STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/12/19 through 02/15/19 and 02/19/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/12/19 through 2/15/19 and 2/19/19. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Eight complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 222 certified bed facility was 208 at the time of the survey. The survey sample consisted of 62 resident reviews; 55 current residents and 7 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		4/3/19

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

Electronically Signed | 03/14/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 1 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility document review, the facility staff failed to provide privacy during a wound dressing change for 1 of 62 residents (Resident #183) in the survey sample. The facility staff failed to ensure Resident #183's door was closed during a left heel wound care observation, allowing public view from the hallway. The findings included: Resident #183 was originally admitted on	F 583	Nurse #2 was educated on privacy immediately on 2/13/19 by the Staff Development Coordinator (SDC). Residents with treatments have the potential to be affected. No other residents having treatments were effected. The SDC and/or designee will educate the License staff on Resident privacy. The DCS (Director of Clinical Service) and/or designee will do wound care observation audit to ensure privacy is provided: Twice weekly audits times 2 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 08/22/16 with a readmission date of 09/28/18. Diagnosis for Resident #183 included, but not limited to, Major Depressive Disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 01/18/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #183 total dependence of two with bathing and transfer, extensive assistance of two with bed mobility, dressing and toilet use and extensive assistance of one with physical hygiene for Activities of Daily Living care. During a wound dressing observation on 02/13/19 at approximately 12:54 p.m., with RN #2, the RN failed to close the door for Resident #183's privacy during a left heel wound dressing change. While wound care was being performed two family members walked by, four residents in there wheel chair rolled by, and six staff members walked by the opened doorway. Resident #183's left foot (pressure ulcer wound) was exposed when wound care was being performed. An interview was conducted with RN #2 on 02/13/19 at approximately 1:25 p.m. The RN said the door should have been closed during Resident #183's dressing change to maintain privacy. On 02/14/19 at approximately 9:25 a.m., an interview was conducted with Director of Nursing (DON) who stated, "The nurse should have close Resident #183's door to maintain her privacy." Review of the facility's clean and dressing	F 583	weekly times 4, and monthly times 2 month and the results will be reported to the Quality Assurance Performance Committee(QAPI) by the DCS for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3 competency skills checklist included but not limited to the following: provide privacy and position resident comfortably and appropriately. The Administrator and DON was informed of the finding during a briefing on 02/14/19 at approximately 3:30 p.m. The facility did not present any further information about the findings. The facility's policy on privacy during wound care was requested but not received.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to maintain a clean, comfortable, homelike environment. Multiple resident rooms were not clean and had wall damage. The activity room wall paper was not maintained. The findings included: During an environmental tour for room #253, it was observed that the heating/air condition unit covering was off. The window was observed to have a copious amount of dust. The Activity room on Unit 1-B was observed to have wall paper coming down. Room #250 was observed with a hole in the wall. Room #235 had a hole in the wall. Room #249-A had tube feed on bed rail and over-bed table. Room #101 had dirt, lint and debris under heat/air	F 584	Room #253 heating/air conditioning unit cover was fixed and window was dusted on 3/5/19. Unit-1 activity room wall paper corrected on by maintenance on 3/5/19. Rooms #250, #235, #114, #173, walls holes repaired by Maintenance. Rooms # 144, #101, #105, #249, #173 was cleaned, swept, and mopped by housekeeping. All residents have the potential to be affected. The facility conducted a facility room audit to identify areas that need maintenance repair work and /or housekeeping. To be completed 3/15/19. Maintenance and housekeeping staff has been educated by Executive Director on audit sheets to identify rooms needing repair and/or housekeeping to maintain a clean comfortable, home like environment to completed on 3/15/19. Housekeeping has been re educated on proper housekeeping techniques by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 condition unit. Room #105 had dirt, lint and debris under air condition unit. Room #114 had holes in the walls. Room #144 had dirt, lint and debris under heat/air condition unit. Room #173 had holes in the wall and dirt, lint and debris under the air condition unit. During an interview with the Assistant Administrator on 2/19/19 at 3:30 P.M. he stated that a new house keeping group was in the building to catch up on the cleaning and repairs of resident rooms. Facility staff failed to maintain a clean comfortable homelike environment. Compliant deficiency.	F 584	Housekeeping supervisor on 3/8/19. The Executive Director and/or designee will complete an audit on the facility grounds and resident rooms five times a week for four weeks then weekly for four weeks then monthly for six months to ensure a clean comfortable homelike environment. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 6	F 622		

otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 7 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility staff failed to provide care plan information to the receiving provider at the time of transfer to the hospital for 1 of 62 Residents in the survey sample, Resident #94 The facility staff failed to convey Resident #94's comprehensive care plan goals upon transfer to	F 622	Resident # 94, resident was returned to the facility on 1/30/18 and has been here ever since . Residents who are transferred out of the facility have the potential to be affected. 30 day review from 2/20/19, residents who were transferred were in compliance. DCS, SDC and/or Designee will re-educate the staff to provide the care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 8 the acute care hospital on 1/24/18. The findings included: Resident #94 was originally admitted to the facility 8/19/14 and was readmitted to the facility 1/30/18, after an acute care hospital stay. The current diagnoses included; paraplegia secondary to a gunshot wound, chronic sacral pressure ulcer, neurogenic bladder with suprapubic catheter placement and recurrent urinary tract infections. The significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #94's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring no help from staff with his activities of daily living. Review of the discharge MDS assessment dated 1/24/18, revealed Resident #94 was discharged-return anticipated. Review of the clinical record revealed a nurse's note dated 1/24/18, which stated Resident #94 requested a transfer to the local acute care hospital's emergency room, even after a visit by the nurse practitioner. Another nurse's note stated he was transported to the hospital at 1:00 p.m. Included on the Hospital Transfer Form was the following information; Contact information of the practitioner who was responsible for the care of	F 622	plan to the receiving provider at the time of transfer to the hospital. The Unit Managers and/or designee will conduct an audit of to ensure the care plan is provided at the time of transfer to the receiving facility daily times 8 weeks. The results will be reported to the Quality Assurance Performance Committee by the DCS for further compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 9	F 622		

the resident, Resident representative information, including contact information, Advance directive information, Treatments and devices, precautions such as isolation or contact, special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions, resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs, some recent immunizations, and allergies.

No documentation was included which stated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.

On 2/14/19 at approximately 5:30 p.m., the Director of Nursing stated at the time of Resident #94's hospital transfer the facility staff was not aware the comprehensive care plan goals were a requirement therefore it was not conveyed to the receiving provider, but since she learned of the requirement a plan of action was put in place effective 10/1/18, however compliance was not achieved.

On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not.

The facility's policy with a revision date of 3/26/18, titled "Transfer/Discharge Notification and Right to Appeal" read under procedure Documentation; When the center transfers or discharges a resident under any circumstances listed above

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 10 the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the medical record to include; the basis for the transfer. The specific resident need(s) that cannot be met, The facility's attempt to meet the resident's needs and the service available at the receiving facility to meet those need(s). Information provided to the receiving provider must include but is not limited to; contact information of the practitioners responsible for the care of the resident. Resident representative information including contact information, Advanced Directives. Special care instructions or precautions for ongoing care as indicated. Comprehensive care plan goals, All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and the facility's policy, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharge for 1 of 62 residents (Resident #94) in the survey sample. The facility staff failed to notify the Long-Term Care Ombudsman of Resident #94's discharge and admission to a local acute care hospital on 1/24/18. The findings included: Resident #94 was originally admitted to the facility 8/19/14 and was readmitted to the facility 1/30/18, after an acute care hospital stay. The current diagnoses included; paraplegia secondary to a gunshot wound, chronic sacral pressure ulcer, neurogenic bladder with suprapubic catheter placement and recurrent urinary tract infections. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #94's daily decision making abilities were intact. In section "G" (Physical functioning) the resident was coded as requiring no help from staff with his activities of daily living. Review of the discharge MDS assessment dated	F 623	Resident #94 Notification to the local Ombudsman of hospital discharge on 3/8/2019 by the DCS. Resident return to facility 1/30/2018 and remains in the facility. All transfer and discharges have the potential to be affected by failing to notify local Ombudsman of discharges. Ombudsman was notified on 3/8/19 for discharges for previous month. All License staff will be educated by the DCS on notification of local Ombudsman. Per Local Ombudsman, discharge list will be sent once a month. DCS or Designee will Audit Ombudsman then monthly for 4 months and the results will be reported to the Quality Assurance Performance Committee by the DCS for compliance for 4 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 14	F 623		

1/24/18, revealed Resident #94 was discharged-return anticipated.

