PRINTED: 08/07/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING __ COMPLETED C 495190 B. WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD CONSULATE HEALTHCARE OF WILLIAMSBURG WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY). **INITIAL COMMENTS** F 000 F 000 Preparation and/or execution of this plan does not constitute admission An unannounced Medicare/Medicaid abbreviated or agreement by the provider of the complaint survey was conducted 7-24-18 through truth of the facts alleged or conclusions 7-26-18. Four complaints were investigated set forth on the statement of during the survey. Significant Corrections are required for compliance with 42 CFR Part 483 deficiencies. This plan of correction is Federal Long Term Care Requirements. prepared and/or executed solely because it is required by the pro-The census in this 90 bed facility was 88 at the time of the survey. The survey sample consisted

F 582

F 582 SS=D

through #3).

§483.10(g)(17) The facility must--

CFR(s): 483.10(g)(17)(18)(i)-(v)

(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-

of 2 current resident reviews (Residents #4, and #5) and 3 closed record reviews (Residents #1

Medicaid/Medicare Coverage/Liability Notice

- (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

visions of federal and state law.

- 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

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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CONSUL	PROVIDER OR SUPPLIER	, es		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185		26/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JI D'RE	(X5) COMPLETION DATE	
	facility's per diem ra (i) Where changes and services covere Medicaid State plan notice to residents or reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident dies transferred and doe facility must refund representative, or e deposit or charges or per diem rate, for the resided or reserved facility, regardless or discharge notice red (iv) The facility must resident representative the resident within 3 date of discharge fro (v) The terms of an behalf of an individual facility must not con these regulations. This REQUIREMEN by: Based on staff inter review, clinical record a complaint investig ensure Advanced Be provided prior to los (Resident #3, and # residents.	icare/ Medicaid or by the ate. in coverage are made to items ed by Medicare and/or by the ate, the facility must provide of the change as soon as is are made to charges for other that the facility offers, the the resident in writing at least elementation of the change. It is not return to the facility, the state, as applicable, any already paid, less the facility's be days the resident actually or retained a bed in the fany minimum stay or quirements. It refund to the resident or tive any and all refunds due to days from the resident's	F 58	3. On 7/31/18, facility execut director reinstated facility? Worker to duties after reeducation with Social Work the Assistant to the Social V to include policy and procederelated to proper completion NOMNC form, procedure for receiving telephone consense Code of Conduct/Ethics. 4. Executive Director/Designeer conduct Quality Improvemene Monitoring of NOMNC letter ensure completion per profestandard completed 5x/week weeks, 3x/week x 4 weeks, when monthly and a needed. Findings to be reposited. Findings to be reposited as needed based or findings. 5. Alleged date of compliance: 28, 2018	er and Vorker dures on of the or t and e to nt rs to essional k x 8 veekly x es rted at eeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	DF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	07/26/2018 DE		
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	and falsified the sign Attorney on those of the Attorney on the Signature of the Findings included th	tion prior to loss of benefits, prature of the Power of documents. facility failed to provide a edicare Non-Coverage letter to discharge from facility, and re on those documents. fed: failed to provide Resident #3 tion prior to loss of benefits, nature of the Power of ocuments. figinally admitted to the facility is hospitalized on 6-4-18, and spitalization on 6-7-18. The resincluded; Femur fracture, tia, Diabetes, schizophrenia, ent #3 expired in the facility on record review was conducted. Inimum Data Set (MDS) was a rent with an Assessment RD) of 6-4-18. The MDS with severe cognitive and range of motion, requiring re or total dependence on staffing, dressing, bathing, toilet use record, hospital record, and	. F 5				
	revealed a "Notice c (NOMNC) documen	re reviewed. The review f Medicare Non-Coverage" ted and allegedly signed on #3's Power of Attorney					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTHCARE OF WILLIAMSBURG			ST 18	REET ADDRESS, CITY, STATE, ZIP CODE 11 JAMESTOWN ROAD ILLIAMSBURG, VA 23185	07/26/2018		
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	the POA had not be refusal to pay for si services (NOMNC) 5-29-18. Review o revealed that the debeen signed by the Copies of the docu admission docume were provided by the On 7-26-18 at 11:04 (Admin E) was interested she had filled she signed the form she did not deny signed to day, she stated produce any eviden Nursing notes were Admin E documente signed today, family The Administrator a findings, and review information was pro	investigation it was found that een notified of medicare killed nursing treatment and was not in the building on the NOMNC document ocument appeared to have individual filling out the form. The second worker and copies of original onto with the POA's signature, are facility and reviewed. Document, and copies of original onto with the POA's signature, are facility and reviewed. Document, The Social worker reviewed with the Administrator sing (DON) present. She dout the form. When asked if a with the POA's signature, and the document, however, ag "I spoke with her." When the POA was not in the building "but I spoke with her, I can't ce that we met." The reviewed, and revealed that and on 5-29-18 "NOMNC of does not want to appeal." The pool was notified of the red the forms. No further	F	582				
į,	written Notice of Me	dicare Non-Coverage letter to discharge from facility, and		į				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D.	2018	
CONSULATE HEALTHCARE OF WILLIAMSBURG STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	<u>2018</u>	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPETED TO THE APPROPRIATE D.		-
DEFICIENCY)	(X5) DMPLETION DATE	-
F 582 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 was made aware of the allegation. The facility was made aware of the allegation. The facility hen 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"		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 582	Administration was the meeting.	aware as they were present in	F 5	82			
	S483.21(b)(3) Composition of the services provided as outlined by the composition of the services provided as outlined by the composition of the services of t	Meet Professional Standards (3)(i) prehensive Care Plans (2) and arranged by the facility, comprehensive care plan, (2) all standards of quality. (3) IT is not met as evidenced (4) arranged by the facility documentation (4) arranged (5) arranged (6) arranged (7) a	F 6	58			
į	4. For Resident #1 the records. The findings include	ne facility falsified clinical					

