250 mg

F 281

2. Unit Managers have conducted quality reviews of residents with physician orders for Vitamin C via medication pass observation. Unit Managers/Designee has conducted quality reviews of physician orders for wheel chair adaptive equipment and visual observation of adaptive equipment for proper placement on wheel chairs and care plan reviews.

9/21/17

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F 281	Continued From page 24 Vitamin C tablets, and administered one tablet. The correct dosage should have been two tablets. At the end of medication pour and pass observations, RN A was interviewed, RN A stated that she had been nervous and "should have given 2 tablets." The facility Director of Nursing stated "Potter & Perry" as the facility references for nursing practice standards. Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." The administrator, and DON (director of nursing) were informed of the failure of RN A to administer the correct dosage of Vitamin C as ordered by the physician, at the end of day debrief on 8-15-17 at 4:00 p.m.	F 281	3. Licensed nursing staff re-educated by DCS/ADCS/Unit Managers on following physician orders for medication administration, adaptive wheel chair equipment and updating care plans. Unit Manager/Designee to conduct quality monitoring for following physician orders for medication administration as evidenced by medication pass observation and nurse adhering to six rights of medication administration weekly x 4, bi-weekly x2 then monthly. Unit 4. Manager/Rehab staff to conduct quality monitoring of physician orders and care plan updates for adaptive wheel chair equipment weekly x 4, bi-weekly x 2 then monthly.	9/21/17 9/21/17

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F 281	Continued From page 25	F 281	Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	9/21/17

2. For Resident #7, the facility staff failed to clarify a physician's order for the use of a wheelchair arm support.

Resident #7 was admitted to the facility on 11/8/2001 with the diagnoses of, but not limited to, CVA (cerebrovascular accident-stroke) with left sided hemiplegia, dementia, and contractures of left arm.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 7/21/17. The MDS coded Resident #7 with severe cognitive impairment; was dependent on staff for transfers, toileting, hygiene, and bathing; required extensive assistance from staff for dressing; and set up assistance for eating.

On 8/14/17 at 3:30 p.m. Resident #7 was observed sitting in a wheelchair inside her room doorway. She was alert and conversational. A padded arm rest support tray was observed positioned hanging down the right side of the wheelchair. Resident #7's left hand was contracted but able to be opened with staff assistance. The Rehab Manager (Employee-B) approached surveyor and resident and stated the

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orthotic specialist was here to fit her (for a leg brace). Employee-B was shown the arm rest support on the side of the wheelchair and not positioned under the resident's right arm.

On 8/14/17 at 3:35 p.m. Employee-B approached and stated Resident #7's right arm tray "Was repositioned and in place."

On 8/15/17 at 8:45 a.m. Resident #7 was observed in the wheelchair participating in a group reading and question activity; the right padded arm support tray was in place. Resident #7 was able to freely move her right arm. At 9:15 a.m. Resident #7's electronic clinical record was reviewed. The review revealed a physician's order with an "order start date" of 5/21/15 which read:

"Pt. to have left arm support with foam pad on wheelchair every shift for positioning of left upper ext. (extremity)."

The medication (MAR) and treatment (TAR) administration records for July and August 2017 were reviewed and revealed the physician's order transcribed as ordered above and the nurses on each of the three shifts initialed to document that the "left" arm support was in use.

On 8/15/17 at 11:15 a.m. Resident #7 was observed in her wheelchair in the activity area. The arm support tray was observed in position on the right side of the wheelchair.

On 8/15/17 at 1:25 p.m. an interview was conducted with Licensed Practical Nurse-B (LPN-B). LPN-B was shown the physician's order for the Left arm support and questioned why the

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support has been on and signed for the Right side. LPN-B had initialed on the TAR for the day shift on 8/14/17 that the left arm support was in place. LPN-B stated "i look and see that it's there." When asked who placed the arm support tray, LPN-B stated "She came over here that way." Resident #7 had been on another unit within the facility a couple of months prior. LPN-B stated she'd look in to it.

On 8/15/17 at 2:30 p.m. an interview was conducted with the Rehab Director (Employee-B) who presented an "Occupational Therapy Treatment Encounter Note" dated 3/18/16 which included:

"...therapist moved lap tray to R (right) to reduce L (left) lateral lean after analysis of pt posture and spinal alignment. Pt demo ability to tilt 1/2 lap tray away from her body and off to side of w/c (wheelchair)."

