PRINTED: 07/12/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495347	B. WING		C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	IINDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 015 SS=C	survey was conducted Corrections are required. CFR Part 483.73, Recomplaints were invested to complaints whether policies and procedure plan set forth in paragramed the communication of the complaints whether place, include, but are complaints whether place, include the complaints whether place, include, but are complaints whether place, include, but are complaints whether place, include, but are complaints whether place, include the	edures. [Facilities] must int emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of sies and procedures must be d at least annually.] At a s and procedures must :  ubsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical of energy to maintain the o protect patient health and e and sanitary storage of itting. extinguishing, and alarm aste disposal.	E 000	Staff will be educated on fire wa	d its s Plan waste eral EP, re lucated ector of e of ds for es for s, and nce the	
ARORATORY (		'ès. Supplier representative's signature	<u> </u>	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

07/24/19

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Rhoades Kreutter

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495347	B. WING			06/	27/2019
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E 015	hospice-operated inporting The policies and proof following:  (iii) The provision of shospice employees a evacuate or shelter in limited to the following.  (A) Food, water, misupplies.  (B) Alternate source following:  (1) Temperature and safety and for the of provisions.  (2) Emergency lifts (3) Fire detection systems.  (C) Sewage and water that the emergency preparate watch training for sewage and wasted dispersely.  The findings included the facility emergency.  The facility emergency to have documentation training and for the provision and the provision of	additional requirements for atient care facilities only. Redures must address the subsistence needs for and patients, whether they a place, include, but are not go edical, and pharmaceutical es of energy to maintain the est to protect patient health est and sanitary storage and sanitary storage aste disposal. The is not met as evidenced ew and staff interview, the provide documentation that redness plan addressed or staff; and for provisions for sposal services during an atient as evidenced evidences of the provide documentation that redness plan addressed or staff; and for provisions for sposal services during an atient and the provide documentation that redness plan addressed or staff; and for provisions for sposal services during an atient and the provisions for sposal services during an atient at the provide documentation that redness plan addressed or staff; and for provisions for sposal services during an atient at the provisions for sposal services during an atient at the provisions for sposal services plan failed	E	015			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		495347	B. WING _				27/2019
	ROVIDER OR SUPPLIER	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487	1 0011	27/2013
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E 015 E 037 SS=C	waste disposal service he did not have document having sewage and waste with the did not have document having sewage and wastered review of employee to indicate staff had been process.  EP Training Program CFR(s): 483.73(d)(1)  (1) Training program. ASCs, PACE organize and dialysis facilities]  (i) Initial training in empolicies and procedures and procedures and procedures annually.  (iii) Provide emergence (iv) Demonstrate staff procedures.  *[For Hospitals at §48 at §491.12:] (1) Train or RHC/FQHC] must (i) Initial training in empolicies and procedures and procedures and procedures and procedures and procedures and procedures annually.  (iii) Maintain document (iv) Demonstrate staff procedures.	es. The administrator stated mentation of the facility vaste disposal services. A raining records did not in trained in the Fire Watch.  The [facility, except CAHs, rations, PRTFs, Hospices, must do all of the following: hergency preparedness rest to all new and existing raining services under unteers, consistent with their ray preparedness training at that in the following: hergency preparedness rest on all new and existing ration of the training. If knowledge of emergency reparedness rest on all new and existing regency preparedness rest on all new and existing ration of the following: hergency preparedness rest on all new and existing ration on-site services under ration of the services under rations of the services and rations of the services are rations of the services.	E		1. The facility will amend its Fed E include an initial emergency prepatraining program for staff.  2. There is only one required EPP therefore no additional reviews we needed.  3. The ED (Executive Director) edithe Maintenance Director and Director and Director and Director and Elinical Services on the importance 42 CFR 483.73- EP Training and Topecific to providing staff with initial annual training on the emergency of the Executive Director/ designed educate staff on the facility emergency plan. Emergency plan training will added to the facility's training caler and will continue to be monitored in accordance with the standard.  4. Any findings will be reported to monthly QAPI Committee for further review.  5. AOC Date: 08/06/19	redness  , re  ucated ector of e of esting I and plan. will ency be ndar, n	

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E 037	policies and procedinospice employees, services under arrarexpected roles.  (ii) Demonstrate state procedures.  (iii) Provide emergelleast annually.  (iv) Periodically reviemergency preparememployees (includin special emphasis pleoprocedures necessates)  *[For PRTFs at §44* program. The PRTF*  (i) Initial training in expolicies and procedustaff, individuals program arrangement, and very expected roles.  (ii) After initial training preparedness training (iii) Demonstrate states procedures.  (iv) Maintain docum preparedness training in expolicies and procedures.  (iv) Maintain docum preparedness training in expolicies and procedures and procedures and procedustaff, individuals programagement, contrains arrangement, contrains arrangement, contrains arrangement, contrains arrangement.	of the following: Impergency preparedness Impergency preparedness Imperse to all new and existing Imperse to all new and existing Impersent, consistent with their Impersent, consistent with their Impersent the services of	E 03	37			

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E 037	least annually.  (iii) Demonstrate sta procedures, including what to do, where to case of an emergen (iv) Maintain docume.  *[For CORFs at §48 CORF must do all of (i) Provide initial trait preparedness policies and existing staff, in under arrangement, with their expected in (ii) Provide emerger least annually.  (iii) Maintain docume (iv) Demonstrate state procedures. All new and assigned specific the CORF's emerged their first workday. To include instruction in alarm systems and sequipment.  *[For CAHs at §485. The CAH must do af (i) Initial training in expolicies and procedure porting and exting and where necessal personnel, and guest cooperation with fire authorities, to all net individuals providing and included in the individuals and included	off knowledge of emergency g informing participants of go, and whom to contact in cy.  entation of all training.  5.68(d):](1) Training. The f the following: ning in emergency es and procedures to all new dividuals providing services and volunteers, consistent roles.  The preparedness training at entation of the training.  Iff knowledge of emergency personnel must be oriented ic responsibilities regarding ncy plan within 2 weeks of the training program must an the location and use of signals and firefighting  625(d):] (1) Training program.  If of the following: If of the following: If of the following: If of the following prompt uishing of fires, protection, ry, evacuation of patients, sts, fire prevention, and fighting and disaster	EO	37				

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
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E 037	least annually.  (iii) Maintain docume (iv) Demonstrate star procedures.  *[For CMHCs at §48 CMHC must provide preparedness policic and existing staff, in under arrangement, with their expected r documentation of the demonstrate staff kn procedures. Thereaf emergency prepared annually.  This REQUIREMEN by: Based on record refacility staff failed to preparedness training.  The findings include  During an interview the administrator, he documentation for a emergency prepared procedures for all neadministrator stated conducted an initial emergency prepared.  The facility staff failed.	cy preparedness training at entation of the training. If knowledge of emergency  5.920(d):] (1) Training. The initial training in emergency es and procedures to all new dividuals providing services and volunteers, consistent oles, and maintain estraining. The CMHC must provide dness training at least  T is not met as evidenced view and staff interview, the have an initial emergency ag program.  d:  on 06/26/19 at 2:22 P.M. with exast asked for an initial training program in dness policies and ew new and existing staff. The ather facility had not training program for dness.	E 0	37			

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F 000 F 000	survey was conducted 6/27/19. Seven compliance with the the Federal Long Tell Life Safety Code survives at this 1 110 at the time of the consisted of 49 curred closed records. Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination complete the promote and facilitate through support of respective to the right (1) through (11) of the §483.10(f)(1) The resident has the promote and facilitate through support of respectives and facilitate through (11) of the §483.10(f)(1) The resident has the promote and facilitate through support of respectives and facilitate through (11) of the §483.10(f)(1) The resident has the promote and facilitate through support of respective to the right (1) through (11) of the facilitate through (11	edicare/Medicaid standard ed from 6/24/19 through plaints were investigated ctions are required for following 42 CFR Part 483 of rm Care requirements. The vey/report will follow.  14 certified bed facility was esurvey. The survey sample ent record reviews and 8  -(3)(8)  rmination.  right to and the facility must be resident self-determination esident choice, including but hits specified in paragraphs (f) is section.	F 00	1. Resident #108 shower prefere were updated. 2. All residents that reside in the are at risk for not having shower preferences followed as indicated comprehensive care plan. An aud	facility I in the dit was dents d Services) staff to s as care plan.	
	waking times), health care services consist assessments, and plapplicable provisions §483.10(f)(2) The rechoices about aspect facility that are significable §483.10(f)(3) The rewith members of the	sident has a right to make ts of his or her life in the		ensure shower preferences are howeekly for 5 residents weekly for weeks, then 5 residents monthly 3 months. The results will be reported to the Quality Assurance Perform Improvement Committee (QAPI) Executive Director monthly for 3 for further compliance and/or revision. AOC date: 08/06/2019	four for orted ance by the months	

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F 561	religious, and comminterfere with the right facility. This REQUIREMEN' by: Based on observation interviews, resident interview that shower preferents for residents in the sufficient interview in the sufficient interview in the compact of the indicated in the compact interview in the sufficient interview in the sufficient interview in the sufficient interview for Mental interview for Mental interview for Mental interview inter	sident has a right to ctivities, including social, unity activities that do not ats of other residents in the T is not met as evidenced ons, record review, staff interview, and facility facility staff failed to ensure ces were followed for one of curvey sample, Resident deto ensure that Resident rences were followed as orehensive care plan.	F	561			

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F 561	Focus: Name (Resid (activities of daily livir deficit related to late I increased need for as Initiated: 10/27/18  Interventions: BATHI requires total assistar bathing and showerin as necessary. Date  On 6/25/19 at 1:45 P. asked what was her p. Resident #108 sta of the week but I pref week. My shower da Thursdays on the 3-1 shower once a month a shower twice a week it makes me feel better that we week are it makes me feel better that we week are feel better that we week are feel better that we were standard that we were st	ent #108) has an ADL  ng) self-care performance oss adl's as exhibited by: ssist with adl's. Date  NG SHOWERING: she nce by one to two staff with ng-prefers twice a week and Initiated: 10/27/18.  M. Resident #108 was preference for bathing. ted, "I take a bed bath most er to have a shower twice a ys are Monday and 1 shift. I'm lucky if I get a M. My preference is to have ek so I can wash my hair and	F	561			

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F 561	Assistant Director of also filling in as the CADON was asked to Shower Schedule ar Flow sheets and to treceived a shower. (Resident #108) sho Thursdays. It looks April, one in May and June so far. She shi twice a week."  On 6/27/19 at approxinformation was shat the Director of Nursic Consultant.	riew was conducted with the Nursing (ADON) who was Green Unit Manager. The review the Green Unit and then Resident #108's ADL cell me when the resident had The ADON stated, "Her wer days are Monday and like she got 2 showers in dishe hasn't gotten any in could have a shower at least eximately 3:30 P.M. the above ared with the Administrator, and and the Corporate Nurse ector of Nursing stated, exceive two showers a week a planned as it being a verwill see that it gets done."  The d'Bathing/Showering eviewed and is documented with showering and bathing ast twice a week and PRN use and refresh the resident. It is asked on admission to by schedule for bathing. This eccedence over the twice a masing. The resident's rences for bathing will be	F 561			

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		495347	B. WING _			06	/27/2019
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF	WINDSOR			IRTHOUSE HIGHWAY		
	_			WINDSOR	R, VA 23487		
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F 580 SS=D	CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must immonsult with the resiconsistent with his of representative(s) who (A) An accident involves and physician intervention (B) A significant charmental, or psychosod deterioration in healts status in either life-than clinical complication (C) A need to alter than eed to discontinuate treatment due to addrown the commence a new form (D) A decision to transident from the fact §483.15(c)(1)(ii).  (iii) When making no (14)(i) of this sectionall pertinent informatic is available and proving physician.  (iii) The facility must resident and the resident and the resident and the resident and the resident and regulation (e)(10) of this section (iv) The facility must resident and the resident an	ication of Changes. mediately inform the resident; dent's physician; and notify, r her authority, the resident ten there is- lving the resident which has the potential for requiring on; nge in the resident's physical, cial status (that is, a th, mental, or psychosocial meatening conditions or s); reatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or nsfer or discharge the cility as specified in tification under paragraph (g) the facility must ensure that tion specified in §483.15(c)(2) rided upon request to the also promptly notify the ident representative, if any, or or roommate assignment alo(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and	F	facilit responsition of mission o	esident #5 no longer resident. Resident #107 notified onsible party and physicial ed on 07/24/19. Resident ician was notified on 07/23 issed dose of insulin. Il residents that reside in the ty are at risk for not having onsible party and physicial ed. An audit was completed east 7 days to ensure notificated by 7/29/19. The DCS or designee will even and physician were notificated by 7/29/19. The DCS or designee will even and physician were notificated by 7/29/19. The DCS or designee will also be that appropriate notification of the DCS or designee will also be that appropriate notification completed on 5 residents months. The results will be tred to the Quality Assurant ormance Improvement Control of the DCS of the Collina months for further or the collina and/or revision. OC date: 08/06/2019	the n was t #6 a 3/19 he g n ed for cation to n was educate eponsible ed 08/01/19. Audit to a tion to n have a monthly be noce mmittee tor	

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F 580	that is a composite di §483.5) must discloss its physical configura locations that comprispart, and must specifi room changes betwee under §483.15(c)(9). This REQUIREMENT by:  Based on staff interview, and clinical redetermined that facili responsible party and resident abuse incide the sample, Resident notify the physician of administered per order of the sample of the sample. The facility of the physician after a sexultion of missed of the sample of the samp	osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations.  This not met as evidenced riew, facility document ecord review, it was ty staff failed to notify the diphysician after a resident to ent for two of 57 residents in the 45 and #107; and failed to finedications not er for Resident #6.  Ind Resident #107, facility the responsible parties and unal encounter had occurred eacility staff failed to notify the doses of insulin.  admitted to the facility on es that included but were not ase (1), muscle weakness, it major depressive disorder. Eccent MDS (Minimum Data is a quarterly assessment ment reference date) of	F	580			