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E COMPTENDED !	(X3) DATE SURVEY COMPLETED	
-		495190	B. WING)]
	PROVIDER OR SUPPLIER		·	1	TREET ADDRESS, CITY, STATE, ZIP CODE 811 JAMESTOWN ROAD VILLIAMSBURG, VA 23185	0772	26/2018
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	Resident #3 was or on 5-17-18 and was readmitted after hos Resident's diagnose Parkinson's dementant and anemia. Resident's diagnose of the most recent Midischarge assessmant Reference Date (AF coded Resident #3 impairment, impairment, impairment, impairment, impairment, of transfers, walking and personal hygier. On 7-24-18, and 7-2 record, admissions of discharge record we revealed physician of following medication. "Novolog solution 10 Aspart) short acting subcutaneously before be given at 6:30 a.m. p.m.) for Diabetes. 5-18-18, and discontant unknown reason. "Lantus solution 100 glargine) long acting subcutaneously 2 times.	B, the facility staff falled to an ordered medications. Iginally admitted to the facility is hospitalized on 6-4-18, and spitalization on 6-7-18. The es included; Femur fracture, tia, Diabetes, schizophrenia, ent #3 expired in the facility on ecord review was conducted. Inimum Data Set (MDS) was a ent with an Assessment RD) of 6-4-18. The MDS with severe cognitive drange of motion, requiring e or total dependence on staff g, dressing, bathing, toilet use ite. 15-18 Resident #3's clinical record, hospital record, and ere reviewed. The review orders which included the its to be administered: 10 units/milliliter (insulin insulin, inject 15 units ore meals 3 times a day." (to ., 11:30 a.m., and at 4:30 The order was given on tinued on 5-19-18, for an units/milliliter (insulin insulin, inject 30 units nes a day." (to be given at o.m.) for Diabetes. The order		358	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 Qu Review of current facility residents Medication Administration/documentation of administration to meet professional standards. Follow up based on findings. 2B. Administrator/Designee complea Quality Review of residents who received non-coverage notification related to completion of Medicare benefits for the last 90 days for completion per professional standarfollow up based on findings.	eted have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA7	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER ATE HEALTHCARE	₹ OF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP C 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	ODE .	/26/2018	
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F 658	supplement, (to be p.m.). The order of the medications and June 2018 Med (MAR) as ordered the following; On 1 out of 3 occalisted that the Reshowever, only at the one specific nurse nurse worked. The medication as admitted that the medication as admitted that the medication, however, and only by one special only by one spec	liliters twice per day e given at 9:00 a.m., and 5:00 was given on 5-23-18. s above were listed on the May edication Administration Record . The MAR document revealed asions the Novolog Insulin MAR ident refused the medication, he 4:30 p.m. dose, and only by for the only occasion that the e other nurses listed the ninistered the other 2 times, tinued for an unknown reason. ccasions the Lantus Insulin e Resident refused the ver, only at the 5:00 p.m. dose, pecific nurse for all 13 nurse worked. All other nedication as administered both asions the Med Pass isted that the Resident refused wever, only at the 5:00 p.m. the same specific nurse for all the nurse worked. All other nedication as administered both tick blood sugar checks mented as having been he Resident's 24 day stay. coumented as completed in the -1-18, 6-2-18, and 6-3-18. The	F 6	3A. Director of Nursing/Deprovided Licensed Nurses Re-education regarding meadministration/documental professional standards. 3B. Social Worker/Social Standards and professional standard compositional	edication etion per ervices eation by ng m per procedure nsent. diregarding ignee to nent eks, 3x/week ex, then eccutive uct Quality of NOMNC on per pleted ek x 4 weeks, enthly and as ported at Meeting. le modified		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 658		s recorded for all 3, which was ame nurse who omitted the	F 658	5. Allegation of Compliance: Au 28, 2018	gust
	notes were review documentation th medications, and	es notes, and nursing progress wed and revealed no at the Resident ever refused neither was there any evidence ohysician was notified of the ions.			
	consumed medica refusals are noted contrary, nursing	s indicate that the Resident ations without difficulty, no I in progress notes, and to the stated "Meds taken whole with , "accepted", "effective", in all of			
		nitted these medications was ne, however, was unable to be iew.			
	admission), revea of "(Resident nam complications rela high cholesterol."	e plan (dated 5-18-18 upon led interventions for the Focus e) is at risk for metabolic ted to diabetes, hypothyroid, Those interventions were nd were the following 8 items;			
	glycemia including consciousness, sl diaphoresis, galt o blurred vision, hea 2. Medications as 3. Provide diet as 4. Notify MD (doc	ordered. ordered.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	OF WILLIAMSBURG		18	REET ADDRESS, CITY, STATE, ZIP CODE 111 JAMESTOWN ROAD ILLIAMSBURG, VA 23185	<u>, 01)</u>	20/2010
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F 658	7. Monitor labs at 8. Blood glucose No blood glucose even after her sho discontinued. Ins no indication that notified, nor that owere ever attempt 16 days after admission of the house sent to	or impairment or changes. s ordered. levels as ordered. monitoring was ever ordered, ort acting insulin was ulin was omitted, and there is the doctor and family were ever orders, or care plan interventions ted to be changed. hission, on 6-4-18, the Resident ospital at 6:00 a.m., with	F6	558			
	Review of Hospita was admitted with 900", Diabetic Ket (blood infection) d records state no b was seen by them report from 6-4-18 revealed a white b	round emesis" according to all records revealed the Resident a "blood sugar greater than to-acidosis, (DKA) and sepsis ue to pneumonia." The hospital cloody or coffee ground emesis at the Resident's laboratory in the emergency room blood cell count of 34.8 (normal realing a serious infection.					
	document that the placed on an insul by intravenous (IV fluids) method, an The hospital docu of importance, tha facility, (that she w with), had no antic medication) used insulin coverage o	rarge record went on to Resident was immediately in drip in the emergency room,) method, fluid resuscitation (IV d (IV) antibiotics were started, ment goes on to mention a note t the medication list from the ras admitted to the hospital coagulant (blood thinning after surgery for fractures, or n it. arge record stated that the DKA					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495190			I	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C 07/26/2018	
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F 658	pneumonia was menowever, the Resimprove, and the Failure while hospit incident. At the tine was not alert, and and hospice service family. Discharge insulin's to be give 6-7-18. The Resident thigh from her femprior, and the hospitalization. The Hospice comfort contained, and morphiservices, with note on 6-12-18 the Resident the Resident that the Reside	the insulin drip, and the sepsis anaged with the antibiotics, dent's mental state did not Resident developed acute heart calized as a result of the ne of discharge the Resident had no purposeful movement, ses were discussed with the medications included both in upon return to the facility on lent still had the staples in her ur fracture surgery 3 weeks oftal recommended they be are discontinued upon facility, on 6-7-18 from the ne Resident returned on are medications only (Atropine, ne) and hospice based expectation of recovery. The sident expired in the facility. The sector of Nursing, and a made aware of the findings, further information they wished tated they were aware of the ations, and had begun a plan of the for it, however, it had not so of the time of survey. The sectt" as their nursing practice of the set follow health care	F6	658			
	providers' orders u are in error or harn	nless they believe the orders n patients. Therefore you need s; if you find one to be					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			TE SURVEY MPLETED				
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	PROVIDER OR SUPPLIE	R OF WILLIAMSBURG		1811	ET ADDRESS, CITY, STATE, ZIP CODE JAMESTOWN ROAD LIAMSBURG, VA 23185	_ 1 _ 01	120120 6
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F 658	erroneous or harr health care provid medication errors medication admir you administer m errors can be link inconsistency in a 1. The right med 2. The right dose 3. The right patie 4. The right route 5. The right docu Facility policy for included: Administer drugs to policy. Chart o observations imm	mful, further clarification from the der is necessary. To prevent a follow the six rights of histration consistently every time edications. Many medication ed, in some way, to an adhering to these rights: ication where the following is a following to the series of the	F	558			
10 m 20 m	record, admission discharge record revealed a "Notice (NOMNC) docum	7-25-18 Resident #3's clinical s record, hospital record, and were reviewed. The review of Medicare Non-Coverage" ented and allegedly signed on ent #3's Power of Attorney					
	the POA had not be refusal to pay for services (NOMNO 5-29-18. Review revealed that the company of the POA had not be revealed to the poart of the POA had not be revealed to the poart of the POA had not be refusal to pay for the POA had not be refusal to pay f	nt investigation it was found that been notified of medicare skilled nursing treatment by and was not in the building on of the NOMNC document document appeared to have e individual filling out the form.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	PROVIDER OR SUPPLIER ATE HEALTHCARE C	PF WILLIAMSBURG		18	REET ADDRESS, CITY, STATE, ZIP CODE B11 JAMESTOWN ROAD VILLIAMSBURG, VA 23185	1 07	20/2018
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F 658	admission documer were provided by the On 7-26-18 at 11:00 (Admin E) was interested and Director of Nursitated she had filled she signed the formshe did not deny signust continued saying she was told that the that day, she stated produce any eviden Nursing notes were Admin E documents signed today, family The facility staff did information after 7-2. 2. For Resident #5, administer physician medications. Resident #5 was or on 7-12-18. The most recent Minan admission assess Reference Date (AF) coded Resident #5 was or on 7-12-18. The most recent Minan admission assess Reference Date (AF) coded Resident #5 was or on 7-12-18.	ment, and copies of original of the with the POA's signature, we facility and reviewed. Dia.m., The Social worker eviewed with the Administrator sing (DON) present. She dout the form. When asked if a with the POA's signature, going the document, however, ag "I spoke with her." When a POA was not in the building "but I spoke with her, I can't ce that we met." Teviewed, and revealed that add on 5-29-18 "NOMNC of does not want to appeal." The facility staff failed to	F	658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	TIPLE CONSTRUCTI	ION	(X3) D	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OF WILLIAMSBURG		STREET ADDRES 1811 JAMESTON WILLIAMSBUR		E C	7/26/2018
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F 658	member for transfit toilet use and person toilet use and person toilet use and person on 7-24-18 the Rewhen asked if she ordered by her doctime, but sometime. On 7-24-18, and 7-record, was review physician orders, a Records" (MARs) orders to be admir such: "Insulin Glargine sessubcutaneously at to begin on 7-13-18, 7-21-18, 7-14-18, 7-21-18, 7-14-18, 7-21-18, 7-14-18 for both times of the drop in both eyand 9:00 p.m.)". Oeye drops were om 7-13-18 for both times of the drop in the	ers, walking, dressing, bathing.	F	558			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE			STRE 1811	ET ADDRESS, CITY, JAMESTOWN RO. LIAMSBURG, VA	AD	<u> 07/</u>	/26/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPH DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	The Resident's castated "Administed On 7-25-18 the D Administrator wer and asked for any to present. They omission of media point" plan of corr however, it had not time of survey. It this Resident, the survey. The failure of staff timely to make survey available to Resid Administrator and	are plan was reviewed and ar medications as ordered. irector of Nursing, and are made aware of the findings, or further information they wished stated they were aware of the cations, and had begun a "4 rection on 7-13-18 for it, but been completed as of the is notable to mention that with omissions continued during If to recognize and intervene are significant medications were ents was reviewed with the Director of Nursing at the end 17-26-18. No further	F	558				
	ensure medication ordered by the physical Resident # 4 a 73 facility on 7/10/202 not limited to ruptu Orthopedic surgical knee pain, Atrial fill In an interview with Resident #4 stated really the worst passed because they ran chad to go to therage	4 the facility staff failed to as were administered as ysician. year old female admitted to the 18 with diagnoses including but ured tendon right lower leg, al aftercare, hemarthrosis, right b (irregular heart rhythm) h Resident #4 on 7/24/18 d "There was a day that was in I have had and it was out of my pain medicine. I by and the appointment with the thing for pain and it was						