When asked why the therapist did not write the order to change the use of the tray support from left to right, Employee-B stated, "The nurses would write the order and update the care plan."

On 8/15/17 at 2:35 p.m. an interview was conducted with LPN-B. The rehab note was discussed and when asked what will be done with the order, LPN-B stated "I'll have my NP (Nurse Practitioner) correct the order."

Guidance given from "Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 (read): Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or

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F 281	Continued From page 28 harmful, further clarification from the health care provider is necessary. Page 584 (read): To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" On 8/15/17 at 3:40 p.m. the Administrator and Director of Nursing were informed of the findings. On 8/16/17 at 8:50 a.m., the Director of Nursing (Admin-B) stated their professional reference source was Lippincott and Potter and Perry. The facility staff presented a physician's order dated 8/15/17 at 3 p.m. which read "Pt. to have right arm support with foam pad on wheelchair."	F 281		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315	1. Resident # 12 is assisted with toileting needs as indicated.	9/21/17

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(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to accommodate the toileting needs for Resident #12.

1. The facility staff allowed Resident #12 to sit in a wheelchair for almost 4 hours with a large urine stain on the front of his sweatpants.

The findings included:

Resident #12, a 77 year old male, was admitted to the facility on 7/28/2014. His diagnoses included chronic kidney disease contractures,

2. Quality review of residents with toileting needs by staff has been conducted by unit manager. Follow up based on findings. 9/21/17
3. Nursing Staff re-educated by Unit Manger/designee on providing timely incontinence care and visible observation of resident clothing for toileting needs. 9/21/17
4. Unit manager/Designee to conduct quality monitoring of residents who needs assistance with toileting needs for absence of soiled clothing or incontinence odor weekly X 4, bi-weekly X 2 then monthly. Findings to be reported to QAPI committee monthly and updated as indicated. Quality Monitoring schedule modified based on findings. 9/21/17

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dementia, anemia, pituitary cancer, high cholesterol, depression, diabetes, hypertension, reflux, anemia, benign prostate hypertrophy, and congestive heart failure.

Resident #12's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/22/2017 was coded as a quarterly assessment. Resident 12 had a BIMS (Brief Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. He was totally deperident on the assistance of 1-2 persons for his activities of daily living and was coded as frequently incontinent of bowel and occasionally incontinent of bladder.

On 8/15/2017 at 2:30 PM a review of the clinical record was conducted. Resident #12's Care Plan stated "incontinence at times". Interventions included "Incontinent briefs when out of bed-check every 2 hours and prn (as needed)."

Resident #12 was observed on 8/15/2017 at 11:30 AM. He was sitting in a wheelchair just inside the main entrance to the facility, facing the entry door. He had on gray sweat pants with a large incontinence stain on the front. He was again observed on 8/15/2017 at 1:00 PM and it was unchanged. At 3:15 PM on 8/15/2017 he was in the same position with the wet pants. He was asked how he was feeling and did he know that he was wet. He stated that he knew. Employee C, Social Services Director, noticed the conversation and wheeled Resident #12 away stating "Let's get you cleaned up".

On 8/15/2017 at 3:30 PM Administration A, Facility Administrator and Administration B, Director of Nursing were informed of the situation.

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F 315	Continued From page 31 They had no comment. Administration was informed of the findings on 8/16/2017 at 11:00 AM.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329	1. Resident # 10 has been assessed by physician regarding the administration of Vistaril medication. Resident #10 receives medications as ordered and care planned for non pharmaceutical interventions. 9/21/17 2. Quality reviews of resident's physician orders for PRN medications administered without attempting non pharmacological interventions by the Unit Manager has been completed. Follow up based on findings. 9/21/17	

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(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation and clinical record review, the facility failed for one resident, Resident #10, in a survey sample of 18 residents, to ensure the resident was free from un- necessary medications.

Resident #10 was given prn (as needed) Vistaril without attempting non pharmacological interventions.

The findings included:

Resident #10, was admitted to the facility on 11/13/12. Diagnoses included Dementia, epilepsy and anxiety.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/24/17 was coded as a quarterly assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "3" out of a possible 15, or severe cognitive impairment. Resident #10 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility and transfer. There were no mood or behaviors during the seven day lookback.