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F 580	out of 15 on the BIM Status) exam. Resid requiring extensive a member with ADLs (	cognitive function scoring 99 S (Brief Interview for Mental ent #5 was coded as assistance from one staff activities of daily living) such bility and transfers; and	F	580				
	11/28/18 with diagnorm not limited to Wernich Hepatitis C (3), and Resident #107's most Data Set) assessment assessment with an date) of 6/25/19. Resident #107 was of Resident #107 was of the Staff Assessment Resident #107 was of the Staff	ARD (assessment reference sident #107 was coded as paired in cognitive function of t for Mental Status exam coded as being independent f daily living) and requiring						
	nursing note that do abuse on 3/6/19. The "Reported to this wri #5) in room (number lured in (number of F with paints (sic) dow each others. Made D	#5's clinical record revealed a cumented possible sexual efollowing was documented: ter that resident (Resident of Resident #5's room) was Resident #107's room). Seen as well as lips touching DON (Director of Nursing)						
	incidents) revealed to the OLC (Office of and other state ager	FRIs (facility reported nat a FRI was not submitted Licensure and Certification) cies regarding this incident. d not be found regarding this						

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F 580	Continued From page	ge 13	F 580				
	#107's clinical recorphysician and responses	esident #5's and Resident of failed to evidence that the onsible parties for both ied.  Eximately 4:00 p.m., an acted with ASM (administrative ne DON (Director of Nursing) reporate consultant. When if her nurses were to report ging in sexual relations each unit, ASM #2 stated that the residents, start an if the incident requires stated that if both residents he would then provide the SM #2 stated that if the give consent, she would then he RPs give consent she esidents are safe and ASM #2 denied being aware 6/19 between Resident #5 despite the nursing note occumenting that the DON was #2 confirmed that there was e physicians and RPs so were notified regarding the					
	On 6/26/19 at 5:13 conducted with LPN #1, the nurse who wasked what had hap stated that a CNA (had alerted her that Resident #107's root because she was no	p.m., an interview was I (Licensed Practical Nurse) was working on 3/6/19. When opened on 3/6/19; LPN #1 Certified Nursing Assistant) she had seen Resident #5 in om. LPN #1 stated that ot sure if the residents were ough to consent to any sexual					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495347	B. WING		06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY NINDSOR, VA 23487	33.21.20.10
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F 580	activity; she separal administration (the land Market Mark	ted the residents, and alerted DON). LPN #1 stated; "I told ector of Nursing). She told me " When asked if she had cians and RP's regarding the LPN #1 stated, " I don't confirmed that she had not be notified the physician and hen asked if he expects to be lent to resident altercation or resident abuse, ASM #8 stated me the facility submits a FRI, #8 stated that she could recall of an incident on 3/20 residents (Resident #5 and M #8 stated that as far as of an incident prior to that, he M #8 stated that he would documented somewhere that SM #8 stated that nurses ting every time they notify him to the public point of the po	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C 06/27/2019	
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP COI 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	•		
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F 580	Clinical Services or C will initiate the proced and reportingAlleged abuseare thorough Executive Director ar Services. Alleged sus violations are reported theOmbudsman and by state law. In all casor Director of Clinical notify the resident's lemember, responsible the alleged, suspected neglect or mistreatmed another resident, the will be contacted and taken to prevent furth abusive resident's be thereby posing a three facility, the resident will be contacted and taken to prevent furth abusive resident's be thereby posing a three facility, the resident will be contacted and taken to prevent furth abusive resident's be thereby posing a three facility, the resident will be contacted by a sledeterioration of behall anguage. People with abnormal substances nerve cells in the dam Pick bodies contain a called tau. This prote but people with Pick's amount or type of this was obtained from The Health. https://rarediseases.icks-disease.	decutive Director, Director of Clinical Services Supervisor dure for incident investigation ed, suspected or observed by investigated by the ad/or Director of Clinical spected or observed dimmediately to diall other officials required ses, the Executive Director Services will immediately egal guardian, family party or significant other of ed or observed abuse, ent. If a resident abuses abusive resident's physician appropriate action will be the entropy of the entropy	F 5	80			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495347	B. WING			06/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF W	INDSOR		2	3352 COURTHOUSE HIGHWAY		
CONSULA	CILILALIII CARL OF V	MADOOK		٧	VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	(vitamin B1). It may redictary deficiencies, publicatory deficiencies, publicatory deficiencies, publicatory deficiency causes dail thalamus and hypothermia deficiency causes dail thalamus and hypothermia, low bloomuscle coordination (was obtained from The Health.  https://www.ninds.nih/Wernicke-Korsakoff-  (3) Hepatitis C- Hepaliver. Chronic hepatiti infection. If it is not trailifetime and cause se including liver damag liver), liver cancer, an spreads through contisomeone who has Hothrough -Sharing drug needle with someone who has States, this is the morget hepatitis CGetting an accidental was used on someon happen in health care-Being tattooed or piewere not sterilized aft who has HCV -Having contact with the someone who has HCV -Sharing personal call	I by the lack of thiamine esult from alcohol abuse, prolonged vomiting, eating cts of chemotherapy. B1 mage to the brain's alamus. Symptoms include ion problems, coma, od pressure, and lack of ataxia)." This information he National Institutes of a syndrome-Information-Page  Ititis is inflammation of the soc is a long-lasting eated, it can last for a rious health problems, e, cirrhosis (scarring of the deven death. Hepatitis C act with the blood of CV. This contact may be so or other drug materials as HCV. In the United est common way that people  I stick with a needle that e who has HCV. This can e settings.  I strong with tools or inks that er being used on someone the blood or open sores of CV re items that may have another person's blood,	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495347	B. WING			C 06/27/2019		
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE		
F 580	HCV." This informat National Institutes of https://medlineplus.g. 2. For Resident #6, physician of missed Resident #6 was re-2/7/18 with diagnose heart failure, hyperlidiabetes, dysphagial long term use of institution to Resident #6.  Resident #6 was as Minimum Data Set (as having minimum glasses. In the area resident was assess the area of Brief Inte (BIMS). Resident #6	ther with HCV I sex with someone who has ion was obtained from The f Health. gov/hepatitisc.html. facility staff failed to notify the	F 5	·				
	transfer and dressin one person physical In the area of Medic assessed as receivi anti-anxiety and anti-A Care Plan dated 3 Resident #6 has dia neuropathy. Goal-R complications relate Diabetes medicatior Monitor / document	d-depressant medications.  3/25/19 indicated: "Focusbetes mellitus and desident will have no d to diabetes. Interventionsas as ordered by doctor.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495347	B. WING		<del></del>	06/:	27/2019
	ROVIDER OR SUPPLIER TE HEALTH CARE OF W	/INDSOR		2	TREET ADDRESS, CITY, STATE, ZIP CODE  3352 COURTHOUSE HIGHWAY  VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	adverse reactions rela Interventions- administ medications as ordered Physician order dated 70/30 flex pen Susperunit/ml (insulin). Lorazepam tablet 0.5 tablet by mouth twice A review of a Medicate (MAR) dated March 2 and 11th Novolin 70/3 units was not administ. A review of the MAR on March 21, 2019 Lotadministered as ordered A review of a MAR da June 20, and 21, 2019 was not administered. A review of a MAR da June 23, 2019 Loraze administered as ordered A Nursing Progress n indicated: Novolin 70/5 subcutaneously in the Diabetes Mellitus with awaiting pharmacy.  A Nursing Progress n (12:50) indicated: "Institute of the progress o	- At risk for discomfort or ated to anti-anxiety therapy. Ster Anti-Anxiety ed by physician."  If 6/10/19 indicated: Novolin Insion Pen-injector 100  Ing (milligram) give one a day.  It ion Administration Record (1019 indicated on March 6, 7 (1019) indicated on March 6, 7 (1019) indicated on March 2019 indicated orazepam 0.5 mg was not red.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Population of 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.  Inted June 2019 indicated on 19 Novolin 70/30 100 units as ordered.	F	580			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMPLE	
			7 501251	_		(	
		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER	/INDSOR	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 582 SS=D	(19:16 (7:16 PM)) me afternoon delivery.  The physician was not being not available ar medications as ordered.  During an interview of the Director of Nursin Consultant they state contacted the doctor of missed insulin.  The facility staff failed physician when medical Medicaid/Medicare Content of Consultant they state contacted the doctor of missed insulin.  The facility staff failed physician when medical Medicaid/Medicare Content of the facility and when the facility offers and service for which the resident (B) Those other items facility offers and for content of the facility offers and the amoservices; and (ii) Inform each Mediconages are made to specified in §483.10(section.	ote dated June 21, 2019 dication did not arrive during of notified of medications and Resident #6 not receiving ed.  In 6/27/19 at 11:45 A.M. with g and the Regional Nurse d, staff should have concerning Resident #6  I to notify Resident #6's cations were not available. overage/Liability Notice ()(18)(i)-(v)  acility must aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and a may not be charged; and services that the which the resident may be bunt of charges for those caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this		580			
		acility must inform each the time of admission, and					

PRINTED: 07/12/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR	MEDICARE &	WEDICAID SERVICES				ONID NO	. 0936-0391
STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	LETED
		495347	B. WING _			06/2	27/2019
NAME OF PROVIDER	OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				23	352 COURTHOUSE HIGHWAY		
CONSULATE HEA	ALTH CARE OF V	VINDSOR		W	INDSOR, VA 23487		
(X4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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period availal service cover facility (i) Whand so Medice reaso (ii) Whitems facility 60 da (iii) If a transf facility represended facility dischalate (iv) The resident the readate of (v) The behalf facility these This Feby:  Base	ble in the facilities, including ared under Medicies under Medicies per diem rate ere changes in ervices covered aid State plan, to residents of nably possible. Here changes a and services the must inform the prior to imple a resident dies erred and does a must refund to sentative, or estait or charges allem rate, for the end or reserved of a regardless of arge notice require facility must ent representative interpresentative in the facility must ent representative in the facility must enterpresentation in the facility must enterpresentative in the facility must representative in the facility must enterpresentations. REQUIREMENT	e resident's stay, of services y and of charges for those ny charges for services not care/ Medicaid or by the e.  coverage are made to items to by Medicare and/or by the the facility must provide the change as soon as is the change as soon as is the remark to charges for other nat the facility offers, the ne resident in writing at least the mentation of the change. Or is hospitalized or is not return to the facility, the or the resident, resident tate, as applicable, any tready paid, less the facility's to days the resident actually or retained a bed in the any minimum stay or uirements.  The resident or we any and all refunds due of days from the resident's	F	582	1. Resident #92 no longer resides facility. 2. All residents are at risk for not receiving timely notification of a not Medicare non coverage. An audit of completed for the last 30 days to enotifications of notice of Medicare coverage were completed timely. It issues were identified. 3. An education was completed with social services department by ED ensure timely notification of notice Medicare non coverage was compon 07/23/19. 4. The MDS Coordinator (Minimum Set Coordinator) or designee will audit to ensure that appropriate notification to responsible party and physician have been completed or residents monthly for 3 months. The results will be reported to the Qual Assurance Performance Improvem Committee (QAPI) by the Executive Director monthly for 3 months for for compliance and/or revision. 5. AOC date: 08/06/2019  Past noncompliance: no plan of correction required.	tice of was ensure non No other ith the to of leted m Data d n 5 ne ity nent e	

