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 _____	C 07/26/2018

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 7-24-18 through 7-26-18. Four complaints were investigated during the survey. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 90 bed facility was 88 at the time of the survey. The survey sample consisted of 2 current resident reviews (Residents #4, and #5) and 3 closed record reviews (Residents #1 through #3).	F 000	F 000 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582	1. Residents #1 and #3 no longer reside in the facility. On 7/26/18, the Executive Director suspended facility Social Worker pending investigation in the matter related to the allegation of "falsified the signature on those documents" and allegation of "falsified the signature of the Power of Attorney on those documents" on Notice of Medicare Non-Coverage (NOMNC) forms. 2. Executive Director/Designee completed a Quality Review on 7/27/18 of NOMNC forms of the past 90 days. No further discrepancies related to resident/responsible party signatures were noted.	

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

Administrator 8/14/18

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 582	Continued From page 1 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. 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 ensure Advanced Beneficiary notices were provided prior to loss of benefits, for 2 residents (Resident #3, and #1), in a survey sample of 5 residents. 1. The facility staff failed to provide Resident #3	F 582	3. On 7/31/18, facility executive director reinstated facility Social Worker to duties after re-education with Social Worker and the Assistant to the Social Worker to include policy and procedures related to proper completion of the NOMNC form, procedure for receiving telephone consent and Code of Conduct/Ethics. 4. Executive Director/Designee to conduct Quality Improvement Monitoring of NOMNC letters to ensure completion per professional standard completed 5x/week x 8 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Findings to be reported at monthly QAPI Committee Meeting. Quality monitoring schedule modified as needed based on findings. 5. Alleged date of compliance: August 28, 2018	

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F 582	Continued From page 2 with written notification prior to loss of benefits, and falsified the signature of the Power of Attorney on those documents. 2. For Resident #1 facility failed to provide a written Notice of Medicare Non-Coverage letter to Resident #1 prior to discharge from facility, and falsified the signature on those documents. The Findings included: 1. The facility staff failed to provide Resident #3 with written notification prior to loss of benefits, and falsified the signature of the Power of Attorney on those documents. Resident #3 was originally admitted to the facility on 5-17-18 and was hospitalized on 6-4-18, and readmitted after hospitalization on 6-7-18. The Resident's diagnoses included; Femur fracture, Parkinson's dementia, Diabetes, schizophrenia, and anemia. Resident #3 expired in the facility on 6-12-18. A closed record review was conducted. The most recent Minimum Data Set (MDS) was a discharge assessment with an Assessment Reference Date (ARD) of 6-4-18. The MDS coded Resident #3 with severe cognitive impairment, impaired range of motion, requiring extensive assistance or total dependence on staff for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18, and 7-25-18 Resident #3's clinical record, admissions record, hospital record, and discharge record were reviewed. The review revealed a "Notice of Medicare Non-Coverage" (NOMNC) documented and allegedly signed on 5-29-18 by Resident #3's Power of Attorney	F 582		

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F 582	Continued From page 3 (POA). During a complaint investigation it was found that the POA had not been notified of medicare refusal to pay for skilled nursing treatment services (NOMNC) and was not in the building on 5-29-18. Review of the NOMNC document revealed that the document appeared to have been signed by the individual filling out the form. Copies of the document, and copies of original admission documents with the POA's signature, were provided by the facility and reviewed. On 7-26-18 at 11:00 a.m., The Social worker (Admin E) was interviewed with the Administrator and Director of Nursing (DON) present. She stated she had filled out the form. When asked if she signed the form with the POA's signature, she did not deny signing the document, however, just continued saying "I spoke with her." When she was told that the POA was not in the building that day, she stated "but I spoke with her, I can't produce any evidence that we met." Nursing notes were reviewed, and revealed that Admin E documented on 5-29-18 "NOMNC signed today, family does not want to appeal." The Administrator and DON were notified of the findings, and reviewed the forms. No further information was provided. 2. For Resident #1 facility failed to provide a written Notice of Medicare Non-Coverage letter to Resident #1 prior to discharge from facility, and	F 582		

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F 582	Continued From page 4 falsified the signature on those documents. Resident #1, a 66-yr. old male was admitted to the facility on 03/30/2018 with diagnoses including but not limited to Intracerebral Hemorrhage (stroke), History of falls, Seizure, neuropathy and diabetes. Resident #1's most recent Minimum Data Set (MDS- an assessment protocol) was coded as a discharge assessment with an Assessment Reference Date (ARD) of 4/12/18. Resident #1 was coded as having a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment. The spouse filed a complaint with OLC that alleges that Resident called her on 4/11/2018 and stated that the facility said she had until 4/12/2018 at 12:30 pm to pick him up or he was being kicked out. On 7/26/18 at approximately 3:00 PM, an interview was conducted with the Social Worker, Administrator, DON and Corporate RN. The facility was made aware of the allegation. The facility then provided the document Notice of Medicare Non-Coverage allegedly signed by the POA (Resident #1's spouse). Upon closer inspection it was discovered that the signature appeared to not match the complainants signature and the last name was misspelled on the Notice of Medicare Non-Coverage. Social Worker stated, "Well I met with her" and "I didn't sign it myself if that's what you think"	F 582		

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F 582	Continued From page 5 Administration was aware as they were present in the meeting. No further information was provided.	F 582		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow professional practice standards for medication administration, and falsifying records for four residents (Residents #3, 5, 1, and #4) of 5 residents in the survey sample. 1. For Resident #3, (a) the facility staff failed to administer physician ordered medications, and (b) falsified a loss of Medicare insurance notice. 2. For Resident #5, the facility staff failed to administer physician ordered medications. 3. For Resident # 4 the facility staff failed to ensure medications were administered as ordered by the physician. 4. For Resident #1 the facility falsified clinical records. The findings included:	F 658		