Review of the clinical record revealed a nurse's note dated 1/24/18, which stated Resident #94 requested a transfer to the local acute care hospital's emergency room, even after a visit by the nurse practitioner. Another nurse's stated he was transported to the hospital at 1:00 p.m.

Included on the Hospital Transfer Form was the following information; Contact information of the practitioner who was responsible for the care of the resident, Resident representative information, including contact information, Advance directive information, Treatments and devices, precautions such as isolation or contact, special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions, resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs, some recent immunizations, and allergies.

No documentation was included which stated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.

On 2/14/19 at approximately 5:30 p.m., the Director of Nursing stated at the time of Resident #94's hospital transfer the facility staff was not aware of the requirement to notify the Long-Term Care Ombudsman therefore he was not notified; but since she learned of the requirement a plan of action was put in place effective 10/1/18, however compliance was not achieved..

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 15 On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not. The facility's policy with a revision date of 3/26/18, titled "Transfer/Discharge Notification and Right to Appeal" read under procedure, Notice Before Discharge; The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 16 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and the facility's policy, the facility staff failed to provide written information to residents explaining how a resident's bed is held while the resident is absent from the facility due to hospitalization for 1 of 62 residents (Resident #94) in the survey sample. The facility staff failed to provide written information to the resident or resident representative which specifies the duration of the bed-hold policy upon transfer to the local acute care hospital on 1/24/18. The findings included: Resident #94 was originally admitted to the facility 8/19/14 and was readmitted to the facility 1/30/18, after an acute care hospital stay. The current diagnoses included; paraplegia secondary to a gunshot wound, chronic sacral pressure ulcer, neurogenic bladder with suprapubic catheter placement and recurrent urinary tract infections. The significant change Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/7/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. This indicated Resident #94's daily decision making abilities were intact.	F 625	Resident #94 readmitted to the facility on 1/30/18 and returned to his previous bed. All residents have the potential to be affected. The facility will conduct a review of all residents to ensure the resident or resident representative were given the bed hold policy upon transfer to the local hospital 30 day review from 2/20/19, residents who were transferred were in compliance. The executive director to educate business development coordinator, care liaison and social services regarding ensuring written information was given to the resident regarding bed hold upon transfer to local acute care hospitals, to be completed on 3/15/19. The nurses, care liaison or business development coordinator will ensure that all transfers are provided in writing information regarding the bed hold policy. The LNHA will review the log monthly times three (3) months and then quarterly thereafter; ensuring process consistency and regulatory compliance. Variances will be addressed promptly; and the log shall be maintained and reviewed monthly in QAPI committee times three (3) months and then quarterly, until otherwise	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 17 In section "G" (Physical functioning) the resident was coded as requiring no help from staff with his activities of daily living. Review of the discharge MDS assessment dated 1/24/18, revealed Resident #94 was discharged-return anticipated. Review of the clinical record revealed a nurse's note dated 1/24/18, which stated Resident #94 requested a transfer to the local acute care hospital's emergency room, even after a visit by the nurse practitioner. Another nurse's note stated he was transported to the hospital at 1:00 p.m. Included on the Hospital Transfer Form was the following information; Contact information of the practitioner who was responsible for the care of the resident, Resident representative information, including contact information, Advance directive information, Treatments and devices, precautions such as isolation or contact, special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions, resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs, some recent immunizations, and allergies. No documentation was included which stated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer. On 2/14/19 at approximately 5:30 p.m., the Director of Nursing stated at the time of Resident	F 625	determined by the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 18 #94's hospital transfer the facility staff was not aware of the requirement to provide written information to the resident or resident representative of the facility's bed-hold policy therefore; he was not notified, but since she learned of the requirement a plan of action was put in place effective, 10/1/18, however compliance was not achieved.. On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not. The facility's policy with a revision date of 3/26/18, titled "Transfer/Discharge Notification and Right to Appeal" read under procedure, Notice Before Transfer; Notify the resident and resident representative(s) of the transfer or discharge and the reason for the move in writing (in a language and manner they understand). Record the reasons for the transfer or discharge in the resident's medical record.	F 625		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for 1 of 62 residents (Resident #183) in the survey	F 677	Resident # 183 is not a current resident in the facility.Current residents that receive showers have the potential to be affected.	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 19 sample who was unable to independently carry out activities of daily living (ADL's). The facility staff failed to ensure Resident #183 was offered and received a scheduled twice-weekly showers to maintain good personal hygiene. The findings included: Resident #183 was originally admitted on 10/25/18 with a readmission date of 11/02/18. Diagnoses for Resident #183 included, but not limited to, Major Depressive Disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 01/18/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. In addition, the MDS coded Resident #183 total dependence of two with bathing and transfer, extensive assistance of two with bed mobility, dressing and toilet use and extensive assistance of one with physical hygiene for Activities of Daily Living care. Resident #183 was also coded always incontinent of bowel and frequently incontinent of bladder. The comprehensive care plan dated 11/16/18 with a revision date of 02/01/19 identified Resident #183's as having an ADL self-care performance deficit. The goal set for the resident by the staff was that the staff will maintain current level of function in all areas of ADL's. One of the interventions/approaches the staff would use to accomplish this goal included bathing and showering: provide sponge bath when a full bath or shower cannot be tolerated and per resident	F 677	The SDC and or designee will educate the Nursing staff on residents being offered and receiving personal care including showers. The DCS (Director of Clinical Service) and or designee will audit Monday □ Friday for 2 weeks, Twice weekly audits for 2 weeks, weekly for 4 and monthly for 2 month the results will be reported to the Quality Assurance Performance Committee by the DCS for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 20	F 677		

scheduled and routine.

An interview was conducted with Resident #183 on 02/12/19 at approximately 12:20 p.m., who stated, "I'm not receiving showers like I am supposed to." The surveyor asked, "How often are you getting showers" she replied, "None for this month but probably like 5-6 since I've been here." The surveyor asked, "Do you want your showers," she replied, "I would love to have my showers but they don't even offer them to me."

On 02/13/19, the surveyor reviewed the unit's shower scheduled. Resident #183 was scheduled to have showers given every Tuesday and Friday (3-11 shift).

Review of Resident #183's documentation survey report for bathing concluded the following:
Showers were not given on the following shower days:
-February 2019 (02/01, 02/05, 02/08, 02/12).
- December 2018 (12/07, 12/14, 12/18, 12/21, 12/25).
-November 2018 (11/02, 11/9, 11/30).
-October 2018 (10/26).

An interview was conducted with the Director of Nursing (DON) on 02/14/19 at approximately 4:10 p.m. The DON reviewed Resident #183's clinical record then stated, "I was unable to locate in Resident #183's clinical record where she refused her showers."

A phone interview was conducted with Certified Nursing Assistant (CNA) #13 on 02/19/19 at approximately 9:45 a.m. The CNA stated, "The resident refused her shower 02/05/19." The surveyor asked, "What is your process when a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 21 resident refuses care" she replied, "I document her refusal and informed the charge nurse." A phone call was placed to CNA #12 on 02/19/19 at approximately 9:30 a.m. The CNA was assigned to Resident #183 on her shower day; 02/08/19. The CNA called back at 10:46 a.m., who stated, "That might be my initials but I did not have her on 02/08/19." A phone call was placed to CNA #11 on 02/19/19 at approximately 9:33 a.m. The CNA was assigned to Resident #183 on her shower days; a message left, CNA never called back. The Administrator and DON was informed of the finding during a briefing on 02/14/19 at approximately 3:30 p.m. The DON stated, "Resident #183 should be getting her showers twice a week and as needed and if she declines; the refusal should be documented. The facility's policy titled Bathing/Showering (Revision date: 09/01/17). -Policy: Assistance with showering and bathing will be provided at least twice a week and as needed to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and as needed cleaning. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference. Compliant Deficiency.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and facility document review, the facility staff failed to provide the necessary care and services to prevent and treat a pressure ulcer and promote healing for 1 of 62 residents (Resident #183) in the survey sample. The facility staff failed to identity a left heel pressure ulcer prior to it being found at an advanced stage; the pressure ulcer was found as an unstageable with 100% eschar (hard black dead tissue). And, the facility staff failed to implement pressure relieving devices as ordered by the physician. The findings included: Resident #183 was originally admitted on 10/25/18 and readmitted on 11/02/18. Diagnoses for Resident #183 included, but not limited, to Major Depressive Disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date	F 686	Resident # 183 no longer resides in facility. Current residents have the potential to be affected. Skin assessments completed on 2/21/2019. The SDC and or designee will educate the License staff on completing skin assessment and follow up,and wound identification. The DCS (Director of Clinical Service) and or designee will do skin audit Twice weekly audits for 4 weeks, weekly for 4 and monthly for 2 month, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

(ARD) of 01/18/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment. In addition, the MDS coded Resident #183 with total dependence of two with bathing and transfer, extensive assistance of two with bed mobility, dressing and toilet use and extensive assistance of one with physical hygiene for Activities of Daily Living care. Resident #183 was also coded always incontinent of bowel and frequently incontinent of bladder.