On 8/14/17 at 3:25 PM, Resident #10 was observed in his room in the recliner chair. There

3. Licensed Nurses re-educated by ADCS/Unit Manager designee on prior to administration of PRN medication, nurse should attempt a non pharmacological intervention as permitted by resident and document in the medical record. 9/21/17
4. Quality review monitoring conducted by Unit Manager/Designee to review medication administration record for documentation of non pharmacological weekly x 4, bi-weekly x 2 then monthly. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 9/21/17

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was a very strong odor (urine/ body odor). The resident was watching TV.

Review of the May, 2017 MAR (medication administration record) revealed that Resident #10 received Vistaril 25 mg (milligrams) once daily on 5/25/17 through 5/28/17 (four doses). The physician ordered medication was for "Vistaril 25 mg give one capsule by mouth as needed for agitation may administer once daily as needed for agitation." There was no documentation of description of the behavior or non pharmacological interventions such as redirection, distraction or simply returning after the resident has calmed. Saunders Nursing Drug Handbook, 2011, page 578, describes Vistaril as a an antianxiety that in the elderly "may cause increased risk of dizziness, sedation, confusion. Hypotension (low blood pressure), hyperexcitability may occur."

Review of Resident #10's care plan dated 5/18/17 revealed the following behaviors: "BPSD (behavioral and psychotic signs and symptoms of dementia), confusion, and cognitive loss, hoarding, sexually inappropriate behavior, verbally and physically abusive, wandering, refuses showers, curses and threatens staff, striking out at staff, swinging at staff/residents. Interventions included: Assess behaviors for underlying medical causes, determine precipitating factors and alleviate, evaluate for elimination needs, evaluate hunger/thirst and assess for pain.

On 8/15/17 at 3:30 PM, the DON (director of nursing) stated, "We try and calm them down, for example a back rub, music, whatever works for the resident." She went on to state that the nurse

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F 329	Continued From page 34 should attempt these interventions prior to the administration of medication. On 8/16/17 at 10:00 AM, an interview with CNA (certified nursing assistant) B was conducted concerning Resident #10's behaviors. CNA (B) stated, "Most days is calm, can be combative." LPN (licensed practical nurse) B (unit manager) stated, "We redirect him, leave him alone and try to come back later." She also stated, "He can be combative , jumping at us. I usually chart when this happens." There was no charting on the days the Vistaril was given by this nurse. On 8/15/17 at 3:30 PM, the Administrator and DON were notified of above findings.	F 329		
F 386 SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and clinical record review, the facility staff failed to ensure recertification of doctor's orders for the	F 386	1. Resident # 11 has been seen by attending physician and current monthly physician orders signed. 9/21/17 2. Medical Records/Unit manager have conducted quality reviews of current residents medical record for signed monthly physician orders. 9/21/17	

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Resident's entire stay, for one resident (Resident #11) of the 18 residents in the survey sample.

For Resident #11, the physician failed to recertify the Resident's orders after admission from the 3-10-17 admission orders until the time of survey on 8-14-17 (5 months).

The findings included:

Resident #11, was initially admitted to the facility 3-10-17. Diagnoses included falls, dysphagia, Alzheimer's dementia, anemia, and heart disease.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-12-17 was coded as a quarterly assessment. The Resident was coded as having severe cognitive impairment. Resident #11 was coded as requiring set up or limited assistance of one staff member with the exception of toileting, and bathing; for which extensive assistance was required. Resident #11 was coded as being always incontinent of bowel, and frequently incontinent of bladder.

Review of the Resident's physician orders, and progress notes showed no review, recertification/recapitulation of orders from the time of admission.

On 8-16-17 at 9:00 a.m., the MDS Coordinator, and DON (director of nursing) were interviewed. They both stated that no recapitulation of physician's orders had occurred for Resident #11 since admission, and it was the facility policy to recert the orders according to federal standards.

3. Medical Record staff, Unit Manager, Physician and Nurse Practitioner re-educated by DCS on recertifying physician orders according to federal standards. 9/21/17
4. Medical Record staff to conduct quality monitoring for physician orders being signed by physician per regulation weekly x 4 then monthly. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 9/21/17

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The Administrator and Director of Nursing were informed of the findings on 8-16-17 at 11:00 a..m. No further information was provided by the facility staff.