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F 658	Continued From page 6 1a. For Resident #3, the facility staff failed to administer physician ordered medications. Resident #3 was originally admitted to the facility on 5-17-18 and was hospitalized on 6-4-18, and readmitted after hospitalization on 6-7-18. The Resident's diagnoses included; Femur fracture, Parkinson's dementia, Diabetes, schizophrenia, and anemia. Resident #3 expired in the facility on 6-12-18. A closed record review was conducted. The most recent Minimum Data Set (MDS) was a discharge assessment with an Assessment Reference Date (ARD) of 6-4-18. The MDS coded Resident #3 with severe cognitive impairment, impaired range of motion, requiring extensive assistance or total dependence on staff for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18, and 7-25-18 Resident #3's clinical record, admissions record, hospital record, and discharge record were reviewed. The review revealed physician orders which included the following medications to be administered: "Novolog solution 100 units/milliliter (insulin Aspart) short acting insulin, inject 15 units subcutaneously before meals 3 times a day." (to be given at 6:30 a.m., 11:30 a.m., and at 4:30 p.m.) for Diabetes. The order was given on 5-18-18, and discontinued on 5-19-18, for an unknown reason. "Lantus solution 100 units/milliliter (insulin glargine) long acting insulin, inject 30 units subcutaneously 2 times a day." (to be given at 9:00 a.m., and 5:00 p.m.) for Diabetes. The order was given on 5-18-18.	F 658	F658: Services Provided meet professional standards 1A. Residents # 3, #4, #5 no longer reside in facility. RN is no longer employed by the facility. 1B. Residents #1, #2, #3 no longer reside in the facility. 2A. DON/Designee completed a Quality Review of current facility residents for Medication Administration/documentation of administration to meet professional standards. Follow up based on findings. 2B. Administrator/Designee completed a Quality Review of residents who have received non-coverage notifications related to completion of Medicare A benefits for the last 90 days for completion per professional standard. Follow up based on findings.	

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F 658	Continued From page 7 "Med Pass 60 milliliters twice per day supplement, (to be given at 9:00 a.m., and 5:00 p.m.). The order was given on 5-23-18. The 3 medications above were listed on the May and June 2018 Medication Administration Record (MAR) as ordered. The MAR document revealed the following; On 1 out of 3 occasions the Novolog Insulin MAR listed that the Resident refused the medication, however, only at the 4:30 p.m. dose, and only by one specific nurse for the only occasion that the nurse worked. The other nurses listed the medication as administered the other 2 times, then it was discontinued for an unknown reason. On 13 out of 17 occasions the Lantus Insulin MAR listed that the Resident refused the medication, however, only at the 5:00 p.m. dose, and only by one specific nurse for all 13 occasions that the nurse worked. All other nurses listed the medication as administered both times per day. On 8 out of 12 occasions the Med Pass supplement MAR listed that the Resident refused the medication, however, only at the 5:00 p.m. dose, and only by the same specific nurse for all 8 occasions that the nurse worked. All other nurses listed the medication as administered both times per day. Only three finger stick blood sugar checks (FSBS) were documented as having been completed during the Resident's 24 day stay. The FSBS were documented as completed in the nursing notes on 6-1-18, 6-2-18, and 6-3-18. The	F 658	3A. Director of Nursing/Designee provided Licensed Nurses Re-education regarding medication administration/documentation per professional standards. 3B. Social Worker/Social Services Assistant provided re-education by Executive Director regarding completion of NOMNC form per professional standard and procedure for receiving Telephone Consent. Executive Director provided re-education to facility staff regarding Ethics/Code of Conduct. 4. Director of Nursing/Designee to conduct Quality Improvement Monitoring of Medication Administration per physicians orders/documentation per professional standard 5x/ week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Executive Director/Designee to conduct Quality Improvement Monitoring of NOMNC letters to ensure completion per professional standard completed 5x/week x 8 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Findings to be reported at monthly QAPI Committee Meeting. Quality monitoring schedule modified as needed based on findings.	

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F 658	Continued From page 8 same number was recorded for all 3, which was 126, and by the same nurse who omitted the above medications. Physician progress notes, and nursing progress notes were reviewed and revealed no documentation that the Resident ever refused medications, and neither was there any evidence that the family or physician was notified of the medication omissions. All progress notes indicate that the Resident consumed medications without difficulty, no refusals are noted in progress notes, and to the contrary, nursing stated "Meds taken whole with no complications", "accepted", "effective", in all of the notes. The nurse who omitted these medications was contacted via phone, however, was unable to be reached for interview. Review of the care plan (dated 5-18-18 upon admission), revealed interventions for the Focus of "(Resident name) is at risk for metabolic complications related to diabetes, hypothyroid, high cholesterol." Those interventions were never changed, and were the following 8 items; 1. Monitor for signs and symptoms of hypo/hyper glycemia including changes in level of consciousness, sleepiness, fatigue/weakness, diaphoresis, gait disturbance, fruity breath, blurred vision, headache. 2. Medications as ordered. 3. Provide diet as ordered. 4. Notify MD (doctor) as indicated. 5. Encourage compliance with diet and medications.	F 658	5. Allegation of Compliance: August 28, 2018	

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F 658	Continued From page 9 6. Monitor skin for impairment or changes. 7. Monitor labs as ordered. 8. Blood glucose levels as ordered. No blood glucose monitoring was ever ordered, even after her short acting insulin was discontinued. Insulin was omitted, and there is no indication that the doctor and family were ever notified, nor that orders, or care plan interventions were ever attempted to be changed. 16 days after admission, on 6-4-18, the Resident was sent to the hospital at 6:00 a.m., with "Vomiting coffee ground emesis" according to nursing notes. Review of Hospital records revealed the Resident was admitted with a "blood sugar greater than 900", Diabetic Keto-acidosis, (DKA) and sepsis (blood infection) due to pneumonia." The hospital records state no bloody or coffee ground emesis was seen by them. The Resident's laboratory report from 6-4-18 in the emergency room revealed a white blood cell count of 34.8 (normal is 4.0 to 11.0) revealing a serious infection. The hospital discharge record went on to document that the Resident was immediately placed on an insulin drip in the emergency room, by intravenous (IV) method, fluid resuscitation (IV fluids) method, and (IV) antibiotics were started. The hospital document goes on to mention a note of importance, that the medication list from the facility, (that she was admitted to the hospital with), had no anticoagulant (blood thinning medication) used after surgery for fractures, or insulin coverage on it. The hospital discharge record stated that the DKA	F 658		