The MDS with an ARD of 01/18/19 under section "M" (Skin Condition-M0100) was coded: Resident has a stage 1 or greater pressure ulcer. Under section (M0150) at risk for developing pressure ulcers was coded yes, under section (M0210) for unhealed pressure ulcers was coded yes, under section (M0300) for having unstageable (1) pressure ulcer was coded yes. Under section (M1200) for skin and treatments was coded for having pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer care and applications of ointments/medications other than feet.

Resident #183's comprehensive care plan dated 12/5/18, prior to finding the left heel prior ulcer, included the following: potential for impaired skin integrity related to fragile skin incontinence and edema. The goal: Resident will have intact skin, free of redness, blisters or discoloration through the next review on 02/01/19. Some of the intervention/approaches to manage goal included: administer treatments as ordered and monitor for effectiveness, float heels, follow physician order for preventative treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24	F 686		

Resident #183 comprehensive care plan with a revision date of 01/31/19 documented resident has pressure ulcer to left heel related to decreased mobility, 01/08/19 left heel unstageable and on 01/31/19- left heel is now a stage II. The goal: the resident's pressure injury will show signs of healing and have minimal risk of infection. Some of the intervention/approaches to manage goal included: administer treatment as ordered and monitor for effectiveness, float heels as indicated while in bed, follow facility policies/protocol for the prevention/treatment of skin breakdown and follow physician order for preventative treatment.

Skin sheets for the 3 weeks prior to the findings were completed with no areas identified.

A Braden Risk Assessment Report was completed on 10/25/18; resident scored a 15 putting Resident #183 at risk for the development of pressure ulcers. Mobility is very limited; makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.

During the initial tour on 02/12/19 at approximately 12:20 p.m., Resident #183 was observed in bed lying in a supine position with her heels position directly on the bed. The resident stated she has a sore to her left heel. The resident's pillow was observed sitting on top of her clothes basket and her prevalon boot was observed sitting on the seat of her wheel chair. On the same day at approximately 3:15 p.m., Resident #183's heels remained directly on the bed. The pillow was still on top of resident clothes basket and the prevalon boot remained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25	F 686		

on the seat of resident's wheel chair.

On 02/13/19 at approximately 9:05 a.m., Resident #183's bilateral heels remained positioned directly on the bed. Her pillow was still on her clothes basket and the prevalon boots remained on the seat of her wheel chair.

Review of Resident #183's clinical note dated 01/05/19 at approximately 9:54 p.m., included the following information: unstageable wound noted to left heel of foot, treatment in place, will endorse to oncoming nurse and wound nurse.

Review of Resident #183's Physician Order Sheet (POS) for February 2019 included the following orders: Starting on 12/07/18 to elevate feet with pillow every shift.

Resident #183's wound care was observed was conducted on 02/13/19 at approximately 12:54 p.m., with Registered Nurse (RN) #2. Prior to starting wound care, RN #2 removed the pillow off the resident's clothes basked then position it under Resident #183's left foot. The dressing was removed from the left heel wound. The wound was observed with a red wound bed with sanguineous drainage with an intact peri-wound edge. After the RN had completed the pressure ulcer care to the left heel, she floated the left heel on the pillow. The right heel remained positioned directly on the bed and the prevalon boots remained sitting in the seat of Resident #183's wheel chair.

Review of Resident #183's Treatment Administration Record (TAR) included the following order starting on 01/06/19: Santyl ointment-apply to left heel topically one time a day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26	F 686		

for unstageable-cleanse heel with dermal wound cleanser-apply santyl ointment, cover with dry dressing.

Review of Resident #183's Physician Order Sheet (POS) for February 2019 included the following orders: Starting on 01/07/19 to apply prevalon boots while in bed every shift for left heel (eschar).

Order changed to left heel wound on 01/08/19: Discontinue Santyl-start Betadine swabsticks-apply to left heel topically every shift for left heel eschar, cover with abdominal pad and wrap with kerlex.

Order changed to left heel wound on 01/30/19 to start Hydrogel: clean left heel open wound daily with normal saline, apply Hydrogel to wound bed, cover with dry dressing daily for stage II pressure ulcer.

Review of Resident #183's pressure ulcer wound round form included the following information to the left heel:

On 01/08/19, the wound measured 2.9 cm x 1.5 cm (stage-unstageable), wound bed with eschar, black in color with small amount of sero-sanquienous drainage with intact peri wound area.

On 01/18/19, the wound measured 2.5 cm x 1.5 cm (stage-unstageable), wound bed with eschar, black in color with no drainage noted with intact peri wound area.

On 01/24/19, the wound measured 2.5 cm x 1.5 cm (stage-unstageable), wound bed with eschar,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27	F 686		

black in color with no drainage noted with intact peri wound area.

On 01/29/19, the wound measured 2.8 cm x 2.3 cm x 0.1 cm (stage II), wound bed with eschar, black in color with no drainage noted with intact peri wound area.

On 02/07/19, the wound measured 2 cm x 1.3 cm (stage II), wound bed with epithelial with red wound bed, small amount of sero-sanquieous drainage with intact peri wound area.

The current treatment as of 02/13/19 was to cleanse left heel wound with normal saline, apply Hydrogel to wound bed, cover with dry dressing daily.

An interview was conducted with Director of Nursing (DON) on 02/14/19 at approximately 9:25 a.m. The surveyor asked, "At what stage do you expect for your staff to first identify a pressure ulcer" she replied, "A stage 1 but no greater than a stage II."

An interview was conducted with the RN #3 (Wound Nurse) on 02/14/19 at approximately 9:47 a.m., who stated, "I went to evaluate the pressure ulcer to Resident #183's left heel." On 01/08/19, the resident asked her to look at her foot because it felt like it was draining. The wound nurse said she removed the dressing from the left heel. The left heel was observed with a pressure ulcer that was black in color (wound unstageable due to black eschar) with a little bit of drainage.

A phone interview was conducted with RN #2 on 02/15/19 at approximately 1:40 p.m. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28	F 686		

surveyor asked, "Prior to starting Resident #183's treatment to her left foot pressure ulcer on 02/13/19 at approximately 12:54 p.m., where were her prevalon boots. The RN stated, "I do not know where they were but I do not remember removing them." The surveyor asked, "After we you finished providing wound care to Resident #183's left heel, should the prevalon boots have been applied or heels elevated after treatment" she replied, "Yes, the prevalon boots should have been applied to her heels; she has an order to wear them while in bed." The surveyor asked, "What is the purpose for Resident #183 wearing the prevalon boots that was ordered by the physician" she replied, " Resident #183 has spasms (involuntary muscle contraction of sudden onset) and involuntary movement (occurring without conscious control or direction) and that may be how she got that pressure ulcer to her left heel." The surveyor asked, "Was Resident #183's preventive measuring put in place to prevent further pressure ulcers, she replied, "Not at that time but they should have been" the surveyor asked, "What should have been" she replied, "Here prevalon boots should have been on while in bed to help prevent further skin breakdown/pressure ulcers."

On 02/19/19 at approximately 9:15 a.m., a phone interview was conducted with Director of Nursing (DON). The surveyor asked, 'What is your expectation for following physician orders, she replied, "I expect for the nurses to apply the prevalon boots according the physician orders" the surveyor asked, "What is the purpose for wearing the prevalon boots" she replied, "To maintain pressure relief."

A phone call was placed to License Practical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

Nurse (LPN) #7 on 02/19/19 at approximately 9:33 a.m. The LPN was assigned to Resident #183 on 01/05/19, who first identified the unstageable to the left heel; a message was left, LPN never called back.