TAGE RECIT ATOM OF CONTROL PROCEDUATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
CONSULATE HEALTHCARE OF WILLIAMSBURG (X4) ID PREFIX TAG (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 15 horrible." Consulate HEALTHCARE OF WILLIAMSBURG (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 658 Continued From page 15 F 658 Continued From page 15 F 658 Controlled Trecords revealed that Resident #4 was not given ordered PRN Hydrocodone (narcotic pain)			495190	B. WING		0.7	_	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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				STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD				
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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
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 with a goal needed 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 rlt/ [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 flu [follow up] appt. [orthopedic		horrible." On 7/24/18 @ 1:00 records revealed the ordered PRN Hydromedication) for 24 7/18/2018. On 7/25/2018 at 11 DON was conducted expected practice of following action whe patients: First call the pharm re-ordered and get and let the MD known are having trouble of hard script. Nurse's notes on 7/Resident #4 was out and needed a new On 7/17/2018 at 11 Physical Therapy was a pain scale of 10 the Therapy notes subton 7/17/2018 at 3:5 that "Resident c/o [olower extremity r/t/] repair. Resident di [Hydrocodone] to gineeded. NP [nurse made aware of neefaxed over to pharm to help with pain who	PM a review of clinical nat Resident #4 was not given ocodone (narcotic pain hrs. beginning on 7/17/2018 - :17 AM an interview with the ed and the DON stated that it is for the nurses to take the en out of a medication for a code to use for the stat box, w, also let the DON know if we getting the medication or the complaint of narcotic pain medicine script :59 PM Resident #4 attended with a pain level of 9-10 out on his is documented on Physical mitted by Employee A. 68 PM the nurses notes state complained of pain to right related to right knee surgical don't have any Norco ve and a hard script was practitioner] was here and ding script and script was nacy. Tylenol given at the time sich is 6/10 to right knee	F 6	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF	OF WILLIAMSBURG		STREET ADDRESS, CITY, STA 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23	ATE, ZIP CODE	120/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 658	Continued From p specialist]" On 7/26/2018 at 2	:30 PM administration was	F	358		
	made aware. No i provided.	further information was				
	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.			,		
	(MDS- an assessn discharge assessn Reference Date (A was coded as havi	trecent Minimum Data Set nent protocol) was coded as a nent with an Assessment (RD) of 4/12/18. Resident #1 ing a Brief Interview of Mental re of 14 indicating no cognitive	-			
	complaint with OLC called her on 4/11/2	ver of Attorney] filed a C that alleges that Resident 2018 and stated that the facility 4/12/2018 at 12:30 pm to pick being kicked out.				
	interview was cond Administrator, DON was made aware of then provided the c	roximately 3:00 PM an lucted with the Social Worker, N and Corporate RN, facility of the allegation. The facility document Notice of Medicare ned by the POA (Resident #1's				
	Upon closer inspec	ction it was discovered that the				:

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OF WILLIAMSBURG		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 811 JAMESTOWN ROAD VILLIAMSBURG, VA 23185	<u>. </u>	20/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BF	(X5) COMPLETION DATE
F 658	signature appeared complainants signa complainant was m Social Worker state didn't sign it myself		F€	558	F692: Nutrition/Hydration Status 1A. Resident #3 no longer resides facility. Nurse no longer employed facility 1B. Resident #3 no longer resides facility 2A. DON/Designee completed a Qu Review of current facility residents	in the	
1	S483.25(g) Assiste (Includes naso-gas both percutaneous percutaneous percutaneous endo enteral fluids). Bas comprehensive assensure that a reside §483.25(g)(1) Main of nutritional status desirable body weighbalance, unless the demonstrates that (preferences indicate §483.25(g)(2) Is off maintain proper hydrogen as a nutritional provider orders a the This REQUIREMENT.	Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and escopic jejunostomy, and ed on a resident's essment, the facility must ent- tains acceptable parameters such as usual body weight or ight range and electrolyte resident's clinical condition his is not possible or resident e otherwise; ered sufficient fluid intake to dration and health; ered a therapeutic diet when problem and the health care	F	692	physician ordered supplements to prevent/intervene significant weig loss for administration as ordered. Follow-up based on findings. 3. Don/Designee provided re-eductor Licensed Nurses regarding administration of Supplements as ordered by physici prevent/intervene significant weig loss. 4A. DON/Designee to conduct Qual Improvement Monitoring of reside with physician ordered supplementadministration as ordered to prevent/intervene significant weigiloss 5x/week x 4 weeks, weekly x 4 weeks, then monthly and as needefindings to be reviewed at monthly QAPI Committee Meeting. Monito schedule modified based on findings. 5. Allegation of Compliance: Augus 28, 2018	ht ation an to ht lity nts ts for d. ring gs.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X	(X3) DATE SURVEY COMPLETED	
		495190	B. WING			C 07/26/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185			01/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
F 692	failed to provide a pupplement, and to for one resident (R) the survey sample. For Resident #3 the supplements as orduring a significant. The findings includ. Resident #3 was orduring a significant. The findings includ. Resident #3 was ordered in the findings includ. Resident's diagnos. Parkinson's demendant anemia. Resident's diagnos. Parkinson's demendant anemia. Resident's diagnos. The most recent M discharge assessm. Reference Date (Al coded Resident #3 impairment,	record review the facility staff ohysician ordered nutritional opervent significant weight loss esident #3) of 5 residents in efacility staff did not provide dered, and failed to intervene weight loss. ed: riginally admitted to the facility is hospitalized on 6-4-18, and spitalization on 6-7-18. The es included; Femur fracture, tia, Diabetes, schizophrenia, lent #3 expired in the facility on record review was conducted. Inimum Data Set (MDS) was a lent with an Assessment RD) of 6-4-18. The MDS with severe cognitive end range of motion, requiring the or total dependence on staffing, dressing, bathing, toilet use	F 6	92		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	ODE U	7/26/2018	
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	6-4-18 - 159.28 in to On 6-4-18 the Resi hospital for evaluat show a weight on the reveals a 31 lb. weight admission on 5-17-6-4-18 (18 days). I loss of 16.32% of the and a half weeks. On 7-24-18, and 7-record, admissions discharge record were vealed physician following schedule the nutritional supplement. Weights - "Notify M practitioner) of weight mutritional supplement. Weights - "Notify M practitioner) of weight mutritional supplement. The order was 5-23-18, as a supplement. (to be go.m.). The order was 5-23-18, as a supplement, as a supplement of the Resi surgery to repair it, as "Administer supplement." No new orders were weight loss in the fire This was the only according to the supplement.	ident was transferred to the tion. The Hospital records hat day of 159.28 lbs. This ight loss in the facility from -18, until hospitalization on This was a significant weight he Resident's weight in two 25-18 Resident #3's clinical record, hospital record, and rere reviewed. The review orders which included the for weights to be obtained, and ent to be administered: ID/NP (doctor or nurse ght every day shift every ay, Friday." Ordered by the 18 for Lymphedema. It is that the Resident was not c, and the lymphedema was e leg fracture and surgical	F 6	392			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			18	TREET ADDRESS, CITY, STATE, ZIP CODE 811 JAMESTOWN ROAD /ILLIAMSBURG, VA 23185	<u> </u>	20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
ĺ	weight loss. The supplement al June 2018 Medica (MAR) as ordered. the following; On 8 out of 12 occ. supplement MAR lithe medication, hordose, and only by a occasions that the nurses listed the mimes per day. Physician progress notes were reviewed documentation that medications, and notes were reviewed documentation exist the family or plemedication supplement trie administer the supplement administer the supplement tries administer the supplement administer the supplement tries administer the supplement admin	cove was listed on the May and tion Administration Record The MAR document revealed asions the Med Pass isted that the Resident refused wever, only at the 5:00 p.m. a specific nurse for all 8 nurse worked. All other edication as administered both notes, and nursing progress ad and revealed no the Resident ever refused either was there any evidence entrysician was notified of the nent omissions. No sted that the nurse who omitted d any other intervention to blement, as, to return later to we another staff member	Fe	692			
	medication was cor	tted the supplement ltacted via phone, however, ached for interview.				# T T T T T T T T T T T T T T T T T T T	
	Review of the nutrit	ion care plan (dated 5-22-18),					