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F 658	Continued From page 10 was reversed with the insulin drip, and the sepsis pneumonia was managed with the antibiotics, however, the Resident's mental state did not improve, and the Resident developed acute heart failure while hospitalized as a result of the incident. At the time of discharge the Resident was not alert, and had no purposeful movement, and hospice services were discussed with the family. Discharge medications included both insulin's to be given upon return to the facility on 6-7-18. The Resident still had the staples in her thigh from her femur fracture surgery 3 weeks prior, and the hospital recommended they be removed. All medications were discontinued upon readmission to the facility, on 6-7-18 from the hospitalization. The Resident returned on Hospice comfort care medications only (Atropine, haldol, and morphine) and hospice based services, with no expectation of recovery. On 6-12-18 the Resident expired in the facility. On 7-25-18 the Director of Nursing, and Administrator were made aware of the findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and had begun a plan of correction on 7-13-18 for it, however, it had not been completed as of the time of survey. The DON gave "Lippincott" as their nursing practice standard. Guidance given from Lippincott, Fundamentals of Nursing, 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	F 658		

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F 658	Continued From page 11	F 658		

erroneous or harmful, further clarification from the health care provider is necessary. 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

Facility policy for "Medication Administration" included:
Administer drugs and ....Chart on MAR according to policy. Chart on nurses's notes: Pertinent observations immediately after administration."

1b. For Resident #3, the facility staff falsified a loss of Medicare insurance notice.

On 7-24-18, and 7-25-18 Resident #3's clinical record, admissions record, hospital record, and discharge record were reviewed. The review revealed a "Notice of Medicare Non-Coverage" (NOMNC) documented and allegedly signed on 5-29-18 by Resident #3's Power of Attorney (POA).

During a complaint investigation it was found that the POA had not been notified of medicare refusal to pay for skilled nursing treatment services (NOMNC) and was not in the building on 5-29-18. Review of the NOMNC document revealed that the document appeared to have been signed by the individual filling out the form.

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F 658	Continued From page 12 Copies of the document, and copies of original admission documents with the POA's signature, were provided by the facility and reviewed. On 7-26-18 at 11:00 a.m., The Social worker (Admin E) was interviewed with the Administrator and Director of Nursing (DON) present. She stated she had filled out the form. When asked if she signed the form with the POA's signature, she did not deny signing the document, however, just continued saying "I spoke with her." When she was told that the POA was not in the building that day, she stated "but I spoke with her, I can't produce any evidence that we met." Nursing notes were reviewed, and revealed that Admin E documented on 5-29-18 "NOMNC signed today, family does not want to appeal." The facility staff did not present any further information after 7-25-18. 2. For Resident #5, the facility staff failed to administer physician ordered significant medications. Resident #5 was originally admitted to the facility on 7-12-18. The Resident's diagnoses included; Sepsis from urinary tract infection, dysphagia, stroke, hypothyroidism, hypertension, heart disease, diabetes, polyneuropathy, and anxiety. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 7-19-18. The MDS coded Resident #5 with no cognitive impairment, no impaired range of motion, however, requiring limited to extensive assistance on one staff	F 658		

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F 658	Continued From page 13 member for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18 the Resident was interviewed, and when asked if she received her medications as ordered by her doctor she stated "most of the time, but sometimes they don't have them." On 7-24-18, and 7-25-18 Resident #5's clinical record, was reviewed. The review revealed physician orders, and "Medication Administration Records" (MARs) which included the following orders to be administered and documented as such: "Insulin Glargine solution inject 10 units subcutaneously at bedtime (9:00 p.m.)." Ordered to begin on 7-13-18. The insuiin was omitted on 7-14-18, 7-21-18, 7-22-18, and 7-23-18, (4 times in 11 days). "Cyclosporin Emulsion antibiotic eye drops "Instill one drop in both eyes every 12 hours (9:00 a.m., and 9:00 p.m.)". Ordered to begin 7-12-18. The eye drops were omitted on 7-12-18 at 9:00 a.m., 7-13-18 for both times, 7-15-18 at 9:00 p.m., and 7-23-18 at 9:00 p.m, (5 times in 11 days). "Levothyroxine sodium 200 micrograms, give 1 tablet by mouth in the morning (6:00 a.m.) Ordered to begin 7-13-18. The Synthroid was omitted on 7-13, 7-23-18, and 7-24-18. (3 times in 12 days). Nursing notes on these days of omissions of drugs, do at times describe "medications unavailable, or, awaiting pharmacy, however, they do not state which drugs are unavailable.	F 658		

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F 658	Continued From page 14 The Resident's care plan was reviewed and stated "Administer medications as ordered. On 7-25-18 the Director of Nursing, and Administrator were made aware of the findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and had begun a "4 point" plan of correction on 7-13-18 for it, however, it had not been completed as of the time of survey. It is notable to mention that with this Resident, the omissions continued during survey. The failure of staff to recognize and intervene timely to make sure significant medications were available to Residents was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7-26-18. No further information was provided. 3. For Resident # 4 the facility staff failed to ensure medications were administered as ordered by the physician. Resident # 4 a 73 year old female admitted to the facility on 7/10/2018 with diagnoses including but not limited to ruptured tendon right lower leg, Orthopedic surgical aftercare, hemarthrosis, right knee pain, Atrial fib (irregular heart rhythm) In an interview with Resident #4 on 7/24/18 Resident #4 stated "There was a day that was really the worst pain I have had and it was because they ran out of my pain medicine. I had to go to therapy and the appointment with the doctor without anything for pain and it was	F 658		