Definitions:

1. Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

2. Pressure Injury-Stage 2-Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions (http://www.npuap.org/resources/educational-and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	**3900 LLEWELLYN AVE NORFOLK, VA 23504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 -clinical-resources/npuap-pressure-injury-stages). 3. Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). 4. Prevalon helps minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals. By off-loading the heel, it delivers total, continuous heel pressure relief (www.hdis.com/prevalon-boot-heel-protector.html). 4. Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts). 6. Betadine swab stick helps reduce bacteria that can potentially cause skin infection (www.drugs.com). 7. Hydrogel is ideal for dry-to-moist clean wounds. Helps create a moist wound environment. Balanced formulation Easy irrigation	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31 Indications: pressure ulcers, partial and full-thickness wounds, leg ulcers, surgical wounds, lacerations, abrasions and skin tears, and first- and second-degree burns (www.medline.com/product/Skintegrity-Hydrogel/Gel/Z05-PF00182). The facility's policy titled Clinical Guideline Skin and Wound (Effective 04/01/17). -Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure ulcer.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to implement interventions to reduce a potential accident hazard for 1 of 62 residents (Resident #183) in the survey sample. The facility staff used a pair of sharp tip scissors to cut off Resident #183's dressing to her left foot. This could have caused potential injury by cutting or poking the resident's skin.	F 689	Nurse #2 was educated immediately on 2/13/19 on the potential hazard of using sharp scissor during wound care and provided bandage scissors. Residents with treatments have the potential to be affected. Bandage scissors are available on treatment carts. The SDC and or designee will educate the License staff on using bandage scissors during wound care.	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 The findings included: Resident #183 was originally admitted on 10/25/18 with a readmission date of 11/02/18. Diagnosis for Resident #183 included but not limited to Major Depressive Disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 01/18/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #183 total dependence of two with bathing and transfer, extensive assistance of two with bed mobility, dressing and toilet use and extensive assistance of one with physical hygiene for Activities of Daily Living care. During a wound dressing observation on 02/13/19 at approximately 12:54 p.m., with Registered Nurse (RN) #2, the RN used regular scissors with a sharp pointed tip to cut the dressing from Resident #183's left foot pressure ulcer wound. The RN slipped the sharp pointed tip scissors under the wrapped kling dressing. The RN starting cutting the dressing from distal to proximal without having visibility of Resident #183's skin while cutting the dressing away from the resident's left foot. After completion of the wound care, the surveyor asked, "What type of scissors should have used when cutting off Resident #183's dressing" she replied, "Probably bandage scissors because the edge is not sharp; they are dull and it will not cut the resident's skin." The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 02/14/19 at approximately 3:30 p.m. The surveyor asked, "What type of scissors should	F 689	The DCS (Director of Clinical Service) and or designee will do wound care observation audit Weekly audits for 4 weeks, Monthly for 2 month. The results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for compliance and or revisions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33 the nurse have used when removing the dressing from Resident #183's left foot" the Administrator replied, "I'm not a nurse but I think bandage scissors because they will not poke the resident's skin." The Administrator also said "bandage scissors would cause less harm to the skin; regular scissors could potentially cause injury to the skin."	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy, the facility staff failed to ensure that pain management was provided for 1 of 62 residents (Resident #80) in the survey sample. The facility staff failed to administer the scheduled opioid pain medication (Hydrocodone-Acetaminophen tablet 5/325 milligrams) to Resident #80, for over 16 consecutive hours; resulting in unnecessary and debilitating pain, constituting harm. The findings included: Resident #80 was originally admitted to the facility 2/1/18 and had never been discharged. The current diagnoses included; a sacral pressure ulcer and chronic pain.	F 697	1. Resident # 80 refill was received. 2. Residents receiving pain medication have the potential to be affected. An audit of prescription refill and supply of pain medicine was completed and no other residents were affected. 3. The SDC and or designee will educate the License staff on medication refill and reordering policy and procedure, also Stat and Emergency box use. 4. The Unit Mangers and or designee will audit all prescriptions for narcotics twice weekly on Monday and Thursdays for refills and new prescriptions for 4 weeks, weekly for 4 and monthly for 2 month, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance and or revision.	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 34	F 697		

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/12/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #80's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with bed mobility, transfers, walking, locomotion, personal hygiene, dressing and eating, extensive assistance of 1 with bathing and toilet use.

In section "J" Resident #80 completed the pain interview which was coded as he was not experiencing pain and he was not receiving scheduled or as needed pain medication, but at section N0410H; the resident was coded as receiving opiods 7 out of 7 days.

An initial interview was attempted with Resident #80 on 2/12/19, at approximately 12:40 p.m., but he asked for the interview to be completed later. The resident was observed lying in bed in a fetal position, with his arms folded.

An interview was conducted with Resident #80, 02/13/19, at approximately 1:33 p.m. The resident stated "when you came by yesterday I was hurting too bad I wanted to talk but I couldn't even get out of bed to empty my urinal." He further stated he had "last received his scheduled pain medicine 2/11/19, at approximately 1:00 p.m. and didn't receive any more until after 2:00 p.m., 2/12/19." The resident also stated the nurses allowed his medication to run out before they ordered more and it wasn't the first time it happened. The resident stated, he "felt they only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 35	F 697		

got the medication for me to take on 2/12/19, because the state was in the building" and stated "by that time the nurse gave it me, (he) hurt so bad I had tears in my eyes." The resident stated "when my pain gets bad like it did on 2/12/19, it takes at least two days to get pain back to a level tolerable." Resident #80 also stated that, "the nurses tell me when there is no Hydrocodone-Acetaminophen tablet 5/325 milligrams available, I can have Tylenol, which does not help, so I don't take it."

The physician order summary revealed, Resident #80 had a physician's order dated 8/1/18 for Hydrocodone-Acetaminophen tablet 5/325 milligrams. Give one tablet by mouth every eight hours related to other chronic pain.

The active care plan dated 8/22/18, had a problem which read; (name of resident) has alteration in pain/comfort related to left stump neuropathy. The first goal read; (name of resident) will voice/demonstrate no side effects related to the use of analgesia through the review date 4/30/19. The second goal read, (name of resident) will not have an interruption in normal activities due to pain through the next review date 4/30/18. The third goal read, (name of resident) will not demonstrate decline in overall function related to pain through the next review 4/30/18. The interventions included; treatment per current physician order related to neuropathy. Administer analgesia as per orders and prior to treatments or care as needed. Evaluate the effectiveness of pain interventions. Review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Monitor and report for side effects of pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 36	F 697		

Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician and/or nurse practitioner. Social service consult as needed.

Hydrocodone-Acetaminophen is a schedule III opioid pain medication.

Review of the Controlled Medication Utilization Record revealed on 2/11/19 at 2:00 p.m. Resident #80 was administered one Hydrocodone-Acetaminophen tablet 5/325 milligrams and the next dose was administered 2/12/19 at 2:00 p.m. Also a bold printed note dated 1/31/19, was written on the top of the Controlled Medication Utilization Record from the pharmacy which read; please contact your physician for a new prescription to maintain therapy. This is the last partial fill from this prescription. On 2/1/19, the facility's nurse who received the medication wrote on the form, Hydrocodone-Acetaminophen tablet 5/325 milligrams; thirty tablets received.

A nurse's note dated 2/11/19 at 9:35 p.m. read an order was received for Hydrocodone-Acetaminophen tablet 5/325 milligrams. Give 1 tablet by mouth every eight hours related to other chronic pain, awaiting pharmacy. The hard script dated 2/11/19, for Hydrocodone-Acetaminophen tablet 5/325 milligrams was signed by the nurse practitioner for thirty tablets was observed.

A concern note dated 2/12/19, (no time documented) was written on behalf of Resident #80. It read; Concern: Did not receive pain medication, medication ran out. Investigation: No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 37	F 697		

medication on the cart, called pharmacy, spoke with (name of the individual). Resident has two orders (for what medication was not documented) one with refills. One with refills, will send out on noon run. Action taken: Medication pulled from back up box. Assistant Director of Nursing was aware Resident #80's personal Hydrocodone-Acetaminophen was exhausted she obtained the medication from the contingency supply box. The process requires the nurse to call the pharmacy, who will review the prescription and give the nurse a code, the nurse will document the authorization code and obtain the medication from the contingency box to administer to the resident. This procedure ensures a resident is never in pain because the pain medication isn't available in their personal supply when it is available in the contingency box.

A Removal of Controlled Substance Medication From Contingency Supply form dated 2/12/19, at 2:00 p.m., revealed one Hydrocodone-Acetaminophen tablet 5/325 milligrams was obtained for Resident #80.