NME OF PROVIDER OR SUPPLIER CONSULATE HEALTHCARE OF WILLIAMSBURG STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMISTOWN ROAD WILLIAMSBURG, VA 23185 WILLIAMSBURG, VA 23185 SWILLIAMSBURG, VA 23185 SWILLIAMSBURG, VA 23185 WILLIAMSBURG, VA 23185 F692 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 ordored. Encourage the resident to comply. Explain consequences of refusal, obesity/mahutrition risk factors. (No refusals were documented) 3. Monitor intake - roor of meal percentage. 4. Provide diet as ordered. 5. RD (registered dietican) 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 67-18 and was on hospice servicos. The 67-18 evaluation still states the Resident weight as 175, when hospital discharge records on 67-18, record the discharge veight 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 over 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 incidication that the doctor and family were ever notified, nor that orders, or care plain interventions were ever attempted to be changed.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
CONSULATE HEALTHCARE OF WILLIAMSBURG WILLIAMSBURG, VA 23185 WILLIAMSBURG, VA 23185 REGULATORY OR ISE PRECISION BY BILL REGULATORY OR ISE DENTIFYING INFORMATION) 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, estblizophrenia, diabetes, Parkinson's disease, hypothyroid, hypertension, iron deficiency anemia, elymphedema." Those interventions were never changed, and were the following 6 items; 1. Assist with meals as needed. 2. Explain and reinforce to the Resident tine importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malhutrition 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 needd). 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 Rosident weight as 175, when hospital discharge records on 6-7-18, record the 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, oven when the weight order was changed to 3 times per week.) No blood glucose maniforing 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			. 495190	B. WING_		=	
FREFIX TAG REGULATORY OR ISO IDENTIFYING INFORMATION) 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, hyportension, 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 tho importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/maintrition 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 ovaluation 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 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					1811 JAMESTOWN ROAD		720/20 10
revealed interventions for the Focus of "(Resident name) has potential for imbalanced nutrition related to let fremoral 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, record the discharge records on 6-7-18, record the 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 onitied, and there is no indication that the doctor and family were ever notified, nor that orders, or care plan interventions were over attempted to be	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP	OULD BE	COMPLÉTION
, \mathbf{I}		revealed intervent name) has potentic related to left femoth history including; diabetes, Parkinson hypertension, iron lymphedema." The changed, and were a length of the Resident returned and was on hospic evaluation still state when hospital discretored the discharge for the Resident's consequences of rectors. (No refustable of the facility, and the facility, and the facility, and the facility of the facility	ions for the Focus of "(Resident al for imbalanced nutrition oral neck fracture, past medical dementia, schizophrenia, on's disease, hypothyroid, deficiency anemia, ose interventions were never e the following 6 items; als as needed. Inforce to the Resident the ntaining the diet ordered. Ident to comply. Explain refusal, obesity/malnutrition risk als were documented) I record meal percentage. I ordered. I dietician) to evaluate and make mendations PRN (as needed). In occurred on initial admission then not again until the from the hospital on 6-7-18 reservices. The 6-7-18 reservices. The 6-7-18 reservices. The 6-7-18 reservices. The 6-7-18 reservices on 6-7-18, are weight as 167.8 lbs. I cy. (This intervention was recare plan, even when the hanged to 3 times per week.) I monitoring was ever ordered, diagnosis of diabetes, and on, even after her short acting inued. Insulin was omitted, cation that the doctor and officed, nor that orders, or care	F 69	92		

PRINTED: 08/07/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0</u>391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495190 B. WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD CONSULATE HEALTHCARE OF WILLIAMSBURG WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 692 | Continued From page 22 F 692 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

insulin coverage on it.

facility, (that she was admitted to the hospital with), had no anticoagulant (blood thinning medication) used after surgery for fractures, or

failure while hospitalized. At the time of

services were discussed with the family.

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

discharge the Resident was not alert, and had no purposeful movement, could not eat, and hospice

Discharge medications included both insulin's to be given upon return to the facility on 6-7-18. The

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A, BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495190	B. WING		·	1	C 26/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULI RENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 692	femur fracture surg hospital recommen All medications wer readmission to the hospitalization. The Hospice comfort ca haldol, and morphir services, with no ex Resident could not wish a feeding tube On 6-12-18 (4 days the facility. On 7-25-18 the Dire Administrator were and asked for any fit to present. They stromission of medica had begun a "4 poir 7-13-18 (one month	e staples in her thigh from her ery 3 weeks prior, and the ded they be removed. e discontinued upon facility, on 6-7-18 from the Resident returned on re medications only (Atropine, le) and hospice based pectation of recovery. The eat, and the family did not	F 692				
F 755 SS=G	timely and revise the with the Administration the end of day meet information was proper Pharmacy Srvcs/Procedus (25): 483.45(a)(b): \$483.45 Pharmacy Street facility must procedus in the facility must procedure in the fa	Scedures/Pharmacist/Records)(1)-(3) Services vide routine and emergency s to its residents, or obtain	F 755	Meet date). (RCA)	oc QAPI Committee ing conducted on (in . Root Cause Analysis completed. Residen no longer reside in t	ts' #4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:,		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUP CONSULATE HEALTHCA	PLIER ARE OF WILLIAMSBURG	1	TREET ADDRESS, CITY, STATE, ZIP CODE 811 JAMESTOWN ROAD VILLIAMSBURG, VA 23185	07/26/2018	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
personnel to a permits, but of a licensed nur §483.45(a) Propharmaceutical that assure the dispensing, and biologicals) to §483.45(b) Semust employ of pharmacist who §483.45(b)(1) aspects of the the facility. §483.45(b)(2) receipt and dissufficient detail reconciliation; §483.45(b)(3) order and that is maintained at This REQUIRE by: Based on staff clinical record of facility docume complaint investmedications were (Residents #4, Resident #4.	The facility may permit unlicensed administer drugs if State law only under the general supervision of sections. A facility must provide all services (including procedures a accurate acquiring, receiving, and administering of all drugs and meet the needs of each resident. Provice Consultation. The facility or obtain the services of a licensed no- Provides consultation on all provision of pharmacy services in Establishes a system of records of sposition of all controlled drugs in a licensel and accurate		2. Director of Nursing/Designed completed a Quality Review current residents physician ordered medications ensuring in stock/available for administration as ordered. Director of Nursing/Designed completed a Quality Review controlled pain medications timely refill/available for administration. Director of Nursing/Designee completed interviews with residents/ (responsible party if not interviewable) who receive prontrolled pain medication to determine efficacy of pain management/medication available/administered upon request. Regional Director or Clinical Services to validate results of Quality Review. Follow up based on findings.	of g of for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	100100	1 5. 11.13			7/26/2018	
	ATE HEALTHCARE C	OF WILLIAMSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185		DE		
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	ensure medications Findings Included: 1. For Resident #4 ineeded) PRN pain resulting in harm. Resident #4 a 73 yr facility on 7/10/2018 not limited to rupture Orthopedic surgical knee pain, Atrial fib. In an interview with Resident #4 stated 'really the worst pain because they ran out o go to therapy and orthopedic surgeon it was horrible". On 7/25/2018 at 11: DON was conducted expected practice for following action when patients: First call the pharma re-ordered and get a and let the MD know are having trouble grand script. Nurse's notes on 7/1	the facility staff failed to were available. the facility failed to provide (as medicine for 1 day (7/18/18) ear old female admitted to the with diagnoses including but ed tendon right lower leg, aftercare, hemarthrosis, right (irregular heart rhythm) Resident #4 on 7/24/18 'There was a day that was I have had and it was I had a had	F 7	Jirector of Nursing/Desprovided re-education Licensed Nurses regard ensuring medication refilled/administered a ordered by physician. of Nursing/Designee pr re-education for Licens Nurses regarding assessment/evaluation, ment of pain per standa practice. Director of Rehabilitation provided education to therapy st regarding assessment/manageme pain per standard of practice.	for ding ding Director rovided ed /manage ard of re- aff		
	Nurse's notes on 7/1	7/2018 at 10:21 AM stated of narcotic pain medicine					

STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA- IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED	
NAME OF BOO	VIDEO 05 01 1001 155	495190	B. WING			07	C //26/2018
	VIDER OR SUPPLIER E HEALTHCARE (DF WILLIAMSBURG		181	REET ADDRESS, CITY, STATE, ZIP CODE I1 JAMESTOWN ROAD LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
ar O. Pi a Tr O. th. lov re [H ne fa: to be sp Or "R mo lov [na ph In on ph 7/7 co. 10 Or ma	nysical Therapy were an scale of 10 to be rapy notes submon 7/17/2018 at 3:5 at "Resident c/o [over extremity r/t/opair. Resident diversed aware of needed. NP [nursed aware of needed aware of needed over to pharm help with pain who fore leaving for f/ecialist]" 17/17/2018 at 4:1 as ident of the point of the point of the point of the properties of the	script. :59 AM Resident #4 attended with a pain level of 9-10 out on his is documented on Physical mitted by Employee A. :58 PM the nurses notes state complained of] pain to right [related to] right knee surgical id not have any Norco eve and a hard script was practitioner] was here and ding script and script was nacy. Tylenol given at the time sich is 6/10 to right knee to [follow up] appt. [orthopedic of that if Resident becomes nee orthopedic specialist hard script to be faxed to get to NP or rounding MD." Physical Therapy Employee A PM employee A stated "I did he Resident #4 on the ena couple of trys to get her to pemplain of pain at 9-10 out of	F 7	755	4. Director of Nursing/Design conduct Quality Improvem Monitoring of resident medications for timely refill/available (in stock)/administered per physician's order 5x/weeks, weeks, weekly x 4 weeks, monthly x 2 months then as needed. Director of Nursing/Designee to condu Quality Improvement Monitoring of resident's pa managed per standard 5x/v 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 pai addressed when expressed while receiving therapy serv 5x/week x 4 weeks, weekly weeks, then monthly x 2 months and as needed. Regional Director of Clinical Services/Designee to validate Quality Improvement Monitoring. Findings to be	ent x 4 s in veek s, s in vices x 4	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	07/ DE	26/2018
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F 755	Resident #5 was o on 7-12-18. The R Sepsis from urinar stroke, hypothyroid disease, diabetes,	the facility staff failed to were available. riginally admitted to the facility esident's diagnoses included; tract infection, dysphagia, ism, hypertension, heart polyneuropathy, and anxiety. inimum Data Set (MDS) was	F 75	reviewed at monthly QA Committee Meeting. Monitoring schedule mo based on findings. 5. Allegation of Compliance August 28, 2018	dified	
	Reference Date (A coded Resident #5 no impaired range limited to extensive member for transfetoilet use and personners. On 7-24-18 the Resident extensive when asked if she ordered by her doc	ssment with an Assessment RD) of 7-19-18. The MDS with no cognitive impairment, of motion, however, requiring assistance on one staffers, walking, dressing, bathing, anal hygiene. sident was interviewed, and received her medications as tor she stated "most of the sthey don't have them."	·			
	record, was reviewed physician orders, an Records" (MARs) w	25-18 Resident #5's clinical ed. The review revealed nd "Medication Administration which included the following stered and documented as				
	subcutaneously at Ito begin on 7-13-18 7-14-18, 7-21-18, 7 in 11 days).	lution inject 10 units pedtime (9:00 p.m.)." Ordered . The insulin was omitted on -22-18, and 7-23-18, (4 times				
	"Cyclosporin Emuls	ion antibiotic eye drops "Instill				-

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	DF WILLIAMSBURG		1	TREET ADDRESS, CITY, STATE, ZIP CODE 811 JAMESTOWN ROAD VILLIAMSBURG, VA 23185		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 755	and 9:00 p.m.)". O eye drops were om 7-13-18 for both tim 7-23-18 at 9:00 p.m. "Levothyroxine sod tablet by mouth in tour ordered to begin 7-23-18 at 9:00 p.m. "Levothyroxine sod tablet by mouth in tour ordered to begin 7-25-13 for 12 days). Nursing notes on the drugs, do at times of unavailable, or, award on the Resident's care stated "Administer of the Resident's care stated "Administer of the present. They stour of saked for any for the present. They stour of survey. It is this Resident, the of survey. The failure of staff to timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-18 for both timely to make sure available to Resider Administrator and Edday meeting on 7-23-24 for both timely to make sure available to Resider Administrator and Edday meeting on 7-24 for both timely to make sure avai	res every 12 hours (9:00 a.m., rdered to begin 7-12-18. The itted on 7-12-18 at 9:00 a.m., nes, 7-15-18 at 9:00 p.m., and n., (5 times in 11 days). ium 200 micrograms, give 1 he morning (6:00 a.m.) -13-18. The Synthroid was 23-18, and 7-24-18. (3 times at times are unavailable. In plan was reviewed and medications as ordered. In plan was reviewed and medications as ordered. In plan was reviewed and made aware of the findings, urther information they wished ated they were aware of the tions, and had begun a "4 ction on 7-13-18 for it, been completed as of the notable to mention that with missions continued during or recognize and intervene significant medications were not was reviewed with the processor of Nursing at the endirector of Nursing at the endirector of Nursing at the endirector.	F	755			
F 760	information was pro Residents are Free	of Significant Med Errors	F 7	60	F760: Residents are Free of Sigr Med Errors	ificant	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER ATE HEALTHCARE OF SUMMARY STA	DF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185 PROVIDER'S PLAN OF CORRECT		26/2018
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760 SS=E	medication errors. This REQUIREMEI by: Based on observat documentation revi in the course of a c staff failed to ensur administered without Residents (Reside sample of 5 Reside 1. For Resident #4 administer Xopener order. 2. For Resident #3, administer significat physician orders. 3. For Resident #5 administer significat cyclosporin, and syr orders. The findings include 1. For Resident #4 administer medicati order. Resident #4 a 73 y facility on 7/10/2018 not limited to rupture Orthopedic surgical	esure that its- lents are free of any significant NT is not met as evidenced tion, staff interview, facility ew, clinical record review, and omplaint survey the facility e medications were ut significant med error for 3 nt's #4, #3 and #5) out of a ents. the facility staff failed to according to physicians the facility staff failed to nt medications, Insulin, as per the facility staff failed to nt medications, Insulin, nthroid, as per physician	F 760	1. Residents # 3, #4, #5 no lon reside in the facility. RN no longe employed by facility 2. DON/Designee completed Quality reswith physician's orders for In Xopenex, cyclosporin and Synfor administration without significant medication error. up based on findings. 3. DON/Designee provided reeducation for Licensed Nurse regarding medication administration and medication errors. DON/Designee complements. DON/Designee complements of Nurses administration of Insulin, Xopenes of Nurses. 4. DON/Designee to complete random Quality Improvement Monitoring of Licensed Nurses administration of Insulin, Xopenes of Nurses administration of Insulin, Xopenes of Nurses administration of Insulin, Xopenes of Nurses administration error Sx/week x 4 weeks, 3x/week weeks, weekly x 4 weeks, the monthly and as needed. Find to be reported at monthly QAC Committee Meeting. Quality	uality idents sulin, nthroid Follow s n eted with e's for penex, thout x 4 n ings	