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F 658	Continued From page 15 horrible." On 7/24/18 @ 1:00 PM a review of clinical records revealed that Resident #4 was not given ordered PRN Hydrocodone (narcotic pain medication) for 24 hrs. beginning on 7/17/2018 - 7/18/2018. On 7/25/2018 at 11:17 AM an interview with the DON was conducted and the DON stated that it is expected practice for the nurses to take the following action when out of a medication for patients: First call the pharmacy and get the medication re-ordered and get a code to use for the stat box, and let the MD know, also let the DON know if we are having trouble getting the medication or the hard script. Nurse's notes on 7/17/2018 at 10:21 AM stated Resident #4 was out of narcotic pain medicine and needed a new script On 7/17/2018 at 11:59 PM Resident #4 attended Physical Therapy with a pain level of 9-10 out on a pain scale of 10 this is documented on Physical Therapy notes submitted by Employee A. On 7/17/2018 at 3:58 PM the nurses notes state that "Resident c/o [complained of] pain to right lower extremity r/t/ [related to] right knee surgical repair. Resident did not have any Norco [Hydrocodone] to give and a hard script was needed. NP [nurse practitioner] was here and made aware of needing script and script was faxed over to pharmacy. Tylenol given at the time to help with pain which is 6/10 to right knee before leaving for f/u [follow up] appt. [orthopedic	F 658		

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F 658	Continued From page 16 specialist]" On 7/26/2018 at 2:30 PM administration was made aware. No further information was provided. 4. For Resident #1 the facility falsified clinical records. Resident #1, a 66-yr. old male was admitted to the facility on 03/30/2018 with diagnoses including but not limited to Intracerebral Hemorrhage (stroke), History of falls, Seizure, neuropathy and diabetes. Resident #1's most recent Minimum Data Set (MDS- an assessment protocol) was coded as a discharge assessment with an Assessment Reference Date (ARD) of 4/12/18. Resident #1 was coded as having a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment. Spouse/ POA [Power of Attorney] filed a complaint with OLC that alleges that Resident called her on 4/11/2018 and stated that the facility said she had until 4/12/2018 at 12:30 pm to pick him up or he was being kicked out. On 7/26/18 at approximately 3:00 PM an interview was conducted with the Social Worker, Administrator, DON and Corporate RN, facility was made aware of the allegation. The facility then provided the document Notice of Medicare Non-Coverage signed by the POA (Resident #1's spouse). Upon closer inspection it was discovered that the	F 658		

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F 658	Continued From page 17 signature appeared to not match the complainants signature and the last name of the complainant was misspelled on the document. Social Worker stated, "Well I met with her" and "I didn't sign it myself if that's what you think" Administration was aware as they were present in the meeting. No further information was provided.	F 658	F692: Nutrition/Hydration Status 1A. Resident #3 no longer resides in the facility. Nurse no longer employed by facility 1B. Resident #3 no longer resides in the facility 2A. DON/Designee completed a Quality Review of current facility residents with physician ordered supplements to prevent/intervene significant weight loss for administration as ordered. Follow-up based on findings. 3. Don/Designee provided re-education for Licensed Nurses regarding administration of Supplements as ordered by physician to prevent/intervene significant weight loss. 4A. DON/Designee to conduct Quality Improvement Monitoring of residents with physician ordered supplements for administration as ordered to prevent/intervene significant weight loss 5x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of Compliance: August 28, 2018	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation	F 692		

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F 692	Continued From page 18	F 692		

review and clinical record review the facility staff failed to provide a physician ordered nutritional supplement, and to prevent significant weight loss for one resident (Resident #3) of 5 residents in the survey sample.

For Resident #3 the facility staff did not provide supplements as ordered, and failed to intervene during a significant weight loss.

The findings included:

Resident #3 was originally admitted to the facility on 5-17-18 and was hospitalized on 6-4-18, and readmitted after hospitalization on 6-7-18. The Resident's diagnoses included; Femur fracture, Parkinson's dementia, Diabetes, schizophrenia, and anemia. Resident #3 expired in the facility on 6-12-18. A closed record review was conducted.

The most recent Minimum Data Set (MDS) was a discharge assessment with an Assessment Reference Date (ARD) of 6-4-18. The MDS coded Resident #3 with severe cognitive impairment, impaired range of motion, requiring extensive assistance or total dependence on staff for transfers, walking, dressing, bathing, toilet use and personal hygiene.

The Resident's weight sheet was requested and reviewed. It revealed the following weights.
5-17-18 upon admit - 190.0 pounds (lbs)
5-23-18 - 182.8
5-25-18 - 177.4
5-28-18 - 170.0
5-29-18 - 170.9
5-30-18 - 163.6 which was later in the day changed to 173.1
6-1-18 - 175.0

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F 692	Continued From page 19 6-4-18 - 159.28 in the hospital On 6-4-18 the Resident was transferred to the hospital for evaluation. The Hospital records show a weight on that day of 159.28 lbs. This reveals a 31 lb. weight loss in the facility from admission on 5-17-18, until hospitalization on 6-4-18 (18 days). This was a significant weight loss of 16.32% of the Resident's weight in two and a half weeks. On 7-24-18, and 7-25-18 Resident #3's clinical record, admissions record, hospital record, and discharge record were reviewed. The review revealed physician orders which included the following schedule for weights to be obtained, and nutritional supplement to be administered: Weights - "Notify MD/NP (doctor or nurse practitioner) of weight every day shift every Monday Wednesday, Friday." Ordered by the physician on 5-22-18 for Lymphedema. It is notable to mention, that the Resident was not prescribed a diuretic, and the lymphedema was expected due to the leg fracture and surgical remedy. "Med Pass 60 milliliters twice per day supplement, (to be given at 9:00 a.m., and 5:00 p.m.). The order was issued by the physician on 5-23-18, as a supplement for wound healing because of the Residents fractured leg and surgery to repair it, according to the care plan "Administer supplements for wound healing". No new orders were issued after a 7 pound (lb) weight loss in the first week for this Resident. This was the only addition to the Resident's orders, and it was not directed for the significant	F 692		