On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. The Director of Nursing stated the resident had two prescriptions one had refills and the controlled medication box contained the medication Hydrocodone-Acetaminophen tablet 5/325 milligrams for which the resident had a prescription. The Director of Nursing also stated medications should be reordered at when a three day supply is left to ensure it arrives to the facility timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 38 The facility's undated policy titled Ordering Schedule III, IV and V controlled Medications. Under Procedure 4.6 1 read; schedule III, IV and V medications may be dispensed and delivered to the Community only upon valid prescription written by a Physician/Prescriber and received by the Pharmacy, or facsimile of a prescription from the Physician/Prescriber's office or pursuant to an oral prescription from the Physician/Prescriber made directly to the pharmacist. 3. New and refill orders for Schedule III, IV and V controlled medications must be ordered as specified in the regular ordering medication procedure.	F 697		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on information obtain during the Infection Control task, staff interview, and facility documentation review, the facility staff failed to ensure 1 of 62 residents was free from unnecessary drugs (Resident #68), in the survey sample. The facility staff administered 18 doses of Ciprofloxacin (an antibiotic) to Resident #68, for a bacteria resistant to the drug. The findings included: Resident #68 was originally admitted to the facility 9/27/13 and readmitted to the facility after an acute care hospital stay 9/27/16. The resident's current diagnoses included; dementia, schizophrenia, depression high blood pressure, and a seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/5/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #68's cognitive abilities for daily decision making are moderately impaired. In section "E" (Behaviors) the resident was coded for rejecting care daily. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene, and total care of 1 person with bathing. The active care plan with a revision date of 1/14/19, had a problem which read; the resident	F 757	Resident #68 a current resident, Correct medication ordered and received on 1/2/2019. Residents receiving medication have the potential to be affected by receiving un-necessary medication. No other residents have been affected. The Assistant Director of Nursing (ADON) and or designee will educate the License staff Antibiotic stewardship and follow practices and policies. The ADON and or designee will do weekly audits for 4 weeks, and monthly for 2 month for use of antibiotics, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance and or revisions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 40	F 757		

has a potential for urinary tract infections (UTI), related to a history of UTIs. The goal read; (name of resident) will remain free of signs/symptoms of UTIs through 3/5/19. The interventions read: Encourage adequate fluid intake. Monitor/document/report to the physician as needed for signs/symptoms of UTIs.

During the Infection Control interview the Assistant Director of Nursing stated Resident #68 exhibited a change in appetite as well as behavior and the urine culture revealed two bacteria of than greater 100,000 colonies; Escherichia Coli (E-Coli) and Extended spectrum beta lactamase (ESBL) requiring the resident to be placed on contact precautions.

A nurse's note dated 12/21/19, at 2:20 a.m., read; "collected urine sample via straight catheter for the ordered urine analysis (UA), culture and sensitivity (C&S) without any problem. No noted odor or cloudiness to the urine sample".

A physician's order dated 12/23/18, revealed an order for Ciprofloxacin Hcl 500 milligram tablets by mouth two times a day for 10 days.

A laboratory report dated 12/23/18 revealed the bacteria growing in Resident #68 urine was resistant to the antibiotic Ciprofloxacin.

A nurse's note dated 12/24/18, read; "Nurse Practitioner notified of lab results, no signs/symptoms of seizure activity, tolerating medications".

Review of the Medication Administration record revealed Resident #68 received the antibiotic Ciprofloxacin 500 milligrams two times daily for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 41	F 757		

UTI, from 12/24/18, through 1/1/19, totaling 18 doses.

On 1/2/19, a nurse's note read Nitrofurantoin Macrocrystal capsule 100 milligrams; give 1 capsule by mouth 2 times a day for UTI for 9 days.

On 2/19/19 at approximately 11:45 a.m., at the conclusion of the Infection Control task the Assistant Director of Nursing stated, "I have some work to do to ensure this doesn't occur again."

The Medication Administration Record also revealed from 6 p.m., 1/3/19 through 12 noon 1/9/19, Resident #68 was administered Nitrofurantoin Macrocrystal Capsules 100 milligrams by mouth every 8 hours for a UTI.

Further review of the laboratory report received by the facility staff on 12/23/18, revealed the two bacteria in Resident #68's urine were susceptible to Nitrofurantoin.

The Nurse Practitioner note dated 1/3/19 read; "patient has episodes of refusing medications and altered mental status. Patient had UA and C&S done. Her urinalysis looks infected. She was started on Cipro, pending urine culture. He urine culture however came back 100,000 E-Coli, ESBL. No report of fever or chills. Report that patient is taking her medications. Also noted her Dilantin level was low, however she was refusing medications."

On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 42 opportunity was given for the facility to provide additional information; no further information was provided by the facility staff.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to ensure medications were stored in a secured location, accessible to designated staff only on 1 of 4 units (Unit 1-A).	F 761	Nurse #2 was educated on 2/13/2019 RE: securing medication in cart. Current Residents receiving over the counter medication have the potential to be affected.	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 43 The facility staff failed to ensure the following medications (Vitamin B12 500 mcg, Multivitamin, Folic Acid 400 mcg, Claritin 10 mg, Magnesium Oxide 400 mg and Calcium + DS 600 mg) were stored in a secured location, accessible to designated staff only. The findings included: Resident #29 was originally admitted on 03/10/15 with a readmission date of 03/27/15. Diagnoses for Resident #29 included but not limited to, Schizophrenia. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 11/10/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. On 02/13/19 at approximately 8:21 a.m., during the medication pass and pour observation, Registered Nurse (RN #2), pulled medications for Resident #29. The RN and surveyor walked to room 114 where the RN administered the medications to Resident #29. The RN and surveyor returned back to the medication cart and observed (6) bottles of medication left on top of the cart; the medications were *Vitamin B12 500 mcg, Multivitamin, Folic Acid 400 mcg, Claritin 10 mg, Magnesium Oxide 400 mg and Calcium + DS 600 mg). The surveyor observed 3 staff members and 2 residents walking by the medication cart. The RN stated, "I should have put the medications back inside the cart before going to administer Resident #29 his medication.	F 761	The SDC and or designee will educate the License staff on medication storage. The DCS and or designee will audit medication storage observation five times week for 1 week, Twice weekly for 2 weeks, weekly for 2 and monthly for 2 month the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance and / or revisions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 44 An interview was conducted with the Director of Nursing (DON) on 02/13/19 10:05 a.m., who stated, "The nurse should have put the medications back inside the medication cart before administering medication to Resident #29. The Administrator and DON was informed of the finding during a briefing on 02/14/19 at approximately 3:30 p.m. The facility did not present any further information about the findings. The facility's policy titled 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles (Last Revision date: 10/31/16). -General Storage Procedures: 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a lock cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F 791		4/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 45 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on a resident record review, staff interviews, facility document review and resident interview the facility staff failed to obtain dental services review for 1 of 62 residents in the survey sample, Resident #146. The facility staff failed to follow physician orders and obtain dental care for Resident #146. The findings included:	F 791	1. Resident #146 dental services continue to be followed up. Resident #146 had follow up x-rays on March 18, 2019. Resident #146 is going to the OR for a tooth extraction scheduled for April 6, 2019. Resident #146 physician orders will be followed. 2. Current residents have the potential to be affected. No other residents are affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 46 Resident #146 was admitted to the facility 11/10/2017. Diagnoses included but were not limited to Psychosis, Non-Alzheimer's Dementia and Major Depressive Disorder. Resident #146's Minimum Data Set (an assessment protocol) Quarterly with an Assessment Reference Date of 01/17/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 10 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #146 as requiring extensive assistance of 2 with bed mobility, dressing, personal hygiene, supervision and set up help only for eating and total dependence of 2 with toilet use and bathing. On 02/13/2019 at 10:44 a.m., an interview was conducted with Resident #146 and he stated, "I have a cavity. I've had a toothache for about a month. They are supposed to be making an appointment for me." On 02/14/2019 at 9:00 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #4 and made her aware that Resident #164 had stated he had a cavity and a toothache. LPN #4 said she would get a dental appointment for the resident. Resident #146 physician orders was reviewed and are documented in part, as follows: 04/30/2018: Dental consult for dental caries. 08/27/2018: Resident is to have a full Panoramic x-ray and mouth series done at a (Name) facility prior to dental appointment. On 02/14/2019 at 9:05 a.m. an interview was	F 791	3. The DCS, SDC and or designee will educate the License staff ensuring residents obtain dental services. 4. The Unit Mangers and or designee will audit to ensure residents receive dental services as ordered by the physician twice weekly for 4 weeks, weekly for 4 weeks and monthly for 2 month, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 moths for further compliance and or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 47	F 791		

conducted with LPN #5 regarding Resident #146's Physician Orders dated 4/30/18 and 8/27/18. LPN #5 stated, "I knew about the Resident requesting to see the dentist and he had been sent out via stretcher on September 2, 2018. He was referred by (Name) Oral Surgeon to have a Panoramic X-ray done. The Resident was unable to sit up so the x-ray couldn't be done."