residents in the survey sample, Resident # 92.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION		(X3) DATE SURV COMPLETED	
		495347	B. WING _			C 06/27/20	<b>019</b>
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, 23352 COURTHOU WINDSOR, VA 2		1 00/27/20	<u> </u>
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F 582	This is cited as Past  The findings included  Resident #92 is a 86 facility on 1/10/19 with not limited to Acute E Generalized Muscle  Resident #92's Notice (NOMNC) document Services ending on 1 documented in part,  Telephone Notification 1/22/19 at 3:20 P.M. mother's last covered 1/23/19. QIO (Qualited Organization) phone and timeframe provide On 06/25/19 at 12:47 conducted with the coregarding the timeframe resident/resident reputheir Notice's of Med Social Worker stated 48 hours prior to the resident has adequatif they desire." The Social Worker Stated 48 hours prior to the resident has adequatif they desire." The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire. The Social Worker Stated 48 hours prior to the resident has adequatif they desire.	year old admitted to the th diagnoses to include but Bronchitis, Dysphagia and Weakness.  e of Medicare Non-Coverage with Skilled Nursing 1/23/19 was reviewed and is as follows:  spoke with son about day for therapy being ty Improvement number given, appeal rights ded/explained: No.  7 PM an interview was urrent facility Social Worker me as to when should a resentative be notified of icare Non-Coverage. The , "The notices should be give last covered day so the te time to request an appeal Social Worker was shown the lon-Coverage for Resident resident had been given a Social Worker stated, "No, it	F	82			
	that 24 hours."  The facility policy title Provider Non-Covera	efore at 3:20 P.M., it was less ed "Notice of Medicare age Generic Notice" revised ewed and is documented in					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		495347	B. WING			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ı	06/27/2019
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F 582	part, as follows:  Policy: A Notice of M Non-Coverage will b non-Medicare covers the CMS (Center Me Notice of Medicare F The form cannot be addition of the facility facility name, addres above the title of the The form will be reviauthorized represent Procedure:  1. The facility will ginotice to the resident than 2 days before the services.  2. The resident must purpose and content for receipt of it. The understand that he content for receipt of it. The understand that he content for receipt of it. The understand the content for receipt of it.	Medicare provider e utilized to notify resident of age. The facility will utilize edicare Services) specific Provider Non-Coverage form. changed other than the y logo and placement of the es and telephone number form if it is not in the logo.  ewed with the resident or tative.  The accompleted copy of the treceiving services no later the termination of skilled  The bable to understand the tes of the notice in order sign resident must be able to or she may appeal the The resident is unable to tents of the notice, it must be ned by an authorized  The services end. If you don't get This notice explains:	F5	582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING				07/0040
NAME OF D	ROVIDER OR SUPPLIER	433347	D: Wilto		DEET ADDRESS CITY STATE ZID CODE	06/	27/2019
	TE HEALTH CARE OF W	/INDSOR		233	REET ADDRESS, CITY, STATE, ZIP CODE  352 COURTHOUSE HIGHWAY  INDSOR, VA 23487		
				771			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 582	after the coverage en Information on your ri about why your cover Your right to a fast ap to contact the Benefic Care Quality Improve (BFCC-QIO) in your some of the Director of Nursin Consultant. The Corp shared that she had consultant. The Corp shared that she had consultant in January 20 Medicare Non-Covera Correction was developed training and weekly Notice of Medicare Non-Covera facility date of compliance will be Medicare Non-Covera after the 2/1/19 date. Personal Privacy/Con CFR(s): 483.10(h)(1)-§483.10(h) Privacy ar The resident has a rig confidentiality of his or records.  §483.10(h)(l) Personal accommodations, me telephone communication and meetings of familians with the surface of the surface	d date given on your notice ght to get a detailed notice ed services are ending peal and information on how ciary and Family Centered ment Organization state to request a fast appeal imately 3:30 P.M. the above ed with the Administrator, g and the Corporate Nurse corate Nurse Consultant done a mock survey in the 219 and identified Notice of age issues. A Plan of opped on 1/17/19 to include on-Coverage audits with a cance of 2/1/19. Past the given since no Notice of age issues were identified infidentiality of Records (-(3)(i)(ii))  and Confidentiality. In the personal privacy and or her personal and medical all privacy includes dical treatment, written and attions, personal care, visits, y and resident groups, but the facility to provide a		582	DEFICIENCITY		
	§483.10(h)(2) The fac	cility must respect the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIEICATION NI IMPED:		PLE CONSTRUCTION  G	(X3)	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C <b>06/27/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		COILITECTS	
				23352 COURTHOUSE HIGHWAY			
CONSULA	ATE HEALTH CARE OF W	/INDSOR		WINDSOR, VA 23487			
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F 583	residents right to pers right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delive than a postal service.  §483.10(h)(3) The resident has the office of the state Loston examine a resident administrative records law.  This REQUIREMENT by:  Based on observation facility staff failed for in the survey sample maintained during a very for Resident #55.  The findings included Resident #55 was orion 01/24/19. Diagnos included but are not liknee amputation. Resident Reference services and services and sees and	sonal privacy, including the or her oral (that is, spoken), a communications, including promptly receive unopened, packages and other the facility for the resident, ared through a means other sident has a right to secure onal and medical records. The right to refuse the release cal records except as (2) or other applicable.  Illow representatives of the ing-Term Care Ombudsman its medical, social, and is in accordance with State. The is not met as evidenced in and staff interviews the one resident (Resident #55), of 57, to ensure privacy was wound care dressing change.  In a containing the low the sident #55's Minimum Data ment protocol) with an one Date of 04/26/19 coded 1 out of a possible score of ew for Mental Status.	F 5	1. LPN #5 was educated or privacy on 06/27/19 by the E 2. Residents with treatment the potential to be affected. other residents having treatr were affected. 3. The DCS and or designe educate the License staff on Resident privacy completed on 08/01/19. 4. The DCS (Director of Clir Service) and or designee wi wound care observation audensure privacy is provided to weekly for 2 weeks, weekly 4 and monthly times 2 month results will be reported to the Quality Assurance Performa Improvement Committee (Q by the Executive Director meters of 3 months for further com and/or revision. 5. AOC date: 08/06/2019	ED.  Its have No ments  Re will In  Inical Itill do Itit to Itill do Itit to Itill do Itill d		

_ ` · · ·		IDENTIFICATION NUMBER		PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	I	00/2//2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 583	impairment. In addit #55 as extensive ass and toilet use and lin dressing and person Daily Living care. Se coded for surgical we Resident #55 resided did not have a private did not have a private dressing observation approximately 8:30 a Nurse (LPN) #5, the door remained open dressing change to F wound to his right sta approximately 8:45 a walked pass the ope being performed by I on Resident #55's op going to close the doc for privacy." People outside of his window	ion, the MDS coded Resident sistance of one with bathing nited assistance of one with all hygiene for Activities of ection M-skin condition was bund care.  d in a private room; the room by curtain. During a wound	F 5	83			
	Nursing (DON) on 06 a.m. She said the not door and window blir maintain privacy and approximately 2:14 pconducted with LPN #55's window blind a closed during the drestump surgical incision. The Administrator, D	nducted with the Director of 6/26/19 at approximately 9:11 urse should have closed the ad during wound care to dignity. On the same day at e.m., an interview was #5 who stated, "Resident and door should have been essing change to his right on to maintain his privacy."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 352 COURTHOUSE HIGHWAY FINDSOR, VA 23487	1 0011	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584 SS=D	did not present any fur findings.  The facility's policy tit Rights and Responsil -Each nursing facility dignified existence, so communication with a services inside and o must protect and pror resident.  As a nursing facility refollowing rights under -Privacy to include bu privacy when care or provided.  Safe/Clean/Comforta CFR(s): 483.10(i)(1)-1.5 (1)-1.	g during a briefing on ately 3:40 p.m. The facility or ther information about the led Virginia Resident's bilities (Effective: 01/07.) resident has a right to a self-determination, and and access to persons and utside the facility. A facility mote the rights of each esident, you have the federal and state law: t not limited to: To have medical treatment is being ble/Homelike Environment (7) conment. If the a safe, clean, elike environment, including treatment and ig safely.		583			