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F 692	Continued From page 20 weight loss. The supplement above was listed on the May and June 2018 Medication Administration Record (MAR) as ordered. The MAR document revealed the following; On 8 out of 12 occasions the Med Pass supplement MAR listed that the Resident refused the medication, however, only at the 5:00 p.m. dose, and only by a specific nurse for all 8 occasions that the nurse worked. All other nurses listed the medication as administered both times per day. Physician progress notes, and nursing progress notes were reviewed and revealed no documentation that the Resident ever refused medications, and neither was there any evidence that the family or physician was notified of the medication supplement omissions. No documentation existed that the nurse who omitted the supplement tried any other intervention to administer the supplement, as, to return later to the Resident, or have another staff member administer the supplement. All progress notes indicate that the Resident consumed medications without difficulty, no refusals are noted in progress notes, and to the contrary, nursing stated "Meds taken whole with no complications", "accepted", "effective", in all of the notes. The nurse who omitted the supplement medication was contacted via phone, however, was unable to be reached for interview. Review of the nutrition care plan (dated 5-22-18),	F 692		

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F 692	Continued From page 21 revealed interventions for the Focus of "(Resident name) has potential for imbalanced nutrition related to left femoral neck fracture, past medical history including; dementia, schizophrenia, diabetes, Parkinson's disease, hypothyroid, hypertension, iron deficiency anemia, lymphedema." Those interventions were never changed, and were the following 6 items; 1. Assist with meals as needed. 2. Explain and reinforce to the Resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. (No refusals were documented) 3. Monitor intake - record meal percentage. 4. Provide diet as ordered. 5. RD (registered dietician) to evaluate and make diet change recommendations PRN (as needed). The only evaluation occurred on initial admission to the facility, and then not again until the Resident returned from the hospital on 6-7-18 and was on hospice services. The 6-7-18 evaluation still states the Resident weight as 175, when hospital discharge records on 6-7-18, record the discharge weight as 167.8 lbs. 6. Weight per policy. (This intervention was never revised in the care plan, even when the weight order was changed to 3 times per week.) No blood glucose monitoring was ever ordered, for the Resident's diagnosis of diabetes, and insulin administration, even after her short acting insulin was discontinued. Insulin was omitted, and there is no indication that the doctor and family were ever notified, nor that orders, or care plan interventions were ever attempted to be changed.	F 692		

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F 692	Continued From page 22 16 days after admission, on 6-4-18, the Resident was sent to the hospital at 6:00 a.m., with "Vomiting coffee ground emesis" according to nursing notes. Review of Hospital records revealed the Resident was admitted with a "blood sugar of "Greater than 900", Diabetic Keto-acidosis, (DKA) and sepsis (blood infection) due to pneumonia." The hospital records state no bloody or coffee ground emesis was seen by them. The Resident's laboratory report from 6-4-18 in the emergency room revealed a white blood cell count of 34.8 (normal is 4.0 to 11.0) revealing a serious infection. The hospital discharge record went on to document that the Resident was immediately placed on an insulin drip in the emergency room, by intravenous (IV) method for the DKA, fluid resuscitation (IV fluids) method for dehydration, and (IV) antibiotics for pneumonia were started. The hospital document goes on to mention a note of importance, that the medication list from the facility, (that she was admitted to the hospital with), had no anticoagulant (blood thinning medication) used after surgery for fractures, or insulin coverage on it. The hospital discharge record stated that the DKA was reversed with the insulin drip, and the sepsis pneumonia was managed with the antibiotics, however, the Resident's mental state did not improve, and the Resident developed acute heart failure while hospitalized. At the time of discharge the Resident was not alert, and had no purposeful movement, could not eat, and hospice services were discussed with the family. Discharge medications included both insulin's to be given upon return to the facility on 6-7-18. The	F 692		

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F 692	Continued From page 23 Resident still had the staples in her thigh from her femur fracture surgery 3 weeks prior, and the hospital recommended they be removed. All medications were discontinued upon readmission to the facility, on 6-7-18 from the hospitalization. The Resident returned on Hospice comfort care medications only (Atropine, haldol, and morphine) and hospice based services, with no expectation of recovery. The Resident could not eat, and the family did not wish a feeding tube be placed. On 6-12-18 (4 days later) the Resident expired in the facility. On 7-25-18 the Director of Nursing, and Administrator were made aware of the findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and supplements, and had begun a "4 point" plan of correction on 7-13-18 (one month after this incident) for it, however, it had not been completed as of the time of survey. The failure of staff to recognize and intervene timely and revise the diet care plan was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7-26-18. No further information was provided.	F 692		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755	F 755 1. Ad hoc QAPI Committee Meeting conducted on (insert date). Root Cause Analysis (RCA) completed. Residents' #4 and 5 no longer reside in the facility.	

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F 755	Continued From page 24 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview, clinical record review, Resident interview, and facility documentation and in the course of a complaint investigation staff failed to ensure medications were available for 2 Residents (Residents # 4, and #5) resulting in harm for Resident #4. 1. For Resident #4 the facility failed to provide (as needed) PRN pain medicine for 1 day (7/18/18)	F 755	2. Director of Nursing/Designee completed a Quality Review of current residents physician ordered medications ensuring in stock/available for administration as ordered. Director of Nursing/Designee completed a Quality Review of controlled pain medications for timely refill/available for administration. Director of Nursing/Designee completed interviews with residents/ (responsible party if not interviewable) who receive prn controlled pain medication to determine efficacy of pain management/medication available/administered upon request. Regional Director of Clinical Services to validate results of Quality Review. Follow up based on findings.	