This surveyor requested a copy of documentation concerning Resident #164 going out to dentist and x-ray procedure. The facility was unable to provide any documentation.

Resident # 146's Progress Note dated 1/24/19 was reviewed and is documented in part, as follows:

1/24/2019 21:08 (9:08 P.M.): resident complained of tooth pain. Scheduled pain med given with positive effects. Requesting dental appointment. md(Medical Doctor)/rp(Responsible Party) and social worker notified."

On 02/14/2019 at 4:00 p.m., an interview was conducted with LPN #6 regarding Resident #164's Physician Orders dated 4/30/18 and 8/27/18. LPN #6 stated, "The Resident went to (Name) Dental and was referred to the Oral Surgeon, because he does extractions. The Resident could not be seen by the doctor because he could not sit up for the Panoramic X-ray." LPN #6 was asked, "Where are we at presently with the dental plan?" LPN #6 stated, "We don't have a plan."

02/19/2019 at 10:20 a.m., an interview was conducted with the Director of Clinical Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 48 regarding the Resident's dental care and what she would have expected from her staff. The Director of Clinical Services stated, "There has been no follow-up and the expectation was for staff to follow up." The facility was unable to provide any documentation concerning Resident #146 going out for the Panoramic X-ray or ever being seen by the dentist for resolving issue with dental caries. The facility policy titled "Dentist Services" last revised 11/27/17 was reviewed and is documented in part, as follows: Policy: The center will contract with a dentist licensed by the Board of Dentistry to provide routine and 24-hour emergency dental services. Procedure: *Obtain order for dental consult. *The nurse or designee will if necessary or if requested assist the patient/resident in making the appointment and arranging for transportation to and from the dentist's office. On 02/19/2019 at approximately 2:10 p.m., at the pre-exit meeting the Director of Clinical Services, Executive Director and the Assistant Executive Director was informed of the findings. The facility did not present any further information about the findings.	F 791		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may	F 849		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 49	F 849		

do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 50	F 849		

notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 51	F 849		

the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 52 with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of the Hospice policy, the facility staff	F 849	Resident # 175 hospice care plan was provided to the facility on 2/15/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 53 failed to ensure the Hospice Agency provided a written agreement describing the provision of services for 1 of 62 residents (Resident #175), in the survey sample. The facility staff failed to ensure the Hospice Agency provided the facility staff with the coordinated plan of care for Resident #175, to identify which services the Hospice Agency would provide, when the services would be provided, the communication process, and when or why the nursing facility staff should notify the Hospice Agency. The findings included: Resident #175 was originally admitted to the facility 12/17/18 and has never been discharged from the facility. The current diagnoses included; Atresia of Foramina of Magendie and Luschka/Dandy-Walker syndrome (congenital abnormality of the central nervous system), strokes, a seizure disorder and dementia. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/18/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #175's cognitive abilities for daily decision making were intact. The resident was coded in section "D" Mood for feeling down/depressed 0-1 day and in section "E" (Behavior) as rejecting care 4-6 days. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with bed mobility, transfers, locomotion, toileting, personal hygiene, and dressing eating, and total care with bathing. In section "O", the	F 849	Current residents receiving hospice services have the potential to be affected. An audit has been completed 3/4/2019 to ensure all hospice residents have a care plan. The DCS, and or designee will educate the License staff on obtaining the hospice coordinated plan of care for the medical record. The Unit Mangers and or designee will do Weekly audits for 4 weeks, monthly for 4 month, the results will be reported to the Quality Assurance Performance Committee by the DCS for further compliance and or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 54	F 849		

resident was coded for Hospice services while a resident in the facility.

The Physician's order summary revealed, an order dated 1/4/19 for a Hospice evaluation and consult.

The care plan with a revision date of 1/14/19, had a problem which read; the resident has a terminal prognosis related to Atresia of Foramina of Magendie and Luschka. The goal read: The resident's comfort will be maintained through 5/2/19. The interventions included; assess the resident's coping strategies and respect the resident's wishes. Consult with the physician and social services to have hospice care for the resident in the facility. Encourage a support system of family and friends. Observe resident closely for signs/symptoms of pain, administer pain medications as ordered. Refer for psychiatric/psychogeriatric consult as indicated. Work with nursing staff to provide maximum comfort for the resident.

On 2/13/18 at approximately 1:35 p.m., Resident #175 was observed in his wheel chair bumping in to walls, objects, and people attempting to get in the elevator to go smoke. He had a box of Kool cigarettes in his hands and repetitively stated his brother told him he could get on the elevator and go smoke. The resident's behavior escalated until staff interventions and 911 services were necessary.

Review of the resident's medication orders revealed the resident was receiving Olanzapine 5 milligrams at bedtime at the time of his admission for delirium and other behaviors exhibited in the hospital. The hospital summary also stated at one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 55	F 849		

point the resident required the use of restraints for agitated behaviors. On 2/14/19, the resident was not receiving any medications to manage his behaviors.

An interview was conducted with Licensed Practical Nurse #8 on 2/14/19, at approximately 2:05 p.m., she stated Resident #175 has exhibited behaviors such as rejecting care, cursing, hitting lighting cigarettes in his room and throwing objects since his admission. She was not aware why the medication Olanzapine was discontinued.

Review of the psychiatric evaluation the Olanzapine was decreased to 2.5 milligrams 12/19/19 and discontinued 1/15/19.

The resident's hospice plan of care was requested but the staff was unable to locate it within the facility. The facility staff stated the hospice agency's documents would describe Resident #175's diagnosis for admission to the hospice program, which disciplines would make visits and what services they would provide, how and what the nursing facility staff was to communicate with the hospice staff, as well as when and if to transfer the resident if a change in condition was identified. The facility staff stated the (name of the Hospice agency) had been contacted and hospice plan of care would be in the facility the following day. The resident's hospice plan of care arrived to the facility 2/14/19.

The hospice plan of care revealed resident #175 was admitted to (name of hospice agency), 1/10/19.

The facility's policy titled "Hospice Services" with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 56 a revision date of 9/20/17, read in the final paragraph; the center will ensure the care plan includes the most current hospice plan of care an the center's plan to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 57 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to maintain good infection control practices for 2 of 62 residents (Residents #145, #52), in the survey sample. 1. The facility staff contaminated the clean left buttock pressure ulcer dressing with the soiled dressings left on the chux pad below Resident #145's left buttock during wound care. 2. The facility staff failed to ensure soap was in a dispenser on 3 survey days in Resident #52's room. Therefore, increasing the chances of spreading infections, illnesses and diseases. The findings included: 1. Resident #145 was originally admitted to the facility 1/10/19 and has never been discharged from the facility. The resident's diagnoses included; quadriplegia related to a motor vehicle accident, tracheostomy, systemic inflammatory response syndrome, seizure disorder and pressure ulcers to bilateral buttocks and the sacrum. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/17/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #145's cognitive abilities for daily decision making were intact.	F 880	1. Nurse provided education on wound care 2/15/2019 and Soap dispenser refilled on 2/15/2019. 2. Current residents during dressing change have the potential to be affected. All residents have potential to be affected by missing soap from the dispenser. The facility conducted a facility room audit to identify washrooms that are in need of soap completed 3/15/19. 3. The SDC and or designee will educate the License staff on clean dressing change to ensure good infection control practices. The Housekeeping director re-educated the housekeeping staff on washroom protocols, including soap dispensers being filled on 3/8/19. 4. The Unit Mangers and or designee will do twice weekly audits for 4 weeks, weekly for 4 and monthly for 2 months, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 month for further compliance and or revisions. The Executive Director and/or designee will complete an audit on the facility washrooms and resident rooms five times a week for four weeks then weekly for four weeks then monthly for six months to ensure soap availability. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59 In section "G" (Physical functioning) the resident was coded as requiring total care of 2 people with bed mobility, transfers, and toileting, and total care of 1 person with dressing, eating, personal hygiene, and bathing. In section "M" (Skin Condition) the resident was coded as having an unstageable pressure injury present on admission. The current physician orders contained the following pressure ulcer treatment orders; 1/11/19 Santyl Ointment, apply to sacral wound topically every day shift sacral wound. Cleanse wound with normal saline, apply Santyl, cover with a dry dressing. 2/1/19 Hydrogel Gel, apply to the left buttock topically every day shift for pressure ulcer. Clean with normal saline, apply Hydrogel and a dry dressing. 2/1/19 Hydrogel Gel, apply to the right buttock topically every day shift for pressure ulcer. Clean with normal saline, apply Hydrogel and a dry dressing. The care plan with a revision date of 2/4/19 read; (name of resident) has a pressure injury to the sacrum related to a history of ulcers and immobility. On 1/30/19 the sacrum wound became unstageable and bilateral buttock were reddened. The goal read; Pressure injury will show signs of healing and have minimal risk of infection through 5/5/19. The interventions included; Supplements to promote wound healing, Low air loss mattress. Weekly interdisciplinary wound meeting. Administer treatments as ordered. Follow the facility	F 880	revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60	F 880		

policy/protocols for prevention/treatment of skin breakdown. Monitor/document/report as needed any changes in skin status.