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
	495347	B. WING _			27/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		21/2013	
0010111 475 11541 711 04 05 05 14	(INDOOR		23352 COURTHOUSE HIGHWAY			
CONSULATE HEALTH CARE OF W	INDSOR		WINDSOR, VA 23487			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
or theft.  §483.10(i)(2) Houseke services necessary to and comfortable interiors.  §483.10(i)(3) Clean bein good condition;  §483.10(i)(4) Private or resident room, as special specia	eeping and maintenance or maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature lly certified after October 1, in temperature range of 71 to maintenance of comfortable is not met as evidenced in and staff interview, the provide a homelike in edining observation from on the Peach Unit (Memory) esident meals on trays ervation on the Peach Unit.	F	1. Staff #9, CNA#7, LPN educated on not serving completed on 7/16/19. 2. All residents have the affected. The facility corto ensure that meals are trays. 3. Nursing staff and died been educated by the Elensure meals are not serin the dining room was by 08/01/19. 4. The Executive Directed designee will complete a trays are not served on room twice weekly for 2 times 4 and monthly time results will be reported to Assurance Performance Committee (QAPI) by the Director monthly for 3 m compliance and/or revisits. AOC date: 08/06/20	meals on trays e potential to be impleted an audit in not served on tary staff have D or designee to rved on the trays completed or and or in audit to ensure trays in the dining weeks, weekly es 2 month. The of the Quality Improvement e Executive onths for further ion.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION		COMPLETED		
		495347	B. WING			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/21/2013	
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F 584	Continued From page	ge 28	F 58	4			
		roximately, 11:56 AM all sitting at the dining table with trays.					
		roximately 12:20 PM all he table had their meals left					
	On 06/27/19 at approximately 12:23 PM all nineteen residents sitting at the dining table had their meals served on trays.						
	interview was condu (Food Service Direct resident's meals on "It's not a fine dining Unit." "Only in main the trays on the tab	eximately 9:00 AM an sucted with Other Staff #9 etor) concerning leaving the their trays. She stated that g experience on the Peach Dining." "We've tried to leave les before but it just didn't a policy on Fine Dining was					
	interview was condu Nursing Assistant) of said "We don't do the	eximately 10:10 AM, an aucted with CNA #7 (Certified concerning the above. She nat back here, because in the dining." "It's been like this e for 2 years."					
	interview was condu Practical Nurse) con responded, "A lot of want anyone to slip	eximately, 10:15 AM an sucted with LPN #8 (Licensed incerning the above. She if them spill stuff." "We don't and fall." "Everything is y." "We have to be very					
	On 6/27/19 at appro	eximately 4:24 PM the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495347	B. WING_			06/	27/2019
	ROVIDER OR SUPPLIER TE HEALTH CARE OF W	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 600 SS=D	concerning Fine Dining policy on Fine Dining. Dining will be institute Alzheimer/Dementia (Con 06/07/19 at approinterview was conducted Consultant, Director of Nurse and the Administrative was another comments made and CFR(s): 483.12(a)(1)	approached for a policy ag. She said that there is no She also stated that Fine ad in the near future on Care Units.  Eximately 4:43 PM a Pre-exit atted with the Nurse of Nursing, The Regional attrator. The above findings Nurse Consultant stated "I ang with it." There were no e.		584			
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemitreat the resident's me §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corporativoluntary seclusion; This REQUIREMENT by:  Based on staff interviand clinical record reviacility staff failed to e	right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  by must-  e verbal, mental, sexual, or or oral punishment, or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 600	separated and protect after a sexual encount two residents; another on 3/20/19.  The findings include:  1a. Resident #5 was 6/20/18 with diagnos limited to Pick's Disedifficulty walking, and Resident #5's most reset) assessment was an ARD (assessment Resident #5 was codimpaired in cognitive on the BIMS (Brief In exam. Resident #5 wextensive assistance ADLs (activities of dabed mobility and tranwith walking.  1b. Resident #107 was 11/28/18 with diagnor not limited to Wernick Hepatitis C (3), and a Resident #107's most data set) assessment with an Adate) of 6/25/19. Resident #107's most data set) assessment with an Adate) of 6/25/19. Resident #107's was called the Staff Assessment Resident #107 was called the Staff Assessment with an Adate) of 6/25/19. Resident #107 was called the Staff Assessment with an Adate) and Staff Assessment with an Adate)	ensure Resident #5 was steed from Resident #107 her on 3/6/19 between the er sexual encounter occurred admitted to the facility on es that included but were not ase (1), muscle weakness, a major depressive disorder. Here the major depressive disorder are quarterly assessment with a reference date) of 3/11/19. He as being severely function scoring 99 out of 15 terview for Mental Status) has coded as requiring from one staff member with hilly living) such as dressing, sfers; and supervision only has admitted to the facility on see that included but were se's encephalopathy (2), altered mental status. It recent MDS (minimum the was a quarterly ARD (assessment reference ident #107 was coded as baired in cognitive function tent for Mental Status exam. oded as being independent foaily living) and requiring	F 600	1. Resident #5 and resident #107 a separated after and resident #5 was transferred off unit. Resident #107 had no further incidents.  2. All residents have the potential to affected. The facility completed an ensure that residents that currently in the facility are free from abuse. No issues were identified.  3. Licensed and non-licensed staffs been educated by the DCS or designent eresidents are separated at the official and incident to ensure they are free abuse was completed on 08/01/19.  4. The ED and or designee will contain audit to ensure residents are separated at the time of an incident and we placed on increased supervision and evaluated by Provider, twice weekly 2 weeks, weekly times 4 and month times 2 month. The results will be reto the Quality Assurance Performant Improvement Committee (QAPI) by Executive Director monthly for 3 months for further compliance and/or revision 5. AOC date: 08/06/2019	has  be be audit to reside to other the time to the time to the parated will be down for ally the ported the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495347	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	- 1	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	nursing note that doc abuse on 3/6/19. The "Reported to this wri" #5) in room (number lured in (number of F with paints (sic) dow each others. Made E aware. Instructed by apart."  Review of the facility incidents) revealed to the OLC (Office of and other state agen. An investigation coul incident.  Further review of Re #107's clinical record were keeping the result of Review of Resident in plan dated 12/10/18 3/21/19; failed to refl between Resident #8  Review of Resident in plan dated 12/12/18 6/25/19; failed to refl between Resident #8  Further review of the incident had occurrence Resident #107 on 3/3 documented in the Funcident date 3/20/19 residents were found	#5's clinical record revealed a cumented possible sexual e following was documented: ter that resident (Resident of Resident #5's room) was Resident #107's room). Seen in as well as lips touching DON (Director of Nursing) DON to keep resident's  *FRIs (facility reported that a FRI was not submitted if Licensure and Certification) icies regarding this incident. It do not be found regarding this sident #5's and Resident the failed to evidence that staff sident's separated.  #5's comprehensive care with the latest revision on ect the above incident and Resident #107.  #107's comprehensive care with the latest revision on ect the above incident and Resident #107.  #107's romprehensive care with the latest revision on elect the above incident and Resident #107.  #107's the following was RI: "Report date 3/20/19,	F 6			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		495347	B. WING		C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 600	the delivery of dinner Resident #5) and (resident #5) and (resident #5) and (resident removed. Neither retained in the had sexual interesident immediately separate completed and not either resident. MD (Responsible Party action initiated or tawas moved to anoth (name of Resident 15 minute checks). did not want to commodification of the five day investive 5/25/19, documented "During dinner time passing out meal trentered the room to she encountered (for (name of Resident #107) was taken to his room. The five day investive assessment of (Namo visualization of pruising, or dischart q 15 minute checks (Resident #5) was unit and placed on (off the locked unit) have experienced a incident. Findings: review of the medic substantiated that the unclothed but there	enediately separatedduring er, staff noted (name of name of Resident #107) on the th their clothing partially esident wanted to discuss if intions. The residents were ated, skin assessments signs of physical injury noted to (Medical Doctor) and RP ) were notifiedEmployee aken: (Name of Resident #5) ther room off the unit and #107) was placed on q (every) (Name of Resident #5's RP)	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER:  A. BUILDI		IPLE CONSTRUCTION  IG	· /	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<u>'</u>	002172010	
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F 600	revealed a social we 2:23 p.m., that documented to be the normally stays in favored by a female understands when the having a relationship reside here. Understands when the will follow. Documented the will follow and things. No agitation monitored for change further review of Resident #5 twice of unsuccessful due to social worker met would and documented the of Resident #5) at be and was easy to aw depressed as evide when mentioning for generally elicits a probe related to the mosurroundings were a swelling to upper lip	esident #107's progress notes orker note dated 3/21/19 at amented the following: one fond of a female resident. In his room but has been a resident. He is alert and opeing spoken to. Denies one with any residents that attands boundaries and voices ones not engage in regins to talk about other or aggression noted. Will be gies."	F 6				
	Review of Resident dated 4/10/19 docur seen for increased in (patient) was moved Blue unit d/t (due to resident on Peach.	#5's psych physician note mented the following: "being reports of depression. Pt d from Peach (locked unit) to interaction with another RN (Registered Nurse) increased with move, spends					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495347	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR	:	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 30/21/2010
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 600	speak to pt (patient) me." Ignored questic depression, anxiety, Encouraged an oper review of chart, spearevaluation, restarting (4)discussed channescitalopram 10 mg QD (every day)will.  There was no furthe experienced continue psychological harm of the above encour.  On 6/25/19 at 5:37 pconducted with LPN when both sexual er When asked the proabuse between two #1 stated that she we the situation and repadministration. Whe coordinator was, LP (Director of Nursing) When asked what we a resident is abused stated that q (every conducted for three tracking record. When staff, i.e. nursing aid aware of resident to stated that nurses a report. When asked	hypersomnia. Attempted to in her room "don't talk to ons about feelings, insomnia, mood. In safe space to talk. After aking to RN, and pt g escitalopram (Lexapro) iges with RNInitiate (milligrams) PO (by mouth) I continue to monitor."  It evidence that Resident #5 led depression or as a result inters with Resident #107.  In an interview was a man interview was	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING			1	C	
NAME OF PE	ROVIDER OR SUPPLIER	40047		STE	REET ADDRESS, CITY, STATE, ZIP CODE	06/	27/2019	
TO WILL OF TH	TO VIBER OR GOLL EIER				852 COURTHOUSE HIGHWAY			
CONSULA	TE HEALTH CARE OF	WINDSOR			NDSOR, VA 23487			
	OLIMANA DV.	DIATEMENT OF DEFICIENCIES					217	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	ge 35	F	300				
	stated, "It should be	updated."						
	On 6/26/19 at approinterview was condustaff member) #2, the and ASM #3, the coasked the process in two residents engages especially on the Peshe would separate investigation to see reporting. ASM #2 scan give consent; so residents privacy. A residents privacy. A residents could not call the RPs and if the would ensure the repracticing safe sex. of the incident on 3/20/19 do made aware. When on 3/20/19 between #107; ASM #2 state	poximately 4:00 p.m., an aucted with ASM (administrative the DON (Director of Nursing) arporate consultant. When if her nurses were to report ging in sexual relations each unit, ASM #2 stated that the residents, start an if the incident requires stated that if both residents the would then provide the asymptotic consent, she would then he RPs give consent she esidents are safe and ASM #2 denied being aware asymptotic forms asked what had happened as Resident #5 and Resident at that it was reported to her						
	#5 with their pants p that at this time Res	was found on top of Resident bulled down. ASM #2 stated sident #5 was able to remove #2 stated that as soon as						
	she found out, she i residents, called the called the physician	immediately separated the eresponsible parties and . ASM #2 stated that she had off the Peach unit and to the						
	an assessment on F visible signs of pene stated that since bo consent at this time incident to the state	stated that she had performed Resident #5 and there were no etration or injury. ASM #2 th residents could not give , she had reported this agencies. ASM #2 stated that						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	00/21/2010	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	advances. ASM #2 denied anything hap Resident #107 said Resident #5 to the be Resident #5 to the be Resident #5's responses she didn't with through that stress nothing was put into incident because she incident on 3/6/19. A was no evidence that (responsible parties incident on 3/6/19.  On 6/26/19 at 4:50 producted with CNA #4, an aide who with on 3/6/19 and 3/20/would immediately streport any suspecte CNA #4 stated that son 3/6/19 but that sl (LPN #1) that Resid room. CNA #4 stated keep the residents street when there was only nurse to the Peach are supposed to be unit. CNA #4 stated #107 was left unatter residents' rooms proonly one nurse work units. CNA #4 stated with the consideration on the stated with th	ge 36 ented to Resident #107's stated that Resident #107 opening. ASM #2 stated that he was trying to take eathroom. ASM #2 stated that he was trying to take eathroom. ASM #2 stated that his ble party did not want the hospital for a rape kit want to put her daughter ASM #2 confirmed that place to prevent the 3/20/19 e was not made aware of the ASM #2 confirmed that there at the physicians and RPs ) were notified regarding the  o.m., an interview was (Certified Nursing Assistant) hessed both sexual incidents 19. CNA #4 stated that she separate the residents and d abuse to her supervisor. She could not recall too much he had reported to the nurse ent #5 was in Resident #107's d that she was just told to separated. CNA #4 stated that d as much as they could to separated and that it was hard by two nursing aides and one unit. CNA #4 stated that there three aides on the Peach that sometimes Resident ended if the aides were in the oviding care and there was and both the blue and peach d that Resident #107 had not all encounters with an other	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C 06/27/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		10/2/1/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 600	total of 5 years.  On 6/26/19 at 5:13 p. conducted with LPN #1, the nurse who wa asked what had happestated that a CNA haseen Resident #5 in I #1 stated that because residents were cognic consent to any sexual residents, and alerted LPN #1 stated; "I told Nursing). She told measked if it was difficul Resident #107 apart, passing out medication providing care, it was them. LPN #1 stated CNA's on Peach Unit two. LPN #1 could nowere on shift the day stated that she is the a.m. to 7 p.m. on the she could provide this checks that were conducted on Resident #107, LPN checks were never we there was no way to were conducted on Resident to resident a LPN #1 stated that she doctor and the responsible of the conducted on Resident to resident a LPN #1 stated that she doctor and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the responsible of the conducted on Resident to resident and the conducted on Resident a	g on the Peach Unit for a  m., further interview was (Licensed Practical Nurse) as working on 3/6/19. When bened on 3/6/19; LPN #1 d alerted her that she had Resident #107's room. LPN as she was not sure if the tively intact enough to al activity; she separated the d administration (the DON). I (Name of Director of a to keep them apart." When at to keep Resident #5 and LPN #1 stated that if she is and a CNA is in a room a difficult to keep an eye on that there should be three a and lately there had been at recall how many CNAs of 3/6/19 or 3/20/19. LPN #1 only nurse usually working 7 Peach Unit. When asked if as writer with the 15 minute	F 6				
	there was no way to were conducted on R When asked if anyon resident to resident a LPN #1 stated that st doctor and the responsible asked if she had contract RP's regarding the in stated, "I don't rement	prove that 15 minute checks desident #107 on 3/6/19. e else was notified after a litercation or sexual incident, ne would alert the medical insible parties (RP). When tacted the physicians and					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<u> </u>	06/27/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	that Resident #5's a plans were not revi Review of the as-w and 3/20/19 as wel all staff working on revealed that both of 3/6/19 and 3/20/19 one nurse worked to not solve the above concered to the abov	RPs. LPN #1 also confirmed and Resident #107's care sed after the 3/6/19 incident.  Orked schedules for 3/6/19 I as the punch time sheets for the Peach and Blue units, units were fully staffed on There was no evidence that both the Blue and Peach units /19.  I as the punch time sheets for the Peach and Blue units, units were fully staffed on There was no evidence that both the Blue and Peach units /19.  I p.m., ASM #1, the I #2, the DON and ASM #3, as consultant were made aware rms.  It's abuse policy documents in "Any person who observes or an incident of resident abuse, ment of resident belongings, aspected or observed, must to the Executive Director, Services Immediately. The Director of Clinical Services or upervisor will initiate the ent investigation and suspected or observed ghly investigated by the and/or Director of Clinical suspected or observed ted immediately to and all other officials required	F 6				
	theOmbudsman a by state law. If a re resident, the abusiv contacted and appr prevent further suc resident's behavior						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING			l	27/ <b>2019</b>	
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	1 00/	2772019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	facility staff.  (1) "Pick 's disease is characterized by a slot deterioration of behavilanguage. People wit abnormal substances nerve cells in the dan Pick bodies contain a called tau. This prote but people with Pick's amount or type of this was obtained from Thealth. https://rarediseases.iicks-disease.  (2) "Wernicke's enceptrain disorder caused (vitamin B1). It may redietary deficiencies, publication disorders, or the effect deficiency causes dathalamus and hypothemental confusion, vishypothermia, low bloomuscle coordination (was obtained from Thealth. https://www.ninds.nih/Wernicke-Korsakoff  (3) Hepatitis C- Hepatics (1) Thealth (1) Thealt	scharged."  In was presented by the  Is a neurological condition owly progressive vior, personality, or In Pick's disease have Is (called Pick bodies) inside Inaged areas of the brain. In abnormal form of a protein In is found in all nerve cells, Is disease have an abnormal Is protein." This information In National Institutes of Info.nih.gov/diseases/7392/pi  Inhalopathy is a degenerative If by the lack of thiamine In the National Institutes of Info.nih.gov/diseases/7392/pi  Inhalopathy is a degenerative If by the lack of thiamine Info.nih.gov/diseases/7392/pi  Inhalopathy is a degenerative If by the lack of thiamine Info.nih.gov/diseases/7392/pi  Inhalopathy is a degenerative If by the lack of thiamine Info.nih.gov/diseases/7392/pi  Inhalopathy is a degenerative Info.nih.gov/diseases/7392/pi	F	600				