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(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 755	Continued From page 25 resulting in harm. 2. For Resident #5, the facility staff failed to ensure medications were available. Findings Included: 1. For Resident #4 the facility failed to provide (as needed) PRN pain medicine for 1 day (7/18/18) resulting in harm. Resident # 4 a 73 year old female admitted to the facility on 7/10/2018 with diagnoses including but not limited to ruptured tendon right lower leg, Orthopedic surgical aftercare, hemarthrosis, right knee pain, Atrial fib (irregular heart rhythm) In an interview with Resident #4 on 7/24/18 Resident #4 stated "There was a day that was really the worst pain I have had and it was because they ran out of my pain medicine. I had to go to therapy and the appointment with my orthopedic surgeon without anything for pain and it was horrible". On 7/25/2018 at 11:17 AM an interview with the DON was conducted and the DON stated that it is expected practice for the nurses to take the following action when out of a medication for patients: First call the pharmacy and get the medication re-ordered and get a code to use for the stat box, and let the MD know, also let the DON know if we are having trouble getting the medication or the hard script. Nurse's notes on 7/17/2018 at 10:21 AM stated Resident #4 was out of narcotic pain medicine	F 755	3. Director of Nursing/Designee provided re-education for Licensed Nurses regarding ensuring medication refilled/administered as ordered by physician. Director of Nursing/Designee provided re-educatjon for Licensed Nurses regarding assessment/evaluation/management of pain per standard of practice. Director of Rehabilitation provided re-education to therapy staff regarding assessment/management of pain per standard of practice.	

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	495190	A. BUILDING _____ B. WING _____	C 07/26/2018

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F 755	Continued From page 26 and needed a new script. On 7/17/2018 at 11:59 AM Resident #4 attended Physical Therapy with a pain level of 9-10 out on a pain scale of 10 this is documented on Physical Therapy notes submitted by Employee A. On 7/17/2018 at 3:58 PM the nurses notes state that "Resident c/o [complained of] pain to right lower extremity r/t/ [related to] right knee surgical repair. Resident did not have any Norco [Hydrocodone] to give and a hard script was needed.. NP [nurse practitioner] was here and made aware of needing script and script was faxed over to pharmacy. Tylenol given at the time to help with pain which is 6/10 to right knee before leaving for f/u [follow up] appt. [orthopedic specialist]" On 7/17/2018 at 4:15 PM Nurses notes stated "Resident Orthopedic called concerning pain medication and stated that if Resident becomes low again just call the orthopedic specialist [named doctors] for hard script to be faxed to pharmacy if cannot get to NP or rounding MD." In an interview with Physical Therapy Employee A on 7/26/18 at 2:15 PM employee A stated " I did physical therapy with Resident #4 on the 7/17/2018 it took me a couple of trys to get her to come." " She did complain of pain at 9-10 out of 10 on a pain scale." On 7/26/2018 at 2:30 PM administration was made aware. No further information was provided.	F 755	4. Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident medications for timely refill/available (in stock)/administered per physician's order 5x/week x 4 weeks, weekly x 4 weeks, monthly x 2 months then as needed. Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident's pain managed per standard 5x/week x 2 weeks, weekly x 4 weeks, monthly x 2 months then as needed. Director of Rehabilitation to conduct Quality Improvement Monitoring of resident's pain addressed when expressed while receiving therapy services 5x/week x 4 weeks, weekly x 4 weeks, then monthly x 2 months and as needed. Regional Director of Clinical Services/Designee to validate Quality Improvement Monitoring. Findings to be	

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F 755	Continued From page 27 2. For Resident #5, the facility staff failed to ensure medications were available. Resident #5 was originally admitted to the facility on 7-12-18. The Resident's diagnoses included; Sepsis from urinary tract infection, dysphagia, stroke, hypothyroidism, hypertension, heart disease, diabetes, polyneuropathy, and anxiety. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 7-19-18. The MDS coded Resident #5 with no cognitive impairment, no impaired range of motion, however, requiring limited to extensive assistance on one staff member for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18 the Resident was interviewed, and when asked if she received her medications as ordered by her doctor she stated "most of the time, but sometimes they don't have them." On 7-24-18, and 7-25-18 Resident #5's clinical record, was reviewed. The review revealed physician orders, and "Medication Administration Records" (MARs) which included the following orders to be administered and documented as such: "Insulin Glargine solution inject 10 units subcutaneously at bedtime (9:00 p.m.)." Ordered to begin on 7-13-18. The insulin was omitted on 7-14-18, 7-21-18, 7-22-18, and 7-23-18, (4 times in 11 days). "Cyclosporin Emulsion antibiotic eye drops "Instill	F 755	reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of Compliance: August 28, 2018	

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F 755	Continued From page 28 one drop in both eyes every 12 hours (9:00 a.m., and 9:00 p.m.)". Ordered to begin 7-12-18. The eye drops were omitted on 7-12-18 at 9:00 a.m., 7-13-18 for both times, 7-15-18 at 9:00 p.m., and 7-23-18 at 9:00 p.m., (5 times in 11 days). "Levothyroxine sodium 200 micrograms, give 1 tablet by mouth in the morning (6:00 a.m.) Ordered to begin 7-13-18. The Synthroid was omitted on 7-13, 7-23-18, and 7-24-18. (3 times in 12 days). Nursing notes on these days of omissions of drugs, do at times describe "medications unavailable, or, awaiting pharmacy, however, they do not state which drugs are unavailable. The Resident's care plan was reviewed and stated "Administer medications as ordered. On 7-25-18 the Director of Nursing, and Administrator were made aware of the findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and had begun a "4 point" plan of correction on 7-13-18 for it, however, it had not been completed as of the time of survey. It is notable to mention that with this Resident, the omissions continued during survey. The failure of staff to recognize and intervene timely to make sure significant medications were available to Residents was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7-26-18. No further information was provided.	F 755		
F 760	Residents are Free of Significant Med Errors	F 760	F760: Residents are Free of Significant Med Errors	

