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 _____	R-C 08/30/2018

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

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 7/24/18 through 7/26/18, was conducted 8/28/18 through 8/30/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 28 current resident reviews and 3 closed record reviews.	{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 755} SS=D	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 §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.	{F 755}	Srvcs/Procedures/Pharmacist/Records 1. Root Cause Analysis completed. Resident # 127 no longer resides in the facility. 2. Director of Nursing / Designee completed a Quality Review of antibiotics for timely refill/availability for administration. Regional Director to validate results of Quality Review. Follow up based on findings.	

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

None | Executive Director | 9/20/18

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 755}	Continued From page 1 §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 observation, staff interview, clinical record review and facility documentation review the facility staff failed to ensure medications were available for administration for 1 resident (Resident #127) of 31 residents in the survey sample. Resident #127 was admitted to the facility from the hospital on 8/27/18 for treatment of an infection with the antibiotic Vancomycin. The antibiotic was unavailable from the pharmacy on 8/28/18. The antibiotic was not administered until on 8/29/18 at 6:00 p.m. The findings included: Resident #127, an 88 year old, was admitted to the facility on 8/27/18. Diagnoses included C. Diff (infection), spondylosis, hypertension, heart disease, diabetes, end stage renal disease, anemia, and arthritis. As the resident was new to the facility, a Minimum Data Set assessment had not been completed. On 8/28/18 at 2:30 p.m., personal protective equipment was observed in a plastic set of drawers outside of Resident #127's room. The	{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 to met with hospital discharge planner to discuss coordination of resident care. 4. Director of Nursing /Designee to conduct Quality Improvement monitoring of resident medications for timely refill/available (in stock)/administered per physician's order 5 x/week x 4 weeks, weekly x 4 weeks. Quality improvement Monitoring, Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of Compliance: October 2, 2018	

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{F 755}	Continued From page 2 resident was not in the room at this time. According to Resident #127's clinical record, contact precautions were in place for Resident #127 due to a C. Diff infection. The "After Visit Summary" from the hospital was included in Resident #127's clinical record. The summary read, "You were discharged on : August 27, 2018." Included in the summary was the "Final Medication List At Discharge." The list included an antibiotic order for Vancomycin take 1 cap (125 milligrams) by mouth every 6 hours for 5 days. A handwritten note on the hospital medication list read, "Verified t.o. (telephone order)." It was signed with the facility nurse's name and the date of 8/27/18. According to Resident #127's computerized facility orders, the order date for the Vancomycin was 8/27/18. The start date was documented as 8/28/18 and the end date was 8/28/18. The "order status" read, "Discontinued." The order was discontinued at 12:39 a.m. and the "Reason for Discontinue" read, "medicine will be delivery on 8/28/2018 in the afternoon." The 8/27/18 Vancomycin order was included on the August 2018 Medication Administration Record (MAR). The MAR entry for 8/28/18 at 0000 (12 a.m.) included the nurse initials and the number 9. According to the "chart codes" a 9 indicated that a nursing note had been written. Other medications with an administration time of 9:00 a.m. were administered on 8/28/18. On 8/28/18 at 2:00 a.m., a Nursing Progress Note	{F 755}		

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{F 755}	Continued From page 3 was written. The note read, "Vancomycin HCL Capsule 125 mg (milligram) Give 1 capsule by mouth every 6 hours for CDIFF for 5 Days until finished called pharmacy, medication will be delivery tomorrow afternoon (8/28/2018). Reschedule medicine." On 8/28/18 at 9:09 a.m., a Nursing Progress Note was written. The note read, "Called pharmacy for medication: Vancomycin HCL capsule 125 mg. Pharmacy told writer that it will be in the afternoon. Rescheduled it. (Husband name), aware On call doctor, aware." A new order for Vancomycin with an order date of 8/28/18 was included in Resident #127's orders. The start date was documented as 8/28/18 and the end date was 9/3/18. The "order status" read, "Active." The new order was include on the August 2018 MAR. The first dose of Vancomycin was scheduled to start 8/29/18 at 6:00 p.m. On 8/30/18 at 1:30 p.m., Licensed Practical Nurse K (LPN K) was asked to describe the pharmacy delivery schedule. LPN K stated that the pharmacy was located in Portsmouth. She stated that the pharmacy delivered medications twice daily Monday- Saturday. The delivery times were between 3-4 p.m. and midnight. On Sunday there was one delivery run at midnight. A stat medication delivery would arrive within 2-4 hours. LPN K pointed to a "Pharmacy Information" sheet taped to the nursing station. When asked if she knew why Resident #127's Vancomycin was not delivered on the midnight run on 8/28/18, LPN K stated that she did not know why. The Pharmacy Information sheet included the	{F 755}		