	liver. Chronic hepatiti infection. If it is not tre							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
			La vivia			С	
		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER  ATE HEALTH CARE OF W	/INDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	lifetime and cause seincluding liver damagiliver), liver cancer, an spreads through contisomeone who has HO through -Sharing drug needles with someone who has States, this is the mosget hepatitis CGetting an accidenta was used on someon happen in health care-Being tattooed or pie were not sterilized aft who has HCV -Having contact with a someone who has HCV -Having personal car come in contact with a such as razors or tool-Being born to a moth-Having unprotected shcv." This information National Institutes of Interest (S): 483.12(b)(1)- §483.12(b) The facility implement written policy shall be supported to the support of the s	rious health problems, e, cirrhosis (scarring of the d even death. Hepatitis C act with the blood of CV. This contact may be so or other drug materials as HCV. In the United at common way that people I stick with a needle that e who has HCV. This can e settings.  I reced with tools or inks that er being used on someone the blood or open sores of CV are items that may have another person's blood, thbrushes her with HCV sex with someone who has an was obtained from The Health.  Dov/hepatitisc.html.  buse/Neglect Policies (3)  Iy must develop and icies and procedures that:  It and prevent abuse, ion of residents and esident property,  Sh policies and procedures		600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495347	B. WING			061		
NAME OF P	ROVIDER OR SUPPLIER	100011	1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/2	27/2019	
TO AVIL OF TH	TO VIBER OIL OUT I EIER				3352 COURTHOUSE HIGHWAY			
CONSULA	TE HEALTH CARE OF W	/INDSOR			VINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
					1. A facility reported incident was i	nitiated		
F 607	Continued From page 41  §483.12(b)(3) Include training as required at		F 6	507	on resident #5, #41, #82 and reside	ent #107		
					according to policy and procedure	and an		
	9483.12(b)(3) include paragraph §483.95,	training as required at			investigation was initiated.			
		is not met as evidenced			2. All residents have the potential t	o be		
	by:				affected. The facility completed an	audit		
		n, staff interview, facility			of the residents that currently reside	ent in		
	document review, and clinical record review, it was determined that facility staff failed to implement abuse policies and report and				the facility for the last 30 days to er			
					that abuse polices have been imple			
		s of abuse; and failed to			, , ,			
		y after abuse had occurred			and reported was completed on 07	23/19.		
	Resident #5, #82, #10	s in the survey sample,			No other issues were identified.			
	1103100111 #3, #02, #10			3. Licensed staff have been educa	ted by			
	1. For Resident #5, fa	acility staff failed to			the DCS or designee on the policy	and		
		cies and report, investigate			procedures of abuse investigation t	hat		
	and ensure Resident	-			was completed by 08/01/19.			
	encounter with Reside	ent #107 on 3/6/19.			4. The ED and or designee will con	nnlete		
	2. For Resident #82,	facility staff failed to			_			
		cies and report, investigate			an audit to ensure policy and proce			
		safety after a physical			of abuse are implemented and inve	stigated		
	altercation with Resid	ent #107 on 6/24/19.			twice weekly for 2 weeks, weekly t	imes		
	2. The facility staff fai	lad to implement the written			4 and monthly times 2 month. The	results		
		led to implement the written to report allegation of abuse			will be reported to the Quality Assu	rance		
	to the Administrator in				Performance Improvement Commit			
	Resident #41.	, <b>,.</b>			•			
					(QAPI) by the Executive Director m	- 1		
	The findings include:				for 3 months for further compliance	and/or		
	4a Dasidant #F was	admitted to the facility on			revision.			
		admitted to the facility on es that included but were not			5. AOC date: 08/06/2019			
		ase (1), muscle weakness,						
		major depressive disorder.						
		ecent MDS (minimum data						
		a quarterly assessment with						
		reference date) of 3/11/19.						
	Resident #5 was code	ed as being severely						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
		495347	B. WING _			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<u>'</u>	33/27/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	on the BIMS (Brief Ir exam. Resident #5 v extensive assistance ADLs (activities of dependent) and train with walking.  1b. Resident #107 w 11/28/18 with diagnor of limited to Wernic Hepatitis C (3), and Resident #107's more data set) assessment with an date) of 6/25/19. Resident #107 was dependent	e function scoring 99 out of 15 interview for Mental Status) was coded as requiring a from one staff member with aily living) such as dressing, insfers; and supervision only was admitted to the facility on insees that included but were like's encephalopathy (2), altered mental status.	F	507			
	nursing note that do abuse on 3/6/19. Th "Reported to this wri #5) in room (number lured in (number of F with paints (sic) dow each others. Made D aware. Instructed by apart." Review of the facility incidents) revealed to to the OLC (Office of and other state ager	#5's clinical record revealed a cumented possible sexual e following was documented: ter that resident (Resident of Resident #5's room) was Resident #107's room). Seen as well as lips touching DON (Director of Nursing). DON to keep resident's FRIs (facility reported that a FRI was not submitted a Licensure and Certification) incies regarding this incident.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED		
		495347	B. WING		C 06/27/2040		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487	06/27/2019		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
F 607	Continued From pa	ge 43	F 60	7			
	#107's clinical reco	esident #5's and Resident rd failed to evidence that staff esident's separated to prevent					
	incident had occurr Resident #107 on 3 documented in the Incident date 3/20/ residents were four room lying together residents were imm the delivery of dinner Resident #5) and (resident #5) and (resident #5) and (resident #5) and (removed. Neither rethe had sexual interimmediately separate completed and not either resident. MD (responsible party) action initiated or tawas moved to anotice (name of Resident 15 minute checks).	de FRIS revealed a second ed between Resident #5 and 8/20/19. The following was FRI: "Report date 3/20/19, 19: Incident Type: The and in (Name of Resident #5's) is partially undressed. The two dediately separatedduring er, staff noted (name of name of Resident #107) on the high their clothing partially esident wanted to discuss if intions. The residents were sted, skin assessments signs of physical injury noted to (medical doctor and RP) were notifiedEmployee sken: (Name of Resident #5) ther room off the unit and #107) was placed on q (every) (Name of Resident #5's RP) did not want to contact the					
	The five day investing 5/25/19, documented "During dinner time passing out meal trentered the room to she encountered (Figure of Resident down around their assertion of the statement of the sta	igation follow up dated ed in part, the following: staff was in the process of ays. As a staff member o get (name of Resident #5) Resident #107) on top of #5) both with there clothing ankles. (Name of Resident ately removed and taken to his					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495347	B. WING			06/	27/2019
NAME OF PR	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSIII	TE HEALTH CARE OF W	/INDSOP		:	23352 COURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF W	MINDSOR		١	WINDSOR, VA 23487		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
					DEI ICIENCI)		
F 607	Continued From page	e 44	F	607	7		
	room. The staff perfor	rmed an assessment of					
	(Name of Resident #5	5) and found no visualization					
	of penetration, rednes	ss, swelling, bruising, or					
	discharge. Staff inforr	med to conduct q 15 minute					
	checks on (Resident	#107). (Resident #5) was					
	immediately transferre	ed off the unit and placed on					
	another unit within the	e facility (off the locked unit).					
	Both residents appea	r not to have experienced					
	any emotional trauma	from the incident. Findings:					
	Based on staff, reside	ent and review of the					
		cility has substantiated that					
	-	partially unclothed but there					
		ence to suggest that sexual					
	intercourse has occur	red"					
	On 6/25/19 at 5:37 p.						
		#1, the nurse who worked					
		counters had occurred.					
	-	ess if she were to see					
		esidents in the facility, LPN					
		ould remove the victim from					
	the situation and repo						
		asked who her abuse					
		I #2 stated that the DON					
	l .*	was the abuse coordinator.					
		s usually put into place after					
		oy another resident, LPN #2					
		5 min) checks are usually					
		ays and recorded on a					
	_	n asked how other clinical					
		s and nurses are made esident abuse, LPN #1					
		d nursing aides are given					
		he purpose of the care plan,					
	T	rpose of the care plan was					
	-	care for the residents.					
	_	re plan should be updated					
		ident altercation, LPN #1					
	stated, "It should be u						
	States, it should be t	ipaaica.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495347	B. WING _			C <b>06/27/2019</b>		
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/2//2013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 607	Continued From pag	ge 45	F 6	507				
	interview was condustaff member) #2, the and ASM #3, the considerable asked the process if two residents engage especially on the Peshe would separate investigation to see reporting. ASM #2 scan give consent; shresidents privacy. As residents could not goall the RPs and if the would ensure the repracticing safe sex. of the incident on 3/6/19 domade aware. When on 3/20/19 between #107; ASM #2 state that Resident #107 white the state that this time Resher own pants. ASM she found out, she in residents, called the called the physician moved Resident #5 Blue unit. ASM #2 s an assessment on Festivated that since bot consent at this time, incident to the state Resident #5 could necession.	ximately 4:00 p.m., an octed with ASM (administrative e DON (Director of Nursing) reporate consultant. When ther nurses were to report ing in sexual relations ach unit, ASM #2 stated that the residents, start an if the incident requires tated that if both residents are would then provide the SM #2 stated that if the give consent, she would then he RPs give consent she sidents are safe and ASM #2 denied being aware 6/19 between Resident #5 despite the nursing note cumenting that the DON was asked what had happened Resident #5 and Resident didnt it was reported to her was found on top of Resident ulled down. ASM #2 stated ident #5 was able to remove a #2 stated that as soon as mmediately separated the responsible parties and ASM #2 stated that she had off the Peach unit and to the tated that she had performed desident #5 and there were no stration or injury. ASM #2 the residents could not give she had reported this agencies. ASM #2 stated that of tell her what had happened ented to Resident #107's						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		495347	B. WING_			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	l	06/27/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	denied anything hap Resident #107 said Resident #5 to the be Resident #5 to the be Resident #5's response Resident #5 sent to because she didn't withrough that stress. Inothing was put into incident because she incident on 3/6/19. A was no evidence that (responsible parties) incident on 3/6/19. On 6/26/19 at 4:50 pconducted with CNA #4, an aide who with on 3/6/19 and 3/20/1 would immediately streport any suspected CNA #4 stated that so on 3/6/19 but that she (LPN #1) that Reside room. CNA #4 stated keep the residents sthe nursing staff tried keep the residents swhen there was only nurse to the Peach unit. CNA #4 stated #107 was left unatter residents' rooms proonly one nurse work units. CNA #4 stated had any other sexual residents, only Residents, only Residents, only Residents, only Residents.	stated that Resident #107 pening. ASM #2 stated that he was trying to take athroom. ASM #2 stated that hisible party did not want the hospital for a rape kit want to put her daughter ASM #2 confirmed that place to prevent the 3/20/19 e was not made aware of the ASM #2 confirmed that there his the physicians and RPs were notified regarding the  a.m., an interview was his (Certified Nursing Assistant) hessed both sexual incidents he could not recall too much he had reported to the nurse her #5 was in Resident #107's he that she was just told to he parated. CNA #4 stated that had as much as they could to he parated and that it was hard had two nursing aides and one had the aides were in the had reported that there had sometimes Resident had of the aides were in the had resident #107 had not had a the sident	F 6	07			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		495347	B. WING _			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	I	33/21/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	conducted with LPN #1, the nurse who wasked what had hap stated that a CNA in seen Resident #5 in #1 stated that becaute residents were cogniconsent to any sexute residents, and alerted LPN #1 stated; "I tol Nursing). She told in asked if it was difficing Resident #107 apar passing out medical providing care, it was them. LPN #1 stated CNA's on Peach unitwo. LPN #1 could in were on shift the dastated that she is the 7a.m. to 7 p.m. on the could provide the checks that were concept there was no way to were conducted on When asked if anyour resident to resident.	p.m., further interview was (Licensed Practical Nurse) was working on 3/6/19. When opened on 3/6/19; LPN #1 and alerted her that she had Resident #107's room. LPN use she was not sure if the nitively intact enough to all activity; she separated the end administration (the DON). If the to keep them apart. When the to keep them apart is and the to keep an eye on the to keep them apart is a room as difficult to keep an eye on that there should be three into the total to keep and the tree in the total to keep and the them and the tree in the total to keep and the tree in the total to keep and the tree in the tre	F6				
	asked if she had con RP's regarding the i stated, " I don't reme that she had not doo	onsible parties (RP). When ntacted the physicians and ncident on 3/6/19, LPN #1 ember." LPN #1 confirmed cumented that she notified the Ps. LPN #1 also confirmed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487	00/21/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 607	Plans were not revision Review of the as-wo and 3/20/19 as well all staff working on revealed that both to 3/6/19 and 3/20/19. One nurse worked bon 3/6/19 and 3/20/19 one nurse worked bon 3/6/19 and 3/20/19 one nurse contended to a standard transfer of the above concerns (1) "Pick's disease in characterized by a standard transfer of the above concerns (1) "Pick's disease in characterized by a standard transfer of the above concerns (1) "Pick's disease in characterized by a standard transfer of the above concerns (1) "Pick's disease in characterized by a standard transfer of the above concerns (1) "Pick's disease in the day abnormal substance nerve cells in the day abnormal substance nerve cells in the day in the people with Pick amount or type of the was obtained from Health. https://rarediseases.  (2) "Wernicke's encoration disorder cause (vitamin B1). It may dietary deficiencies, disorders, or the eff deficiency causes of thalamus and hypotics."	and Resident #107's care sed after the 3/6/19 incident.  Drked schedules for 3/6/19 as the punch time sheets for the Peach and Blue units, units were fully staffed on There was no evidence that both the Blue and Peach units 19.  Dp.m., ASM #1, the #2, the DON and ASM #3, the insultant were made aware of the second and the second and the second are second as a neurological condition	F 607	7		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2//2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 607	muscle coordination was obtained from Thealth. https://www.ninds.ni/Wernicke-Korsakof.  (3) Hepatitis C- Hepliver. Chronic hepati infection. If it is not tifetime and cause sincluding liver dama liver), liver cancer, a spreads through corsomeone who has hethrough sharing drug needle with someone who has hethrough states, this is the miget hepatitis C. Getting an accident was used on someone happen in health carbeing tattooed or pwere not sterilized a who has HCV someone who has hesharing personal carbeing born to a molenaving unprotected.	cood pressure, and lack of (ataxia)." This information The National Institutes of the National Institu	F 60	7		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495347	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 002772010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 607	implement abuse por and ensure Resider altercation with Res 2a. Resident #82 wa 3/15/19 and readmit that included but we without behavioral dand high blood pres recent MDS (minimula quarterly assessment referent #82 was coded as botto cognitive function or Mental Status Exam 2b. Resident #107 val 1/28/18 with diaground limited to Wernich Hepatitis C, and alter #107's most recent assessment was a cast ARD (assessment resident #107 was impaired in cognitive Assessment for Mer #107 was coded as (activities of daily livonly with walking.  Review of Resident the following nursing "resident attempting roommate was observed."	in, facility staff failed to plicies and report, investigate at safety after a physical ident #107 on 6/24/19.  It is admitted to the facility on ted on 5/9/18 with diagnoses are not limited to dementia listurbance, muscle weakness sure. Resident #82's most rum data set) assessment was arent with an ARD roce date) of 5/21/19. Resident reing severely impaired in the Staff Interview for an admitted to the facility on ones that included but were ocke's encephalopathy, arend mental status. Resident MDS (minimum data set) quarterly assessment with an eference date) of 6/25/19. The coded as being moderately as function of the Staff and Status exam. Resident being independent with ADL and requiring supervision and requiring supervision are set out of bed and derved hitting him in the face any down. no bruising	F 60	07	
	The next note dated	6/24/19 documented the			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495347	B. WING		C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2//2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 607	made aware of incident revealed the following resident yelling from CNA (Certified Nursident) observed this resident make him lay down message to return of made aware. Super Director of Nursing)  Review of the facility incidents) revealed to the OLC (Office of and other state age An investigation control incident.  On 6/25/19 at 2:21 conducted with CNA #5. When asked the resident hit another she would separate situation and redire stated that she would charge nurse. CNA stated that Resident the day prior at app she had reported the #1). CNA #5 stated statement for her nurse doing to ensure that the same time. Whe that morning, CNA stated material morning material morning material morning material morning material material morning material	all to RP (Responsible Party) dent with roommate."  #107's clinical record ng note dated 6/24/19: "Heard n room lay down lay down. sing Assistant) entered room ent hitting roommate trying to . Call placed to RP left call. PA (Physician's Assistant) rvisor and ADON (Assistant	F 60	0.7	