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F 760 SS=E	Continued From page 29 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint survey the facility staff failed to ensure medications were administered without significant med error for 3 Residents (Resident's #4, #3 and #5) out of a sample of 5 Residents. 1. For Resident #4 the facility staff failed to administer Xopenex according to physicians order. 2. For Resident #3, the facility staff failed to administer significant medications, Insulin, as per physician orders. 3. For Resident #5, the facility staff failed to administer significant medications, Insulin, cyclosporin, and synthroid, as per physician orders. The findings included: 1. For Resident #4 the facility staff failed to administer medications according to physicians order. Resident # 4 a 73 year old female admitted to the facility on 7/10/2018 with diagnoses including but not limited to ruptured tendon right lower leg, Orthopedic surgical aftercare, hemarthrosis, right knee pain, Atrial fib (irregular heart rhythm)	F 760	1. Residents # 3, #4, #5 no longer reside in the facility. RN no longer employed by facility 2. DON/Designee completed Quality Review of current facility residents with physician's orders for Insulin, Xopenex, cyclosporin and Synthroid for administration without significant medication error. Follow up based on findings. 3. DON/Designee provided re-education for Licensed Nurses regarding medication administration and medication errors. DON/Designee completed Medication Pass competency with Licensed Nurses. 4. DON/Designee to complete random Quality Improvement Monitoring of Licensed Nurse's for administration of Insulin, Xopenex, cyclosporin and Synthroid without significant medication error 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and as needed. Findings to be reported at monthly QAPI Committee Meeting. Quality	

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F 760	Continued From page 30 On 7/13/2018 at 6:45 PM Resident #4 was also given an order for Xopenex 0.63 (mg) milligrams per (ml) milliliter (Levalbuteral HCL solution-a bronchodilator) 1 application inhale orally via nebulizer (machine used for dispersing orally inhaled solutions) every 4 hours as needed for wheezing / congestion give first dose when it arrives. The Xopenex first dose was administered on 7/16/2018 at 8:45 AM according to the MAR. On 7/25/2018 an interview was conducted with the Employee B and she stated "I was not here that day but the Xopenex arrived on 7/14/18 I know that because I can pull up the pharmacy receipt in the computer." Employee B printed out the document and submitted document. On 7/25/2018 at 11:17 AM an interview with the DON was conducted and the DON stated that it is expected practice for the nurses to take the following action when out of a medication for patients: First call the pharmacy and get the medication re-ordered and get a code to use for the stat box, and let the MD know, also let the DON know if we are having trouble getting the medication or the hard script. The DON further stated neither of these medications required a hard script and should have been available in the stat box. Administration was notified on 7/26/2018 and no further information was provided.	F 760	monitoring schedule modified as needed based on findings. 5. Allegation of Compliance: August 28, 2018	

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F 760	Continued From page 31 No further information was provided. 2. For Resident #3, the facility staff failed to administer significant medications, Insulin, as per physician orders. Resident #3 was originally admitted to the facility on 5-17-18 and was hospitalized on 6-4-18, and readmitted after hospitalization on 6-7-18. The Resident's diagnoses included; Femur fracture, Parkinson's dementia, Diabetes, schizophrenia, and anemia. Resident #3 expired in the facility on 6-12-18. A closed record review was conducted. The most recent Minimum Data Set (MDS) was a discharge assessment with an Assessment Reference Date (ARD) of 6-4-18. The MDS coded Resident #3 with severe cognitive impairment, impaired range of motion, requiring extensive assistance or total dependence on staff for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18, and 7-25-18 Resident #3's clinical record, admissions record, hospital record, and discharge record were reviewed. The review revealed physician orders which included the following medications to be administered: "Novolog solution 100 units/milliliter (insulin Aspart) short acting insulin, inject 15 units subcutaneously before meals 3 times a day." (to be given at 6:30 a.m., 11:30 a.m., and at 4:30 p.m.) for Diabetes. The order was given on 5-18-18, and discontinued on 5-19-18, for an unknown reason.	F 760		

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F 760	Continued From page 32 "Lantus solution 100 units/milliliter (insulin glargine) long acting insulin, inject 30 units subcutaneously 2 times a day." (to be given at 9:00 a.m., and 5:00 p.m.) for Diabetes. The order was given on 5-18-18. "Med Pass 60 milliliters twice per day supplement, (to be given at 9:00 a.m., and 5:00 p.m.). The order was given on 5-23-18. The 3 medications above were listed on the May and June 2018 Medication Administration Record (MAR) as ordered. The MAR document revealed the following; On 1 out of 3 occasions the Novolog Insulin MAR listed that the Resident refused the medication, however, only at the 4:30 p.m. dose, and only by one specific nurse for the only occasion that the nurse worked. The other nurses listed the medication as administered the other 2 times, then it was discontinued for an unknown reason. On 13 out of 17 occasions the Lantus Insulin MAR listed that the Resident refused the medication, however, only at the 5:00 p.m. dose, and only by one specific nurse for all 13 occasions that the nurse worked. All other nurses listed the medication as administered both times per day. On 8 out of 12 occasions the Med Pass supplement MAR listed that the Resident refused the medication, however, only at the 5:00 p.m. dose, and only by the same specific nurse for all 8 occasions that the nurse worked. All other nurses listed the medication as administered both times per day.	F 760		