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 (mi) millilliter (Levalbutera! HCL solution-a bronchodilator) 1 application inhale orally via nebulizer (meshine 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		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
CONSULATE HEALTHCARE OF WILLIAMSBURG (MA) D SUMMARY STATEMENT OF DEFICIENCIES REPERLY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLATORY OR LSC IDENTIFYING INFORMATION) FRETRY TAG 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 (mi) millitler (Levalbuteral HCL solution-a bronchodilator) 1 application inhale orally via nebulizor (machine used for dispersing orally inhaled solutions) every 4 hours as needed for wheezing / congestion give 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, also let the DON know, disto 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			495190	B. WING_				07		
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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) millilliter (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		•	•		1811 JA	MESTOWN ROA	VD		120/2010	
On 7/13/2018 at 6:45 PM Resident #4 was also given an order for Xopenex 0.63 (mg) milligrams per (ml) millifiter (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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECT CROSS-REFERENC	TIVE ACTION SH CED TO THE API	HOULD BE	COMPLETION	
have been available in the stat box. Administration was notified on 7/26/2018 and no further information was provided.		On 7/13/2018 at 6: given an order for 2 per (ml) milliliter (Le bronchodilator) 1 a nebulizer (machine inhaled solutions) e wheezing / congest arrives. The Xopenex first of 7/16/2018 at 8:45 A On 7/25/2018 an in the Employee B and that day but the Xoknow that because receipt in the compathe document and some conducted of following action where the following action wher	A5 PM Resident #4 was also Xopenex 0.63 (mg) milligrams evalbuteral HCL solution-a application inhale orally via e used for dispersing orally every 4 hours as needed for tion give first dose when it dose was administered on AM according to the MAR. Interview was conducted with a she stated "I was not here upenex arrived on 7/14/18 I all can pull up the pharmacy outer." Employee B printed out submitted document. In AM an interview with the end and the DON stated that it is for the nurses to take the en out of a medication for a code to use for the stat box, w, also let the DON know if we getting the medication or the stated neither of these and a hard script and should be in the stat box. Inotified on 7/26/2018 and no	F 76	5.	needed based	d on findings.			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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	PROVIDER OR SUPPLIE	OF WILLIAMSBURG		STF 181	REET ADDRESS, CITY, STATE, ZIP CODE 1 JAMESTOWN ROAD LLIAMSBURG, VA 23185	<u> 07/</u>	26/2018
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F 760		page 31 ation was provided.	F	760			
	administer signific physician orders. Resident #3 was o	3, the facility staff failed to ant medications, Insulin, as per priginally admitted to the facility					
	readmitted after he Resident's diagno Parkinson's deme and anemia. Resi	as hospitalized on 6-4-18, and ospitalization on 6-7-18. The ses included; Femur fracture, ntia, Diabetes, schizophrenia, dent #3 expired in the facility on record review was conducted.					
	discharge assessr Reference Date (A coded Resident #3 impairment, impair extensive assistan	Minimum Data Set (MDS) was a ment with an Assessment MRD) of 6-4-18. The MDS with severe cognitive red range of motion, requiring ce or total dependence on staffing, dressing, bathing, toilet use ene.		-			
	record, admissions discharge record v revealed physician	-25-18 Resident #3's clinical serecord, hospital record, and were reviewed. The review orders which included the ons to be administered:				TO THE PARTY OF TH	
	Aspart) short acting subcutaneously be be given at 6:30 a. p.m.) for Diabetes.	100 units/milliliter (insulin g insulin, inject 15 units fore meals 3 times a day." (to m., 11:30 a.m., and at 4:30 The order was given on ntinued on 5-19-18, for an					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OF WILLIAMSBURG		18	TREET ADDRESS, CITY, STATE, ZIP CODE 311 JAMESTOWN ROAD /ILLIAMSBURG, VA 23185	1 07	/26/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	OBE	(X5) COMPLETION DATE
F 760	"Lantus solution 10 glargine) long actin subcutaneously 2 t	0 units/milliliter (insulin g insulin, inject 30 units imes a day." (to be given at p.m.) for Diabetes. The order	F 7	760			
	"Med Pass 60 millil supplement, (to be p.m.). The order w The 3 medications and June 2018 Med (MAR) as ordered.						
	listed that the Resid however, only at the one specific nurse f nurse worked. The medication as admi	ions the Novolog Insulin MAR lent refused the medication, 2 4:30 p.m. dose, and only by or the only occasion that the other nurses listed the nistered the other 2 times, nued for an unknown reason.					
	MAR listed that the medication, however and only by one spe occasions that the r	rasions the Lantus Insulin Resident refused the or, only at the 5:00 p.m. dose, position rurse for all 13 nurse worked. All other edication as administered both					
	the medication, how dose, and only by th 8 occasions that the	sions the Med Pass ted that the Resident refused ever, only at the 5:00 p.m. e same specific nurse for all nurse worked. All other edication as administered both					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
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	CONSULATE HEALTHCARE OF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP CO 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185			1	20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	(FSBS) were docu completed during to The FSBS were do nursing notes on 6 same number was 126, and by the sa above medications. Physician progress notes were reviewed documentation that medications, and rethat the family or periodication omission. All progress notes consumed medications are noted contrary, nursing seno complications, the notes. The nurse who ome contacted via phonoreached for interviewed for in	tick blood sugar checks mented as having been the Resident's 24 day stay. Documented as completed in the 1-1-18, 6-2-18, and 6-3-18. The recorded for all 3, which was me nurse who omitted the state of the Resident ever refused the recorded not the Resident ever refused the recorded and revealed not the Resident ever refused the recorded to the recorded t	F	760			
İ	diaphoresis, gait di blurred vision, head	sturbance, fruity breath, dache.				 	