An observation of Resident #145's pressure ulcers dressing change on 2/14/19, at 11:15 a.m., revealed the unstageable pressure ulcer was to the sacrum and bilateral buttock pressure ulcers were present. The resident's entire bottom was inflamed with redness and areas of maceration. After the wound care nurse removed each old pressure ulcer dressing a foul odor emitted the room.

The wound care nurse removed her gloves, sanitized her hands and donned new gloves, she cleaned the right buttock with saline and gauze, sanitized her hands, and donned another pair of gloves, cleaned the pressure ulcer again removed her gloves and washed her hands at the sink. The wound care nurse donned gloves, applied Hydrogel and 4x4 gauze to the right buttock and a border gauze.

She removed her gloves, sanitized her hands, donned new gloves removed the old sacral dressing, removed her gloves, sanitized her hands, applied new gloves and cleaned the resident's sacrum with normal saline two times, removed her gloves, sanitized her hands, donned new gloves, and applied Santyl to sacrum with a 4x4, then applied a 4x4 soaked with saline over Santyl, followed by a border gauze.

The wound care nurse then removed her gloves sanitized her hands, donned new gloves, removed the old left buttock pressure ulcer dressing, pushing it down on to the chux pad on the resident's bed and the other old dressings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61	F 880		

removed during the wound care. She removed the soiled gloves washed her hands at the sink, donned new gloves, cleaned the left buttock pressure ulcer with a 4x4 and normal saline, removed her gloves, sanitized her hands, donned new gloves and applied, the Hydrogel with gauze to the left buttock. As she applied the new dressing the old dressings on the chux pad were touching the new dressings and eventually stuck to the new border gauze.

An interview was conducted with the wound care nurse, after the wound care observation was completed on 2/14/19, she stated she was aware the clean dressing had touched the soiled dressings in the bed.

On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not.

The facility's with a revision date of 12/6/17 read; a clean dressing will be applied by a nurse as ordered to promote wound healing. Under procedure the it stated remove and dispose of soiled dressings, remove gloves, perform hand hygiene, apply gloves, cleanse wound as ordered, dispose of gauze, remove gloves, perform hand hygiene, apply treatment as ordered and a clean dressing.

2. Resident # 52 was originally admitted to the facility 08/30/17. The current diagnoses included cancer, hypertension, thyroid disorder, seizure disorder and depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62	F 880		

The Quarterly Review Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/31/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident # 52's cognitive abilities for daily decision making were intact.

In section "G" the resident was coded as requiring no setup or physical assistance is needed from staff with ADLs (activities of daily living). Eating and personal hygiene required setup help only.

On 02/13/19 at approximately 11:12 AM surveyor entered resident's room for observation. He shared his room with two other residents. Resident #52 was discussing that his room gets cleaned every morning at 8:30 AM while holding up a large bottle of hand sanitizer, he said "my mom brought this in for me because we've been out of soap in the bathroom for 1 week." He said that he "has asked the staff to put soap in the dispenser in the bathroom on several occasions."

On 02/14/19 12:20 PM CNA (Certified Nursing Assistant) #5 was observed handling the resident's dirty laundry with gloves on. CNA #5 took off the gloves without washing her hands. Other Staff # 2,(housekeeping supervisor) carried the laundry to be placed in clothing bin outside of resident's room. Hand hygiene was not performed by either staff member prior to exiting the resident's room.

On 02/15/19 11:26 AM Resident #52's soap dispenser was still empty. The other two roommates were asked how long have they been out of soap in the bathroom. One resident said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 63	F 880		

about 1 month, the other resident stated that "it's been a while." They said that they kept a bottle of hand sanitizer in their bedside table.

On 02/15/19 at approximately 12:08 PM LPN (Licensed Practical Nurse) # 1, was asked "how do you find out if a resident is out of soap?" She stated that "if a resident tells her or if she find out by checking the dispenser then contacting housekeeping."

On 02/15/19 at 12:08 PM an interview was conducted with CNA # 5, concerning Resident # 52, room being without soap for several days. She stated that she will call housekeeping to refill soap.

On 02/15/19 at 12:19 PM a brief interview was conducted with housekeeping supervisor (Other # 2) concerning empty soap dispenser in bathroom that resident #52 shared with two other residents. He said that they do mark survey assignments daily. Someone was responsible to check restrooms for soap and paper towels daily. He also said that once housekeeping is notified that a restroom need soap it is filled up right away.

On 02/15/19 at approximately 03:09 PM, the soap dispenser was observed to be refilled with soap.

A policy was provided by the facility Administrator on Infection Prevention and Control. Nothing was written in the policy concerning hand hygiene.

On 02/19/19 at approximately 2:05 PM, a pre-exit interview was held with the Administrator, the Director of Nursing, the Assistant Director of Nursing and Regional Consultant. The facility staff did not present any further information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 64 regarding the findings.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on information obtain during the Infection Control task, staff interview, and facility documentation review, the facility staff failed, for 1 of 62 residents (Resident #68) in the survey sample, to implement their antibiotic use protocol/policy. The facility staff administered a course of Ciprofloxacin (an antibiotic) to Resident #68 for a urinary tract infection however, the bacteria was resistant to the drug. The findings included: Resident #68 was originally admitted to the facility 9/27/13 and readmitted to the facility after an acute care hospital stay 9/27/16. The resident's current diagnoses included; dementia, schizophrenia, depression high blood pressure, and a seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date	F 881	Resident # 68 correct medication ordered and received on 1/2/2019. Current Residents receiving antibiotic medication have the potential to be affected. The ADON and or designee will educate the License staff Antibiotic stewardship. The ADON and or designee will do weekly audits for 4 weeks, and monthly for 2 month to ensure antibiotics are ordered appropriately, the results will be reported to the Quality Assurance Performance Committee by the DCS for 4 months for further compliance and or revisions.	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 65	F 881		

(ARD) of 12/5/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #68's cognitive abilities for daily decision making are moderately impaired. In section "E" (Behaviors) the resident was coded for rejecting care daily. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene, and total care of 1 person with bathing.

The active care plan with a revision date of 1/14/19, had a problem which read; the resident has a potential for urinary tract infections (UTI), related to a history of UTIs. The goal read; (name of resident) will remain free of signs/symptoms of UTIs through 3/5/19. The interventions read; Encourage adequate fluid intake. Monitor/document/report to the physician as needed for signs/symptoms of UTIs.

During the Infection Control interview the Assistant Director of Nursing stated Resident #68 exhibited a change in appetite as well as behavior and the urine culture revealed two bacteria of than greater 100,000 colonies; Escherichia Coli (E-Coli) and Extended spectrum beta lactamase (ESBL) requiring the resident to be placed on contact precautions.

A nurse's note dated 12/21/19, at 2:20 a.m., read: collected urine sample via straight catheter for the ordered urine analysis (UA), culture and sensitivity (C&S) without any problem. No noted odor or cloudiness to the urine sample.

A physician's order dated 12/23/18, revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 66	F 881		

order for Ciprofloxacin Hcl 500 milligram tablets by mouth two times a day for 10 days.

A laboratory report dated 12/23/18 revealed the bacteria growing in Resident #68 urine was resistant to the antibiotic Ciprofloxacin.

A nurse's note dated 12/24/18, read: Nurse Practitioner notified of lab results, no signs/symptoms of seizure activity, tolerating medications.

Review of the Medication Administration record revealed Resident #68 received the antibiotic Ciprofloxacin 500 milligrams two times daily for a UTI, from 12/24/18, through 1/1/19, totaling 18 doses.

On 1/2/19, a nurse's note read Nitrofurantoin Macrocrystal capsule 100 milligrams; give 1 capsule by mouth 2 times a day for UTI for 9 days.