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F 760	Continued From page 33 Only three finger stick blood sugar checks (FSBS) were documented as having been completed during the Resident's 24 day stay. The FSBS were documented as completed in the nursing notes on 6-1-18, 6-2-18, and 6-3-18. The same number was recorded for all 3, which was 126, and by the same nurse who omitted the above medications. Physician progress notes, and nursing progress notes were reviewed and revealed no documentation that the Resident ever refused medications, and neither was there any evidence that the family or physician was notified of the medication omissions. All progress notes indicate that the Resident consumed medications without difficulty, no refusals are noted in progress notes, and to the contrary, nursing stated "Meds taken whole with no complications", "accepted", "effective", in all of the notes. The nurse who omitted these medications was contacted via phone, however, was unable to be reached for interview. Review of the care plan (dated 5-18-18 upon admission), revealed interventions for the Focus of "(Resident name) is at risk for metabolic complications related to diabetes, hypothyroid, high cholesterol." Those interventions were never changed, and were the following 8 items; 1. Monitor for signs and symptoms of hypo/hyper glycemia including changes in level of consciousness, sleepiness, fatigue/weakness, diaphoresis, gait disturbance, fruity breath, blurred vision, headache.	F 760		

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F 760	Continued From page 34 2. Medications as ordered. 3. Provide diet as ordered. 4. Notify MD (doctor) as indicated. 5. Encourage compliance with diet and medications. 6. Monitor skin for impairment or changes. 7. Monitor labs as ordered. 8. Blood glucose levels as ordered. No blood glucose monitoring was ever ordered, even after her short acting insulin was discontinued. Insulin was omitted, and there is no indication that the doctor and family were ever notified, nor that orders, or care plan interventions were ever attempted to be changed. 16 days after admission, on 6-4-18, the Resident was sent to the hospital at 6:00 a.m., with "Vomiting coffee ground emesis" according to nursing notes. Review of Hospital records revealed the Resident was admitted with a "blood sugar greater than 900", Diabetic Keto-acidosis, (DKA) and sepsis (blood infection) due to pneumonia." The hospital records state no bloody or coffee ground emesis was seen by them. The Resident's laboratory report from 6-4-18 in the emergency room revealed a white blood cell count of 34.8 (normal is 4.0 to 11.0) revealing a serious infection. The hospital discharge record went on to document that the Resident was immediately placed on an insulin drip in the emergency room, by intravenous (IV) method, fluid resuscitation (IV fluids) method, and (IV) antibiotics were started. The hospital document goes on to mention a note of importance, that the medication list from the facility, (that she was admitted to the hospital	F 760		

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F 760	Continued From page 35 with), had no anticoagulant (blood thinning medication) used after surgery for fractures, or insulin coverage on it. The hospital discharge record stated that the DKA was reversed with the insulin drip, and the sepsis pneumonia was managed with the antibiotics, however, the Resident's mental state did not improve, and the Resident developed acute heart failure while hospitalized. At the time of discharge the Resident was not alert, and had no purposeful movement, and hospice services were discussed with the family. Discharge medications included both insulin's to be given upon return to the facility on 6-7-18. The Resident still had the staples in her thigh from her femur fracture surgery 3 weeks prior, and the hospital recommended they be removed. All medications were discontinued upon readmission to the facility, on 6-7-18 from the hospitalization. The Resident returned on Hospice comfort care medications only (Atropine, haldol, and morphine) and hospice based services, with no expectation of recovery. On 6-12-18 the Resident expired in the facility. On 7-25-18 the Director of Nursing, and Administrator were made aware of the significant medication errors findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and had begun a plan of correction on 7-13-18 for it, however, it had not been completed as of the time of survey.	F 760		

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F 760	Continued From page 36 3. For Resident #5, the facility staff failed to administer significant medications, Insulin, cyclosporin, and synthroid, as per physician orders. Resident #5 was originally admitted to the facility on 7-12-18. The Resident's diagnoses included; Sepsis from urinary tract infection, dysphagia, stroke, hypothyroidism, hypertension, heart disease, diabetes, polyneuropathy, and anxiety. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 7-19-18. The MDS coded Resident #5 with no cognitive impairment, no impaired range of motion, however, requiring limited to extensive assistance on one staff member for transfers, walking, dressing, bathing, toilet use and personal hygiene. On 7-24-18 the Resident was interviewed, and when asked if she received her medications as ordered by her doctor she stated "most of the time, but sometimes they don't have them." On 7-24-18, and 7-25-18 Resident #5's clinical record, was reviewed. The review revealed physician orders, and "Medication Administration Records" (MARs) which included the following orders to be administered and documented as such: "Insulin Glargine solution inject 10 units subcutaneously at bedtime (9:00 p.m.)." Ordered to begin on 7-13-18. The insulin was omitted on 7-14-18, 7-21-18, 7-22-18, and 7-23-18, (4 times in 11 days).	F 760		

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F 760	Continued From page 37 "Cyclosporin Emulsion antibiotic eye drops "Instill one drop in both eyes every 12 hours (9:00 a.m., and 9:00 p.m.)". Ordered to begin 7-12-18. The eye drops were omitted on 7-12-18 at 9:00 a.m., 7-13-18 for both times, 7-15-18 at 9:00 p.m., and 7-23-18 at 9:00 p.m, (5 times in 11 days). "Levothyroxine soduim 200 micrograms, give 1 tablet by mouth in the morning (6:00 a.m.) Ordered to begin 7-13-18. The Synthroid was omitted on 7-13, 7-23-18, and 7-24-18. (3 times in 12 days). Nursing notes on these days of omissions of drugs, do at times describe "medications unavailable, or, awaiting pharmacy, however, they do not state which drugs are unavailable. The Resident's care plan was reviewed and stated "Administer medications as ordered. On 7-25-18 the Director of Nursing, and Administrator were made aware of the findings, and asked for any further information they wished to present. They stated they were aware of the omission of medications, and had begun a "4 point" plan of correction on 7-13-18 for it, however, it had not been completed as of the time of survey. It is notable to mention that with this Resident, the omissions continued during survey. The failure of staff to recognize and intervene timely to make sure significant medications were available to Residents was reviewed with the Administrator and Director of Nursing at the end of day meeting on 7-26-18. No further information was provided.	F 760		

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 _____	C 07/26/2018

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