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495347	B. WING _			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	CODE	39/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B	
F 607	confirmed that the reduring this time. Who made aware of reside CNA #5 stated that reduced a ware of residence of the reduced for an intervence on 6/25/19 at 2:59 preached for an intervence on 6/25/19 at 2:59 preached for an intervence of the resident #82 was reduced for an intervence of the resident altercation and #82. ASM #2 standinistrator had sugo check.  On 6/25/19 at 5:20 provides the reduced for an intervence of the reduced for an intervence of the reduced for a sugor check.  On 6/25/19 at 5:20 provides for a sugor check was aware of the reduced for a sugor check.	during lunch. CNA #5 esidents were not separated en asked how CNAs were ent to resident altercations, nurses tell them in report.  a.m., LPN #1 could be riew.  a.m., the FRI and or Resident #107 and quested from the DON (ASM (administrative staff 2 stated that she didn't have vasn't aware of any resident in between Resident #107 ated that maybe the abmitted one and she would  a.m., ASM #3, the corporate Administrator had been esident to resident altercation for and #82 on 6/24/19, but cident to the appropriate state in investigation because s. ASM #3 stated that she the Administrator on the int over when to report and SM #3 stated that the sing the old abuse policy and we to report and separate the later were no injuries. ASM #3 just moved Resident #107 to offect Resident #82.  a.m., this writer was able to	F	607		
	get in touch with LPI	N #1. When asked what had 9 between Resident #107				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION IG		E SURVEY MPLETED
		495347	B. WING			C 6/27/2010
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		6/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	reported to her by the had slapped Resident staff attempted to get room but were unsuch they did q 15 minute. When asked if she could they did q 15 minute when asked if she could this. LPN #1 stated the incident to the ADON stated that most of the was out of the room a activities with the act told about the above asked if Resident #82 Resident #107 after the #107, LPN #1 stated Resident #107 to a p this was after this sure by asking for a FRI, LON 6/27/19 at 12:00 conducted with ASM asked the process what was after the sure between two resident would report actual a appropriate state age residents and start and stated that the incide and #82 was reported he did not report the appropriate state age he figured he did not	PN #1 stated that it was e CNA that Resident #107 at #82. LPN #1 stated that the Resident #107 out of his cessful. LPN #1 stated that checks on Resident #107. Sould provide those checks, are staff were not writing it not prove staff were doing that she had reported this and Administrator. LPN #1 are day 6/25/19, Resident #82 and at the table doing sivity assistant. LPN #1 was observations at lunch. When 2 was protected from being slapped by Resident that they just moved rivate room. When asked if the reyor had alerted the DON LPN #1 stated yes.  p.m., an interview was #1, the Administrator. When hen it is reported to him that on of abuse had occurred ts, ASM #1 stated that he buse that day to the	F6	507		
	reporting the incident	asked why he ended up on 6/25/19, ASM #1 stated and submitted				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		495347	B. WING _			C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/21/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	SHOULD BE	(X5) COMPLETION DATE
F 607	surveyor the fax con incident to the OLC of asked why an invest immediately and what Resident #82 from Review of the facility in Februar he was.  Review of ASM #1 error was educated on the Review of the in-sent that he and the DON abuse policy.  On 6/27/19 at 5:30 produced and the additional service on the above concerns.  Review of the facility part, the following: "Abecomes aware of an eglect or mistreatm whether alleged, sus report the incident to Director of Clinical Services Supprocedure for incident reportingAlleged, so	incident. ASM #1 showed this firmation to report the on 6/25/19 at 3:47 p.m. When igation wasn't started at they had in place to protect desident #107, ASM #1 strator and ADON) felt at the en asked if he was educated prior to his employment with rry 2019; ASM #1 stated that mployee file revealed that he abuse policy on 2/15/19. Vice dated 6/25/19 revealed were re-educated on the design and as were re-educated on the sultant were made aware of mincident of resident abuse, ent of resident belongings, spected or observed, must at the Executive Director, ervices Immediately. The Director of Clinical Services or pervisor will initiate the	F	607		
	Services. Alleged su violations are reporte	nd/or Director of Clinical spected or observed ed immediately to nd all other officials required				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495347	B. WING		C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	WINDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 607	resident, the abusive contacted and appropresent further such resident's behavior oposing a threat of hat the resident will be of the resident will be	dent abuses another resident's physician will be priate action will be taken to behavior. If the abusive cannot be controlled, thereby arm to others in the facility,	F 607		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 50125	_		Ι,	С
		495347	B. WING				27/2019
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	2112019
	10 115211 011 001 1 21211				3352 COURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF	WINDSOR			VINDSOR, VA 23487		
					 T		I
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	2018 addressed to the Health from the facili (Administration #6), Assistant (CNA) #2 she walked into Resher to be disrobed with CNA #1. The letter Protective Services 09/24/2018 to invest anonymous caller. Adult Protective Ser to (County) Law Enfwas in the facility on would return on 10/0 investigation. The Freviewed and it indict to Virginia Departmet Certification, Adult Fombudsman on 09/0 dated 09/24/2018, 00 which had been obtoof CNA #2's Witness 09/22/2018 she was Resident #41 and sher room and Resid naked with only her and CNA #1 came finame) door and staft towels and helping finight clothes. CNA #1 him touch (Resident reason to be in her in never told the nurse wasn't sure what was report it to the nurse	led a letter dated October 1, he Virginia Department of ity's previous Administrator, stating that Certified Nursing reported that on 09/22/2018 ident #41's room and found vith a male CNA in the room, also stated that Adult visited the facility on tigate in response to an The letter also stated that vices reported the allegation or occement and a detective 19/25/2018 and stated he 01/2018 to complete his fax Transaction Report was exated that the letter was faxed ent of Licensure and 24/2018. Witness statements 19/25/2018 and 09/30/2018 ained were reviewed. Review as Statement revealed that on a doing 1 on 1 care with the opened the door to go into ent #41 was completely pants around her right ankle from behind (Resident's ted that he was delivering Resident #41 to get into her #2 had written, "I never saw "s name) but he had no from." CNA #2 wrote, "I on duty that night because I is happening but decided to e on Sunday. I reported it to	F	607	DEFICIENCY)		
	Peach Unit. " CNA#	lurse (LPN) # 1 on the 2 also wrote that she it Manager on that Sunday.					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE COMP	SURVEY LETED
					(	
	495347	B. WING			06/	27/2019
ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE	-	
TE HEALTH CARE OF	WINDSOP		2335	52 COURTHOUSE HIGHWAY		
TE HEALTH CARE OF	WINDSOR		WIN	IDSOR, VA 23487		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	I	x			(X5) COMPLETION DATE
Review of LPN #1's 09/24/2018 revealed what she had seen she immediately re and the Unit Manage that she interviewed and then assigned Resident #41 was gof Administrative S Manager) Witness revealed that on 09 concern to her about witnessed with Resident's Name) for at least a year a yells and screams in inappropriately of if this did not occur or reported (Resident crying, I did not ser reassigned." Review Action Form revealed that on 09/24/2018 and Screams in inappropriately of if this did not occur or reported (Resident crying, I did not ser reassigned." Review Action Form revealed that change to Room (Notes) on 06/25/2019 at a control of the side of the service was conditioned in the side of the side	witness Statement dated at that CNA #2 reported to her . LPN #1 documented that ported to the supervisor on ger. LPN #1 also documented d Resident #41 and CNA #1 CNA #1 male residents and given to another CNA. Review staff Member's (ASM) #7 (Unit Statement dated 09/24/2018 b/23/2018 a CNA had voiced a ut an incident that she had sident #41 and CNA #1. ASM follows, "I did not call the g as CNA #1 has had on his assignment on and off and a half. (Resident Name) if anyone touches her is he perceives any injury. As in 09/23/2018 and no one name) yelling, screaming or and CNA #1 home, I had him ew of "Employee Corrective aled that the facilities previous (ASM #5) had counseled CNA and the Corrective Plan of led in part as follows, ing investigation is "Review of Census Entry to Resident #41 had a room slumber) on 09/25/2018.  Approximately 5:10 p.m., an ucted with CNA #1 and he 41's 1 on 1 nurse had stepped why, may have went to get levent into (Resident's name)	F	607			
	Continued From particles Regulatory of Continued From particles Review of LPN #1's 09/24/2018 revealed what she had seen she immediately reand the Unit Managethat she interviewed and then assigned Resident #41 was goof Administrative Standard Witness revealed that on 05 concern to her about witnessed with Resident's Name) for at least a year at yells and screams in inappropriately of if this did not occur or reported (Resident Crying, I did not ser reassigned." Revied Action Form revealed that on 09/24/2018 at Action is document "Suspension pending recommended" report revealed that change to Room (Note that the control of the commended	CORRECTION IDENTIFICATION NUMBER: 495347	ROVIDER OR SUPPLIER  TE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57  Review of LPN #1's Witness Statement dated 09/24/2018 revealed that CNA #2 reported to her what she had seen. LPN #1 documented that she intreviewed Resident #41 and CNA #1 and then assigned CNA #1 male residents and Resident #41 was given to another CNA. Review of Administrative Staff Member's (ASM) #7 (Unit Manager) Witness Statement dated 09/24/2018 revealed that on 09/23/2018 a CNA had voiced a concern to her about an incident that she had witnessed with Resident #41 and CNA #1. ASM #7 documented as follows, "I did not call the Director of Nursing as CNA #1 has had (Resident's Name) on his assignment on and off for at least a year and a half. (Resident Name) yells and screams if anyone touches her inappropriately of if she perceives any injury. As this did not occur on 09/23/2018 and no one reported (Resident name) yelling, screaming or crying, I did not send CNA #1 home, I had him reassigned." Review of "Employee Corrective Action Form" revealed that the facilities previous Director of Nursing (ASM #5) had counseled CNA #1 on 09/24/2018 and the Corrective Plan of Action is documented in part as follows, "Suspension pending investigation is recommended" Review of Census Entry report revealed that Resident #41 had a room change to Room (Number) on 09/25/2018.  On 06/25/2019 at approximately 5:10 p.m., an interview was conducted with CNA #1 and he stated, "Resident #41's 1 on 1 nurse had stepped away, don't know why, may have went to get something to eat. I went into (Resident's name) room to pass out towels and when I turned	A BUILDING  A95347  ROVIDER OR SUPPLIER  TE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57  Review of LPN #1's Witness Statement dated 09/24/2018 revealed that CNA #2 reported to her what she had seen. 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LPN #1 documented that she immediately reported to the supervisor on and the Unit Manager. LPN #1 also documented that she interviewed Resident #41 and CNA #1 and then assigned CNA #1 male residents and Resident #41 was given to another CNA. Review of Administrative Staff Member's (ASM) #7 (Unit Manager) Witness Statement dated 09/24/2018 revealed that on 09/23/2018 a CNA had viced a concern to her about an incident that she had witnessed with Resident #41 and CNA #1. ASM #7 documented as follows, "1 did not call the Director of Nursing as CNA #1 hash bad (Residents Name) on his assignment on and off for at least a year and a half. (Resident Name) yells and screams if anyone touches her inappropriately of if she perceives any injuy. As this did not occur on 09/23/2018 and no one reported (Resident name) yelling, screaming or crying, I did not send CNA #1 home, I had him reassigned. Review of "Employee Corrective Action Form" revealed that the facilities previous Director of Nursing (ASM #5) had counseled CNA #1 on 09/24/2018 and the Corrective Plan of Action is documented in part as follows, "Suspension pending investigation is recommended" Review of Census Entry report revealed that Resident #41 had a room change to Room (Number) on 09/25/2018.  On 06/25/2019 at approximately 5:10 p.m., an interview was conducted with CNA #1 and he stated, "Resident #41" in 1 n. nurse had stepped away, don't know why, may have went to get something to eat. I vent into (Resident's name) room to pass out towels and when I turned	A BUILDING  495347  B. WIND  STREETADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 57  Review of LPN #1's Witness Statement dated 09/24/2018 revealed that CNA #2 reported to her what she had seen. LPN #1 aloc uncented that she immediately reported to the supervisor on and the Unit Manager. LPN #1 aloc documented that she interviewed Resident #41 and CNA #1 and then assigned CNA #1 male residents and Resident #41 and collect that she had witnessed with Resident #41 and CNA #1. ASM #7 documented as follows, "I did not call the Director of Nursing as CNA #1 has had (Resident's Name) on his assignment on and off (rar at least a year and a half. (Resident Name) yells and screams if anyone touches her inappropriately of if she perceives any injury. 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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	:	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 607	her clothes. Then ( waked back in the r walked out of the ro Resident #41 have the room?" CNA #' asked, "Did you usu #1 stated, "Yes." C were you taken off o stated, "The next d (Resident's name) a assignment with jus  On 06/26/2019 at a interview was condu her to review the int that involved Reside stated, "I can't reme asked, "What would abuse or something occurred?" LPN #1 resident and go to t and Supervisor. I w from the situation."  On 06/26/2019 at a telephone number of Manager whom had on 09/24/2018, Reg Director of Nursing longer an employee  On 06/27/2019 at 7 conducted over the she stated, "I was a (Resident's name). go to the bathroom. outside her room in	on the bed and had taken off Resident's name) 1 on 1 aide oom and the 1 on 1 aide and I oom." CNA #1 was asked, "Did clothes on when you went into I stated, "Yes." CNA #1 was aally pass out towel's?" CNA NA #1 was asked, "When of the assignment?" CNA #1 ay I was told not to work with and I was put on an at male resident's."  pproximately 2:00 p.m., an acted with LPN #1 and asked cident in September of 2018 ent #41 and CNA #1. LPN #1 ember anything." LPN #1 was I you do if you suspected yout of the normal had stated, "I would assess my he DON (Director of Nursing) yould remove the resident  pproximately 3:00 p.m., a was requested for the Unit I provided a witness statement yistered Nurse (RN) #5. The stated that the nurse was no	F 607			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	_	<del></del>	Ι,	C
		495347	B. WING			06/27/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CONCUL	TE HEALTH CARE OF	MANDOOD		2	3352 COURTHOUSE HIGHWAY		
CONSULA	ATE HEALTH CARE OF	WINDSOR		v	VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	station and then about back down to her rowas told if she was a home, it was about she had worked a dip.m. and second shi opened the door up the door, standing cand holding somethis something, and he ji CNA #2 was asked, located in the room standing closer to the #1 stated, "CNA #1 (Resident's name)." may have been com #1 stated he was he was asked, "How die #41's room if you we #2 stated, "When I whad my back to the written up for leaving asked, "Can you expassigned to do 1 on of Resident #41's cano, it's a little difficul name) was on CNA assigned to do 1 on usually work back the worked on the Gree work things. I didn't helped Resident #4'should say somethin odd. I kept thinking reported it to the nurshould have reporter repeated several times.	o and went to the nurses out 10 minutes later I went om to check on her because I asleep I could leave and go 10 p.m." CNA #1 stated that ouble shift that day, 7 am - 3 ift. CNA #1 stated, "When I I saw CNA #2 at the back of loser to the bathroom door ing in his hand, a gown or umped like he was startled."  "Where was Resident #41 or CNA #2 stated, "She was the middle of the room." CNA	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495347	B. WING _		-	06/2	27/2019
	ROVIDER OR SUPPLIER	/INDSOR	•	STREET ADDRESS, CITY, STA 23352 COURTHOUSE HIGH WINDSOR, VA 23487		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC' CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 607		e 60 proximately 6:15 p.m., at Administrator and Registered	F 6	507			
	Nurse Consultant was The facility did not pre about the findings.	s informed of the findings. esent any further information					
F 609 SS=D	Complaint Deficiency Reporting of Alleged \(^1\) CFR(s): 483.12(c)(1)(	√iolations 4)	F 6	009			
	, , , .	se to allegations of abuse, or mistreatment, the facility					
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allega that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to a dult protective service for jurisdiction in long accordance with State procedures.	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the state is state in the law provides the state facilities in the law through established					
	designated represent accordance with State Survey Agency, within	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION (X3) DATE SI COMPLE		LETED	
		495347	B. WING _			06/	27/2019
	ROVIDER OR SUPPLIER	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487	00/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	This REQUIREMENT by: Based on staff interv review, and clinical redetermined that facilitiallegation of abuse to agencies for four of 5 sample, Resident #5,  1. Facility staff failed that had occurred bet Resident #107 on 3/6 agencies.  2. Facility staff failed resident altercation the Resident #82 and Rethe appropriate state  3. The facility staff failed resident at the appropriate state  3. The facility staff failed resident #82 and Rethe appropriate state  1a . Resident #5 was 6/20/18 with diagnose limited to Pick's Diseadifficulty walking, and Resident #5's most reset) assessment was an ARD (assessment Resident #5 was codimpaired in cognitive on the BIMS (Brief Intexam. Resident #5 wextensive assistance ADLs (activities of date and control to the staff of th	e action must be taken. Is not met as evidenced  iew, facility document cord review, it was y staff failed to report an the appropriate state 7 residents in the survey #82, #107 and #41.  to report a sexual encounter ween Resident #5 and /19 to the appropriate state  to report a resident to eat had occurred between sident #107 on 6/24/19 to agencies.  led to report allegation of oner for Resident #41.  admitted to the facility on es that included but were not lase (1), muscle weakness, major depressive disorder. ecent MDS (minimum data a quarterly assessment with reference date) of 3/11/19. ed as being severely function scoring 99 out of 15 terview for Mental Status)	F	609	1. A facility reported incident was submitted and reported to the approagencies on resident #5, #107, #82 and #41completed on 06/25/19.  2. All residents have the potential to affected. The facility completed and of the residents that currently reside the facility for the last 30 days to ensith that allegations of abuse were reported a timely fashion was completed on 07/26/19. No other issues were idential at the RDCS (Regional Director of Clin Services) on reporting of an allegation at timely manner was completed 06/2 All staff will complete education on the reporting of abuse.  4. The ED and or designee will companied and the ensure timely notification allegation twice weekly for 2 weeks, times 4 and monthly times 2 month results will be reported to the Quality Assurance Performance Improvemed Committee (QAPI) by the Executive Director monthly for 3 months for fur compliance and/or revision.  5. AOC date: 08/06/2019	o be audit ent in sure eted in etified. ed by etical on in equation in equatio	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED			
		495347	B. WING		C 06/27/2019		
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487	1 332772010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
F 609	11/28/18 with diagram not limited to Wernic Hepatitis C (3), and Resident #107's modata set) assessment assessment with an date) of 6/25/19. Rebeing moderately in the Staff Assessmer Resident #107 was with ADL (activities supervision only with Review of Resident nursing note that do abuse on 3/6/19. The "Reported to this wr #5) in room (number of with paints (sic) doweach others. Made I aware. Instructed by apart."  Review of Resident revealed no docume incident.  Review of the facility incidents) revealed to the OLC (Office of and other state age! An investigation councident.	vas admitted to the facility on oses that included but were cke's encephalopathy (2), altered mental status. st recent MDS (minimum nt was a quarterly ARD (assessment reference sident #107 was coded as apaired in cognitive function of nt for Mental Status exam. coded as being independent of daily living) and requiring	F 609				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED	
		495347	B. WING		C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	WINDSOR	:	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 609	when both sexual e When asked the pro abuse between two #1 stated that she w the situation and re administration. Whe coordinator was, LF (Director of nursing) On 6/26/19 at appro interview was condu staff member) #2, th and ASM #3, the co asked the process i two residents engage especially on the Pe she would separate investigation to see reporting to the app #2 stated that if both she would then prov ASM #2 stated that consent, she would RPs give consent si are safe and practic being aware of the in Resident #5 and Re nursing note written the DON was made the administrator was  On 6/26/19 at 5:13 conducted with LPN #1, the nurse who w asked what had hap stated that a CNA (calerted her that she	I #1, the nurse who worked nocunters had occurred. occss if she were to see residents in the facility, LPN would remove the victim from	F 609		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE COMP	SURVEY PLETED				
		495347	B. WING				C <b>27/2019</b>
	ROVIDER OR SUPPLIER	VINDSOR	1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	cognitively intact end activity; she separate administration (the D (Name of DON). She apart."  On 6/27/19 at 5:30 p. Administrator, ASM # the corporate nurse of the above concerns.  2. Facility staff failed resident altercation the Resident altercation the Resident #82 and Resident #82 and Resident #82 and readmitte that included but wer without behavioral dis and high blood press recent MDS (minimula a quarterly assessment reference #82 was coded as be cognitive function on Mental Status Exam.  2b. Resident #107 was 11/28/18 with diagnoral not limited to Wernick Hepatitis C, and alter #107's most recent Massessment was a quarken (assessment research Massessment research	as sure if the residents were ugh to consent to any sexual and the residents, and alerted ON). LPN #1 stated; "I told told me to keep them  Im., ASM #1, the #2, the DON and ASM #3, consultant were made aware s.  Ito report a resident to nat had occurred between esident #107 on 6/24/19 to agencies.  Is admitted to the facility on eed on 5/9/18 with diagnoses eenot limited to dementia esturbance, muscle weakness ure. Resident #82's most modata set) assessment was ent with an ARD conducted to the facility on the set of 5/21/19. Resident eng severely impaired in the Staff Interview for  In as admitted to the facility on ses that included but were ke's encephalopathy, and mental status. Resident IDS (minimum data set) uarterly assessment with an ference date) of 6/25/19, oded as being moderately	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495347	B. WING		C 06/27/2019		
	ROVIDER OR SUPPLIER	WINDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23552 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 33/21/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION		
F 609	#107 was coded as I	e 65 tal Status exam. Resident being independent with ADL ng) and requiring supervision	F 609				
	the following nursing "resident attempting	to get out of bed and rved hitting him in the face y down. no bruising					
	revealed the followin resident yelling from CNA (Certified Nursi observed this resider make him lay down. (Responsible Party) PA (Physician's Assis	left message to return call. stant) made aware. N (Assistant Director of					
	incidents) revealed to to the OLC (Office of and other state agen	FRIs (facility reported nat a FRI was not submitted Licensure and Certification) cies regarding this incident. d not be found regarding this					
	conducted with CNA if she were to see a in CNA #5 stated that is residents, deescalate the residents. CNA # report the incident to then gave an examp	.m., an interview was #5. When asked the process resident hit another resident, he would separate the e the situation and redirect 5 stated that she would her charge nurse. CNA #5 le and stated that Resident mate the day prior at					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495347	B. WING		06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	23	REET ADDRESS, CITY, STATE, ZIP CODE 352 COURTHOUSE HIGHWAY INDSOR, VA 23487	30/2/12010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 609	reported this to her #5 stated that she h nurse. When asked ensure Resident #8: #107, CNA #5 stated ensure that they we same time. When as morning, CNA #5 stated ensure that they we same time. When as morning, CNA #5 stated that the reduring this time. Wh made aware of resident #5 stated that the CNA #5 stated that the CNA #5 stated that the reduring this time. When also was a confirmed that the reduring this time. When also was a confirmed that the resident #82 was redured to resident #82 was redured to resident altercation and #82. ASM #2 stated that the resident altercation and #82. ASM #2 stated that the made aware of the reduced that the made aware of the reduced that the made aware of the reduced that the were no injurie that just in-serviced abuse policy and we investigate abuse. Administrator was univestigate abuse. Administrator was universided that the confidence of the reduced abuse policy and we investigate abuse. Administrator was universided abuse. Administrator was universided abuse with the confidence of the reduced abuse. Administrator was universided abuse.	charge nurse (LPN #1). CNA and written a statement for her what staff were doing to 2 was safe from Resident d that they were trying to re not in their room at the sked if she had worked that ated that she did and was CNA #5 was told about the during lunch. CNA #5 residents were not separated ren asked how CNAs were lent to resident altercations, hurses tell them in report.  To.m., the FRI and for Resident #107 and requested from the DON of (ASM-administrative staff 2 stated that she didn't have wasn't aware of any resident in between Resident #107	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2//2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 609	stated that they had a private room to promote a pro	phere were no injuries. ASM #3 just moved Resident #107 to obtect Resident #82.  o.m., this writer was able to N #1. When asked what had 9 between Resident #107 PN #1 stated that it was the CNA that Resident #107 Int #82. LPN #1 stated that the Resident #107 out of his occessful. LPN #1 stated that the checks on Resident #107 could provide those checks, the staff were not writing it I not prove staff were doing that she had reported this N and Administrator. LPN #1 the day 6/25/19, Resident #82 and at the table doing stivity assistant. LPN #1 was to observations at lunch. When 82 was protected from being slapped by Resident d that they just moved orivate room. When asked if urveyor had alerted the DON	F 60	09		
	residents and start a stated that the incid	encies, separate the and investigation. ASM #1 ent between Resident #107 ed to him on 6/24/19 but that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495347	B. WING		06/27/2019		
	ROVIDER OR SUPPLIER	WINDSOR	23	REET ADDRESS, CITY, STATE, ZIP CODE 352 COURTHOUSE HIGHWAY SINDSOR, VA 23487	33.21.20.10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 609	appropriate state ag he figured he did no no physical injuries to intervention. When reporting the incider that his DON had as a FRI regarding the surveyor the fax conincident to the OLC asked why an invest immediately and wh. Resident #82 from F stated, "We (Administime to monitor." Who on the abuse policy the facility in Februar he was.  Review of ASM #1 e was educated on the Review of the in-serthat he and the DON abuse policy.  On 6/27/19 at 5:30 p. Administrator, ASM corporate nurse conthe above concerns.  Review of the facility part, the following: "A becomes aware of a neglect or mistreatm whether alleged, sus report the incident to Director of Clinical Sexecutive Director, I	incident until 6/25/19 to the encies. ASM #1 stated that that that that that that that tha	F 609				