On 2/19/19 at approximately 11:45 a.m., at the conclusion of the Infection Control task the Assistant Director of Nursing stated, "I have some work to do to ensure this doesn't occur again."

The Medication Administration Record also revealed from 6 p.m., 1/3/19 through 12 noon 1/9/19, Resident #68 was administered Nitrofurantoin Macrocrystal Capsules 100 milligrams by mouth every 8 hours for a UTI.

Further review of the laboratory report received by the facility staff on 12/23/18, revealed the two bacteria in Resident #68's urine were susceptible to Nitrofurantoin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 67 The Nurse Practitioner note dated 1/3/19 read; "patient has episodes of refusing medications and altered mental status. Patient had UA and C&S done. Her urinalysis looks infected. She was started on Cipro, pending urine culture. He urine culture however came back 100,000 E-Coli, ESBL. No report of fever or chills. Report that patient is taking her medications. Also noted her Dilantin level was low, however she was refusing medications." On 2/19/18, at approximately 2:00 p.m. the above findings were shared with the Administrator, Assistant Administrator, the Director of Nursing and the Regional Director of Clinical Services. An opportunity was given for the facility to provide additional information but they did not. The facility's policy with a revision date of 11/20/17 included the following information under tracking; Review and track whether appropriate test such as cultures were obtained prior to prescribing antibiotics, are cultures results communicated as soon as possible and changes in antibiotic therapy during the course of treatment and prevalence of antibiotic use per month.	F 881		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to provide a safe, comfortable	F 921	Rooms #146, #139, #137, #136, #2-A activity door, #148, #149, #152, #153,	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 68 environment for residents and the public. Multiple resident room and general doors within the facility had chipped sharp edges. The findings included: During the Environmental Tour on 2/19/19 at 10:00 A.M. Room #146 door was observed to have chipped, sharp edges. Room #139 door was observed to have chipped sharp edges. Room #137 door was observed to have chipped, sharp edges. Room #136 room door was observed to have chipped sharp edges. The 2-A Activity Room door was observed to have chipped sharp edges. Room #148 door was observed to have chipped sharp edges. Room #149 door was observed to have chipped sharp edges. Room #152 door was observed to have chipped sharp edges. Room #153 door was observed to have chipped sharp edges. Room #160 door was observed to have chipped sharp edges. Room #163 door was observed to have chipped sharp edges. Room #164 bathroom door was observed to have chipped sharp edges. Room #172 door was observed to have chipped sharp edges. Room #173 door was observed to have chipped sharp edges. On Unit 1-A-Room #122 door was observed to have chipped sharp edges. Room #119 door was observed to have chipped sharp edges. Room #117 door was observed to have chipped sharp edges. Room #116 door was observed to have chipped sharp edges. Room #105 door was observed to have chipped sharp edges. On Unit 1-B-Room #207 door was observed to have chipped sharp edges. The Activity Room	F 921	#160, #163, #164, #172, and #173 door edges are in repair of their chipped and/or sharp edges. Rooms #122, #119, #117, #116, #105, #207, #200, hallway corridor, #214, 1-B unit storage door, Activity room door, #222, #226, #228, #232, #237, #248, #252, #258, #259, #262, #268, #272, and Physical therapy doors are in repair of chip and sharp edges. To be completed on 3/20/19. All residents have the potential to be affected. Doors will be audited for sharp or chipped edges. The facility has assigned room rounds to report any observed chipped or sharp edges to be addressed 5 days a week for correction. Room audit sheet has been implemented to identify rooms with need for door repair. Maintenance has been educated on audit sheets by Assistant Executive Director. Maintenance has been re educated on room round observation by Assistant Executive Director. The Executive director and or designee will complete an audit on the facility doors five times a week for four weeks then weekly for four weeks then monthly for six months to ensure a clean comfortable homelike environment. The results will be reported to the Quality Assurance Performance Committee by the Executive Director monthly for 3 months for further compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 69 door was observed to have chipped sharp edges. Room #200 door was observed to have chipped sharp edges. The Hall Way corridor doors were observed to have chipped sharp edges. Room #214 door was observed to have chipped sharp edges. The 1-B Unit Storage Room door was observed to have chipped sharp edges. Room #222 door was observed to have chipped sharp edges. Room #226 door was observed to have chipped sharp edges. Room #228 door was observed to have chipped sharp edges. Room #232 door was observed to have chipped sharp edges. Room #237 door was observed to have chipped sharp edges. Room #248 door was observed to have chipped sharp edges. Room #252 door was observed to have chipped sharp edges. Room #258 door was observed to have chipped sharp edges. Room #259 door was observed to have chipped sharp edges. Room #262 door was observed to have chipped sharp edges. Room #268 door was observed to have chipped sharp edges. Room #272 door was observed to have chipped sharp edges. The double doors to the Physical Therapy Room was observed to have chipped sharp edges. During an interview with the Assistant Administrator on 2/19/19 at 3:30 P.M. he stated, Capital Improvement plan was in the works.	F 921		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, facility record review,	F 925	Pest Control Company was called and	4/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 70 and staff interview, the facility staff failed to maintain an effective pest control program. Roaches and/or mice were seen in the resident rooms, the courtyard, dining room, supply closets, refrigerator, nursing desk drawer, hallways, and conference room. The findings included: During the Initial Tour on 2/12/19 at 11:22 A.M. a live roach was observed in room #242. A live roach was observed in room #244 and 249. A review of the Pest Log for Unit 1-B indicated: On 2/11/19 at 9:00 A.M. a roach was seen in the hallway. On 2/11/19 at 12:10 P.M. a roach was seen in the upstairs dinning room. On 2/13/19 at 11:35 A.M. a roach was seen in the upstairs dinning room. A review of the Pest Log indicated: On 11/20/18 Roaches were seen in rooms 255, 257 and 266. Roaches were seen near the elevator on 11/26/18, 11/29/18, 12/04/18, 12/06/18, 12/15/18, 12/18/18, 12/21/18. On 12/27/18 three (3) house mice were seen in the smoking area of the courtyard. On 12/31/18 mice were seen in room #236. On 1/2/19 at 10:50 A.M. roaches were seen in the 2-B supply closet. A review of the Pest Log for Unit 2-B indicated: Roaches were seen on 12/15/18, 12/16/18, 12/18/18, 12/27/18, 1/2/19, 1/17/19, 1/29/19, 2/1/19, 2/16/19, 2/7/19, 2/11/19, 2/11/19 in room 207, 2/13/19. On 11/11/18 roach in room 226-A, 11/18/18 roach in room 228, 11/24/18 roach on resident in room 226-B seen by staff, 11/19/18 roaches seen in room 214 bathroom.	F 925	treated rooms #242, #244, #249. upon finding pest. All residents have the potential to be affected. Pest control company availble to treat facility. Pest Control company and Assistant Executive director schedule a meeting reviewing alternate professional treatment and control for building. Pest control company scheduled 2 times week visits to maintain a pest control and as needed. Staff to be re-educated on logging items in pest control book. The QAPI committee as noted below will be responsible for the ongoing monitoring of this process as follows: a) Pest Book will be reviewed by Maintenance or Assistant Executive Director weekly for concerns times 4 weeks. b) The maintenance director, and/or assistant executive director will conduct a walking audit of rooms and facility grounds weekly x four (4) weeks then monthly x six (6) months which includes the monitoring of traps and pest control devices. Variances will be addressed promptly. The QAPI committee will determine the frequency of continued ongoing monitoring thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 71 On Unit 1-A the Pest Log indicated: 11/27/18 roaches in nursing station. 12/2/18 roaches in nursing station desk drawer. 12/1/18 roaches in fridge at nursing station. 12/31/18 roaches in hallway. 12/31/18 mice in smoking area. 1/9/19 roaches in room #116. 2/5/19 roaches in room 116-A. 2/11/19 roaches on nursing station desk. On Unit 2-A the Pest Log indicated: 12/5/18 roaches in room #135. 12/6/18 roaches in room #136. 1/2/19 roaches in conference room. 2/9/19 roach in staff wig. 2/11/19 roaches all over the unit, at nursing station, in resident rooms and in the hallway. 2/14/19 roaches in hallway. 2/14/19 roaches in room #139. During an interview on 2/13/19 at 12:45 P.M. with the Pest Control Company the vendor staff stated, he has been coming out to the facility two times a week for the past month to get a handle on the pest issues. During an interview on 2/19/19 at 4:15 P.M. with the Assistant Administrator he stated, the facility is try all it can to get a handle on the pest issue.	F 925		