F 431 483.45(b)(2)(3)(g)(h) DRUG RECORDS, SS=D LABEL/STORE DRUGS & BIOLOGICALS

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facllity must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary

F 386

F 431

1. Resident # 11 has been receiving physician ordered medications Aspirin 81 mg, Vitamin D 1000 U, B complex, Vitamin C 250 mg, Fish Oil 50 mg and Cyanocobalamin 50 mg from new opened dated bottles. The bottles with no open date have been discarded. 9/21/17
2. A quality review of facility's current medication carts and treatment carts conducted. Undated open medications were discarded by the licensed nurse. 9/21/17

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495190	A. BUILOING _____ B. WING _____	08/16/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
CONSULATE HEALTHCARE OF WILLtAMSBURG	1811 JAMESTOWN ROAD WILLtAMSBURG, VA 23185

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 37	F 431		

instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview, facility staff failed to ensure that drugs and biological's were properly stored in one of four medication carts, and that one Resident (Resident #11) did not receive potentially expired medications, of the 18 residents in the resident sample.

Facility staff failed to discard open and available, potentially expired drugs during medication pour and pass observations, and administered them to Resident #11.

Findings included:

Resident #11, was initially admitted to the facility 3-10-17. Diagnoses included; falls dysphagia, Alzheimer dementia, anemia, and heart disease.

3. Licensed Nurses re-educated by DCS/ADCS and Unit Managers to date over the counter medications (OTCs)bulk container when opened. 9/21/17
4. Unit Manager/Designee to conduct quality monitoring of medication bottles/vials for dating when opening weekly x 4, bi-weekly x 2 then monthly. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 9/21/17

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	495190	A. BUILOING _____ B. WING _____	08/16/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS. CITY. STATE. ZIP COOE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 38	F 431		

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6-12-17 was coded as a quarterly assessment. The Resident was coded as having severe cognitive impairment. Resident #11 was coded as requiring set up or limited assistance of one staff member with the exception of toileting, and bathing, for which extensive assistance was required. Resident #11 was coded as always being always incontinent of bowel, and frequently incontinent of bladder.

For Resident #11, on 8-16-17 beginning at 8:35 a.m., medication pour and pass observations were conducted with RN A. During the observations it was noted that RN A was preparing and administering medications to Resident #11 that were from bulk dose containers which had no date marked on the bottles. It was unknown as to when the medications had been unsealed and opened for use, and so no known expiration date could be predicted.

Pharmacy, nursing, and manufacturing standards of practice dictate that opened medications, which had been previously sealed by the manufacturer, have an expiration date of a shortened time frame once opened. This means that the expiration date printed on the bottle/container, when sealed by the manufacturer, is only a valid shelf life date for unopened and unsealed medications. Once the medication is unsealed the shelf life no longer applies, and the expiration date is then based upon the type or form of medication administered. The basic rule for pill form medications that do not have specific and shorter requirements (such as antibiotics), is one year from opening/unsealing. At this time the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(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 431	Continued From page 39	F 431		

efficacy (potency) is in question, and the medication should be discarded, and replaced.

RN A was also observed opening new unsealed medications during medication pour and pass, and administering them. As she opened each unopened bottle, she documented the open date on each, however, she continued to administer medications from the undated bottles as well.

Resident #11 was observed during medication pour and pass observations, receiving the following 6 medications with no open date/expiration date known, and so could have been expired.

1. Aspirin 81 mg (milligrams).
2. Vitamin D 1000 iu (internationalized units)
3. B Complex
4. Vitamin C 250 mg.
5. Fish oil 500 mg.
6. Cyanocobalamine 500 mcg (micrograms)

RN A was asked what the facility policy was on such items, at the end of the observations, and she stated they should all be discarded, and if a bottle was opened, the open date should be written on the bottle immediately.

The Administrator and DON (director of nursing) were informed of the above findings during the end of day debrief on 8-15-17 at approximately 4:00 p.m. No further information was provided by the facility.

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Brook Pittinger
Acting EXECUTIVE DIRECTOR

Brian M. McGraw
State Fire Marshal

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Tidewater Region
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Director
Office of Licensure/Certification
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Consulate Healthcare Of Williamsburg
1811 Jamestown Road
Williamsburg, VA 23185
File Number: **T-0360-001**
CMS Certification Number: **495190**
Event ID Number: **I8BL21**

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

[ ] Recommend certification based on compliance with Life Safety Code.
[X] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

Ronald C Reynolds - JJC

Ronald C. Reynolds
Deputy State Fire Marshal

Survey Date: 08/29/2017 **SOD Sent:** 09/01/2017 **POC Rec'd:** 09/08/2017 **POC to HQ:**09/08//2017
Highest Scope/Severity: E