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION  G	COMPLE	COMPLETED	
		495347	B. WING		C 06/27	7/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	06/27	72019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	reportingAlleged, abuseare thoroug Executive Director as Services. Alleged s violations are reportheOmbudsman aby state law."  3. The facility staff abuse in a timely management of the state	ent investigation and suspected or observed why investigated by the and/or Director of Clinical suspected or observed ted immediately to and all other officials required failed to report allegation of sanner for Resident #41.  Admitted to the facility on charged to the hospital on cosis included but were not be Brain Injury and Epilepsy. Charge Assessment Minimum seessment Reference Date of ded for short-term memory reately impaired cognitive skills	F 60	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				_	<del></del>	، ا	С
		495347	B. WING				27/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112013
					3352 COURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF V	VINDSOR			WINDSOR, VA 23487		
0(0)15	CHMMADV C	CATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 70	F	609			
	to Virginia Departme	nt of Licensure and					
		rotective Services and					
	i i	24/2018. Witness statements					
	dated 09/24/2018, 09	9/25/2018 and 09/30/2018					
	which had been obta	ined were reviewed. Review					
	of CNA #2's witness	statement revealed that on					
		doing 1 on 1 care with					
		e opened the door to go into					
		ent #41 was completely					
		pants around her right ankle					
	and CNA #1 came from						
	· · · · · · · · · · · · · · · · · · ·	ed that he was delivering					
		esident #41 to get into her 2 had written, "I never saw					
		s name) but he had no					
		oom." CNA #2 wrote, "I					
		on duty that night because I					
		s happening but decided to					
		on Sunday. I reported it to					
		urse (LPN) #1 on the					
	Peach Unit. " CNA #2	2 also wrote that she					
	reported it to the Unit	Manager on that Sunday.					
	Review of LPN #1's \	witness statement dated					
	09/24/2018 revealed	that CNA #2 reported to her					
	what she had seen.	LPN #1 documented that					
		orted to the supervisor on					
	_	r. LPN #1 also documented					
		Resident #41 and CNA #1					
	_	NA #1 male residents and					
	_	ven to another CNA. Review					
		off Member's (ASM) #7 (Unit tatement dated 09/24/2018					
	· • ·	23/2018 a CNA had voiced a					
		an incident that she had					
		lent #41 and CNA #1. ASM					
		ollows, "I did not call the					
	Director of Nursing a					ĺ	
	_	n his assignment on and off					
	•	d a half. (Resident Name)				ĺ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		495347	B. WING _			C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	'	30,21,23,10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 609	this did not occur on reported (Resident in crying, I did not send reassigned." Review Action Form" reveal Director of Nursing (#1 on 09/24/2018 and Action is documente "Suspension pending recommended" report revealed that change to Room (nu On 06/26/2019 at ap interview was condulher to review the incit that involved Reside stated, "I can't remer asked, "What would abuse or something occurred?" LPN #1 resident and go to the and Supervisor. I wo from the situation."  On 06/26/2019 at ap telephone number w Manager whom had on 09/24/2018, Reging Director of Nursing solonger an employee  On 06/27/2019 at ap pre-exit meeting the Nurse Consultant was	anyone touches her the perceives any injury. As 09/23/2018 and no one ame) yelling, screaming or I CNA #1 home, I had him of "Employee Corrective ed that the facilities previous ASM #5) had counseled CNA d the Corrective Plan of d in part as follows, g investigation is Review of Census Entry Resident #41 had a room mber) on 09/25/2018.  proximately 2:00 p.m., an cted with LPN #1 and asked dent in September of 2018 int #41 and CNA #1. LPN #1 inber anything." LPN #1 inber anything." LPN #1 was you do if you suspected out of the normal had stated, "I would assess my e DON (Director of Nursing) ould remove the resident  proximately 3:00 p.m., a as requested for the Unit provided a witness statement stered Nurse (RN) #5. The tated that the nurse was no	F6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
	495347	B. WING		C <b>06/27/2019</b>
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/10/10
TE HEALTH CARE OF W	INDSOP	2	3352 COURTHOUSE HIGHWAY	
TE REALTH CARE OF W	INDSOR	\	VINDSOR, VA 23487	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG		
Continued From page	72	F 609		
Complaint Deficiency.				
Investigate/Prevent/C	orrect Alleged Violation	F 610		
CFR(s): 483.12(c)(2)-	(4)		1. A facility reported incident and a	n
\$492 12(a) In roopons	es to allegations of abuse		investigation was initiated and comp	oleted
			for residents #5, #107 and #82 on 3	3/25/19
must:	,		and 6/28/19.	
			2 All residents have the potential to	o he
			· ·	
violations are thoroug	my investigated.		, ,	
§483.12(c)(3) Prevent further potential abuse,				
investigation is in prog	gress.			ted was
\$483 12(c)(4) Report	the results of all		completed on 07/26/19. No other	
			allegations were noted.	
			3. ED and DCS have been educate	ed by the
			RDCS on investigating allegation o	f abuse
			was completed on 06/25/19.	
			·	nnlete
			_	•
-				
			_	
			,	-
	•		Assurance Performance Improvement	ent
sample, Resident #5	and Resident #82.		Committee (QAPI) by the Executive	ļ l
Facility staff failed t	o investigate a sexual		Director monthly for 3 months for fu	rther
			compliance and/or revision.	
	•		-	
	encounter with Resident		5	
	CORRECTION  COVIDER OR SUPPLIER  TE HEALTH CARE OF W  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From page  Complaint Deficiency. Investigate/Prevent/C CFR(s): 483.12(c)(2)-  §483.12(c) In respons neglect, exploitation, of must:  §483.12(c)(2) Have eviolations are thoroug  §483.12(c)(3) Prevent neglect, exploitation, of investigation is in prog  §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, withir incident, and if the alle appropriate corrective This REQUIREMENT by: Based on observation document review, and was determined that f an investigation and k further abuse for two sample, Resident #5 a  1. Facility staff failed t encounter between R #107 on 3/6/19; and fi	OVIDER OR SUPPLIER  TE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  Complaint Deficiency. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to conduct an investigation and keep residents free from further abuse for two of 57 residents in the survey sample, Resident #5 and Resident #82.  1. Facility staff failed to investigate a sexual encounter between Resident #5 and Resident #5 from a second sexual encounter with Resident	OVIDER OR SUPPLIER  TE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  Complaint Deficiency. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  \$483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to conduct an investigation and keep residents free from further abuse for two of 57 residents in the survey sample, Resident #5 and Resident #82.  1. Facility staff failed to investigate a sexual encounter between Resident #5 and Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident	OVIDER OR SUPPLIER  TE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  Complaint Deficiency, Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  \$483.12(c) (1) response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  \$483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to conduct an investigation and keep residents free from further abuse for two of 57 residents in the survey sample, Resident #5 and Resident #82.  1. Facility staff failed to investigate a sexual encounter between Resident #5 and Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident #107 on 3/6/19; and failed to protect Resident #5 from a second sexual encounter with Resident