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{F 755}	Continued From page 4 pharmacy order timelines for admissions. The sheet read, Monday- Friday medications ordered by 11:00 a.m. had a delivery window of 12:00 p.m. and medications ordered by 10:00 p.m. had a delivery window of 12:00 a.m. On 8/30/18 at 1:50 p.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #127's Vancomycin. The DON stated that Resident #127 arrived at the facility on 8/27/18 at 5:30 p.m. and the medications were put in with the pharmacy on 8/27/18 evening. She stated that the facility staff were told the Vancomycin would come on the 8/28/18 midnight run. She stated that medications for new admissions were top priority. The DON stated that the Vancomycin did not come on the midnight run. She asked that the survey team speak with the Unit Manager, Licensed Practical Nurse C (LPN C), as LPN C was involved with the situation. On 8/30/18 at 2:00 p.m., LPN C was asked how the pharmacy received orders from the facility. LPN C stated that when a nurse entered an order into the computer system, the order was sent to the pharmacy automatically. LPN C stated that Resident #127's orders went to the pharmacy on 8/27/18. LPN C stated that she called the pharmacy on 8/28/18 and asked about the Vancomycin. LPN C stated the pharmacy would stat the medication. She stated that the medication was delivered on 8/28/18. LPN C was asked to provide the pharmacy phone number. She provided the phone number and the pharmacy contact, Other A. On 8/30/18 at 2:15 p.m., a call was placed to the pharmacy. Other A answered the phone and was	{F 755}		

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{F 755}	Continued From page 5 asked to provide medication order information for Resident #127. Other A stated that the pharmacy received the order for the Vancomycin on 8/27/18 at 8:17 p.m. Other A stated that the medication should have gone out on the midnight delivery on 8/28/18. She did not know why it did not go on the midnight delivery. Other A stated the Vancomycin was sent out on 8/28/18 on the noon delivery run. She stated that the Vancomycin delivery was signed by Licensed Practical Nurse G (LPN G) at the facility on 8/28/18 at 2:30 p.m. On 8/30/18 at 2:35 p.m., LPN G was asked if she signed for Resident #127's Vancomycin. LPN G stated that she worked from 7:00 a.m. until 4:45 p.m. on 8/28/18 and did remember signing for the Vancomycin. She stated that she signed a hard copy and an electronic copy of the receipt. LPN G stated that the paper copy was placed in a basket at the nursing station. She looked through the basket during the interview and could not locate the receipt. The "Proof of Delivery" shipment summary was provided by the facility staff. LPN G signed for the medication on 8/28/18 at 2:30 p.m. On 8/30/18 at 3:02 p.m., the DON was asked why the original Vancomycin order was discontinued. The DON stated that the Vancomycin did not arrive from the pharmacy on the midnight run. The on-call doctor was called and a new order was written. The DON was asked why the Vancomycin delivered on 8/28/18 at 2:30 p.m. was not administered to Resident #127 until 8/29/18 at 6:00 p.m. The DON stated she did not know why the Vancomycin was put into the computer to	{F 755}		

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{F 755}	Continued From page 6 start on 8/29/18 at 6:00 p.m. It was reviewed with the DON that Resident #127 did not receive the antibiotic until 48 hours after admission. At the end of day meeting on 8/30/18, the Administrator, DON and Corporate Nurse were notified of the issue. They were asked to provide all information pertaining to the issue.	{F 755}		