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		495190	B. WING		0.	C 7/26/2018	
	PROVIDER OR SUPPLIE	OF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP COD 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185		12012018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE	
	medications. 6. Monitor skin fo 7. Monitor labs as 8. Blood glucose No blood glucose even after her sho discontinued. Inst no indication that in notified, nor that o were ever attempt 16 days after adm was sent to the ho "Vomiting coffee g nursing notes. Review of Hospita was admitted with 900", Diabetic Ket (blood infection) di records state no b was seen by them report from 6-4-18 revealed a white b	ordered. ordered. tor) as indicated. npliance with diet and r impairment or changes. ordered. levels as ordered. monitoring was ever ordered, ort acting insulin was allin was omitted, and there is the doctor and family were ever rders, or care plan interventions		760			
,	document that the placed on an insul by intravenous (IV fluids) method, and The hospital docur of importance, that	arge record went on to Resident was immediately n drip in the emergency room, method, fluid resuscitation (IV d (IV) antibiotics were started. ment goes on to mention a note the medication list from the as admitted to the hospital					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495190	B. WING		07	C 07/26/2018	
	PROVIDER OR SUPPLIER	OF WILLIAMSBURG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185	<u> </u>	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 760	with), had no anticomedication) used a insulin coverage or The hospital discharge reversed with pneumonia was mathowever, the Residimprove, and the Residimprove, and the Residure while hospital discharge the Residure with the included both insuling the facility on 6-7-1 staples in her thigh surgery 3 weeks precommended they All medications were readmission to the hospitalization. The Hospice comfort call haldol, and morphing services, with no expected on 7-25-18 the Residure on 7-25-18 the Direct Administrator were medication errors fifurther information is stated they were aware dications, and hall medications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications, and hall medications are stated they were aware dications.	pagulant (blood thinning fter surgery for fractures, or it. arge record stated that the DKA the insulin drip, and the sepsis anaged with the antibiotics, ent's mental state did not esident developed acute heart alized. At the time of dent was not alert, and had no ent, and hospice services were family. Discharge medications n's to be given upon return to 8. The Resident still had the from her femur fracture ior, and the hospital — be removed. The discontinued upon facility, on 6-7-18 from the eremoved. The Resident returned on remedications only (Atropine, e) and hospice based expectation of recovery. The dident expired in the facility. The cotor of Nursing, and made aware of the significant andings, and asked for any hey wished to present. They ware of the omission of end begun a plan of correction wever, it had not been	F 7	60			
						i 	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		E SURVEY IPLETED
		495190	B. WING		i	C 26/2018
	PROVIDER OR SUPPLIE	OF WILLIAMSBURG		STREET ADDRESS, CITY, STATE, ZIP CO 1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185		20/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BF	(X5) COMPLETION DATE
F 760	3. For Resident administer signific cyclosporin, and corders. Resident #5 was on 7-12-18. The Sepsis from urina stroke, hypothyro disease, diabetes. The most recent an admission ass Reference Date (coded Resident # no impaired range	page 36 #5, the facility staff failed to cant medications, Insulin, synthroid, as per physician originally admitted to the facility Resident's diagnoses included; ary tract infection, dysphagia, idism, hypertension, heart a, polyneuropathy, and anxiety. Minimum Data Set (MDS) was ressment with an Assessment ARD) of 7-19-18. The MDS is with no cognitive impairment, as of motion, however, requiring the assistance on one staff	F 760			
	toilet use and per On 7-24-18 the R when asked if she ordered by her do time, but sometim On 7-24-18, and 7 record, was review physician orders, Records" (MARs) orders to be admissuch: "Insulin Glargine subcutaneously at to begin on 7-13-1	fers, walking, dressing, bathing, sonal hygiene. esident was interviewed, and e received her medications as ector she stated "most of the les they don't have them." 7-25-18 Resident #5's clinical wed. The review revealed and "Medication Administration which included the following nistered and documented as solution inject 10 units to bedtime (9:00 p.m.)." Ordered 18. The insulin was omitted on 7-22-18, and 7-23-18, (4 times				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495190	B. WING			1	С	
NAME OF	PROVIDER OR SUPPLIE		B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 07/</u>	26/2018	
		OF WILLIAMSBURG		18	B11 JAMESTOWN ROAD VILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 760	Continued From p	page 37	F 7	760	,	***		
	one drop in both e and 9:00 p.m.)". (eye drops were or 7-13-18 for both ti	Ision antibiotic eye drops "Instill eyes every 12 hours (9:00 a.m., Ordered to begin 7-12-18. The mitted on 7-12-18 at 9:00 a.m., mes, 7-15-18 at 9:00 p.m., and m, (5 times in 11 days).				·		
	tablet by mouth in Ordered to begin	duim 200 micrograms, give 1 the morning (6:00 a.m.) 7-13-18. The Synthroid was 7-23-18, and 7-24-18. (3 times						
	drugs, do at times unavailable, or, av	these days of omissions of describe "medications vaiting pharmacy, however, they drugs are unavailable.			• ,			
, .		re plan was reviewed and medications as ordered.			-			
	Administrator were and asked for any to present. They somission of medic point" plan of corre however, it had no time of survey. It is	rector of Nursing, and emade aware of the findings, further information they wished stated they were aware of the ations, and had begun a "4 ection on 7-13-18 for it, to been completed as of the s notable to mention that with omissions continued during						
	timely to make sur available to Reside Administrator and	to recognize and intervene e significant medications were ents was reviewed with the Director of Nursing at the end 7-26-18. No further ovided.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/07/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 495190 B. WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1811 JAMESTOWN ROAD CONSULATE HEALTHCARE OF WILLIAMSBURG WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)