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C	
	NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	06/27/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 610	investigate a reside between Resident # failed to prevent fur Resident #107.  The findings include 1a. Resident #5 wa 6/20/18 with diagnol limited to Pick's Dis difficulty walking, at Resident #5's most set) assessment wa an ARD (assessme Resident #5 was compaired in cognitiv on the BIMS (Brieflexam. Resident #5 extensive assistant ADLs (activities of a bed mobility and trawith walking.  1b. Resident #107 with the patitis C (3), and Resident #107's modata set) assessment with ar date) of 6/25/19. Rebeing moderately in the Staff Assessme Resident #107 was	e, facility staff failed to int to resident altercation #82 and Resident #107; and ther potential abuse from ses that included but were not ease (1), muscle weakness, and major depressive disorder. recent MDS (minimum data as a quarterly assessment with int reference date) of 3/11/19. Interview for Mental Status) was coded as requiring se from one staff member with daily living) such as dressing, insfers; and supervision only was admitted to the facility on oses that included but were cke's encephalopathy (2), altered mental status. The part of the par	F 6			
	Review of Resident	#5's clinical record revealed a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	<b>495347</b> B. WING			C 06/27/2019	
	NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2/12013
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F 610	Continued From pag	e 74 cumented possible sexual	F 6	10	
	abuse on 3/6/19. The "Reported to this writh "#5) in room (number lured in (number of F with paints (sic) down each others. Made D	ter following was documented: ter that resident (Resident of Resident #5's room) was Resident #107's room). Seen in as well as lips touching OON (Director of Nursing) DON to keep resident's			
	incidents) revealed to to the OLC (Office of and other state agen	FRIs (facility reported nat a FRI was not submitted Licensure and Certification) cies regarding this incident. d not be found regarding this			
	#107's clinical record	sident #5's and Resident I failed to evidence that staff sident's separated to prevent			
	incident had occurre Resident #107 on 3/3 documented in the F Incident date 3/20/19 residents were found room lying together presidents were imme the delivery of dinner Resident #5) and (nabed in her room with removed. Neither resident had sexual intent immediately separate completed and no significant.	FRIS revealed a second d between Resident #5 and 20/19. The following was RI: "Report date 3/20/19, 2: Incident Type: The I in (Name of Resident #5's) partially undressed. The two ediately separatedduring r, staff noted (name of ame of Resident #107) on the their clothing partially sident wanted to discuss if tions. The residents were ed, skin assessments gns of physical injury noted to Medical Doctor) and RP were notifiedEmployee			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C <b>06/27/2019</b>	
	NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2/12013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 610	action initiated or ta was moved to anoth (name of Resident # 15 minute checks). did not want to cont The five day investig 5/25/19, documente "During dinner time passing out meal traentered the room to she encountered (R (name of Resident # down around their a #107) was immedia room. The staff perf (Name of Resident of penetration, redn discharge. Staff inforchecks on (Resident immediately transferanother unit within the Both residents appears any emotional traun Based on staff, resimedical record the from the staff performediately transferanother unit within the Both residents were is no supporting evicintercourse has occurred with LPN when both sexual eviction when sked the programmediated that she with situation and registration in the situation in the situ	ken: (Name of Resident #5) her room off the unit and her room off Resident #5's RP) her room of Resident #5's RP) her room of look up dated doin part, the following: her staff was in the process of her says. As a staff member her get (name of Resident #5) her room of Resident #5) her room of Resident her staff was in the process of her says. As a staff member her get (name of Resident #5) her room of Resident #5) her room of Resident her staff was resident her says welling, bruising, or her facility (not the locked unit). Her root to have experienced her facility (off the locked unit). Her root to have experienced her facility has substantiated that her partially unclothed but there her dence to suggest that sexual her unit and process if she were to see her residents in the facility, LPN hould remove the victim from	F 61			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	100041		STREET ADDRESS, CITY, STATE, ZIP CODE	•	06/27/2019	
				23352 COURTHOUSE HIGHWAY			
CONSULATE HEALTH CARE OF WINDSOR			WINDSOR, VA 23487				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	Continued From page	e 76	F 61	0			
	When asked what wa a resident is abused stated that q (every 1 conducted for three of tracking record. Whe staff, i.e. nursing aide aware of resident to stated that nurses an report. When asked the LPN #1 stated the put to serve as a guide to When asked if the care	was the abuse coordinator. as usually put into place after by another resident, LPN #2 5 min) checks are usually lays and recorded on a n asked how other clinical as and nurses are made resident abuse, LPN #1 d nursing aides are given the purpose of the care plan, tropose of the care plan was o care for the residents. re plan should be updated sident altercation, LPN #1 updated."					
	interview was conducted staff member) #2, the and ASM #3, the corporated asked the process if two residents engaging especially on the Peashe would separate to investigation to see it reporting. ASM #2 stocan give consent; show residents privacy. AST residents could not go call the RPs and if the would ensure the respracticing safe sex. And the incident on 3/6 and Resident #107, owritten on 3/6/19 door made aware. When a on 3/20/19 between #107; ASM #2 stated	ach unit, ASM #2 stated that he residents, start an it the incident requires ated that if both residents e would then provide the incident that if the ive consent, she would then e RPs give consent she					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495347	B. WING				C 27/2019
	ROVIDER OR SUPPLIER	WINDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	1 001	2772013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	that at this time Reher own pants. ASI she found out, she residents, called the called the physician moved Resident #8 Blue unit. ASM #2 an assessment on visible signs of penstated that since be consent at this time incident to the state Resident #5 could and if she had consadvances. ASM #2 denied anything had Resident #5 to the Resident #5 to the Resident #5 sent to because she didn't through that stress nothing was put intincident because sincident on 3/6/19. was no evidence the (Responsible Participation of 19.)  On 6/26/19 at 4:50 conducted with CN #4, an aide who with on 3/6/19 and 3/20 would immediately report any suspectic CNA #4 stated that on 3/6/19 but that stress on 3/6/19 but that stress had a side who with the side of 19.	pulled down. ASM #2 stated sident #5 was able to remove M #2 stated that as soon as immediately separated the e responsible parties and h. ASM #2 stated that she had off the Peach unit and to the stated that she had performed Resident #5 and there were no letration or injury. ASM #2 oth residents could not give be, she had reported this eagencies. ASM #2 stated that anot tell her what had happened sented to Resident #107's stated that Resident #107 appening. ASM #2 stated that the was trying to take bathroom. ASM #2 stated that to be party did not want to the hospital for a rape kit want to put her daughter. ASM #2 confirmed that to place to prevent the 3/20/19 he was not made aware of the ASM #2 confirmed that there hat the physicians and RPs es) were notified regarding the p.m., an interview was A (certified nursing assistant) thessed both sexual incidents /19. CNA #4 stated that she separate the residents and ed abuse to her supervisor. If she could not recall too much she had reported to the nurse dent #5 was in Resident #107's	F	610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495347	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	IIP CODE	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE	ACTION SHOULD BE TO THE APPROPRIA	DATE
F 610	room. CNA #4 stated keep the residents set the nursing staff tried keep the residents set when there was only nurse to the Peach u are supposed to be the unit. CNA #4 stated the tresidents' rooms provonly one nurse working units. CNA #4 stated had any other sexual residents, only Residents, only Residents, only Residents, only Residents had been working total of 5 years.  On 6/26/19 at 5:13 p. conducted with LPN the nurse who was weaked what had happ stated that a CNA (Chad alerted her that see Resident #107's room because she was not cognitively intact end activity; she separate administration (the DO) (Name of DON) (Directon keep them apart." to keep Resident #5 and LPN #1 stated that there see Peach unit and lately could not recall how and any of 3/6/19 or 3/20, and the residents are set that there is the product of the peach unit and lately could not recall how and any of 3/6/19 or 3/20, and the residents are set that there is the peach unit and lately could not recall how and any of 3/6/19 or 3/20, and the peach unit and lately could not recall how and any of 3/6/19 or 3/20, and the peach unit and lately could not recall how any of 3/6/19 or 3/20, and the peach unit and lately could not recall how any of 3/6/19 or 3/20, and the peach unit and lately could not recall how any of 3/6/19 or 3/20, and the peach unit and lately could not recall how any of 3/6/19 or 3/20.	that she was just told to eparated. CNA #4 stated that as much as they could to eparated and that it was hard two nursing aides and one nit. CNA #4 stated that there had sometimes Resident and if the aides were in the widing care and there was ng both the blue and peach that Resident #107 had not encounters with an other ent #5. CNA #4 stated that g on the Peach Unit for a  m., further interview was (licensed practical nurse) #1, orking on 3/6/19. When bened on 3/6/19; LPN #1 ertified Nursing Assistant) she had seen Resident #5 in n. LPN #1 stated that a sure if the residents were ugh to consent to any sexual and the residents, and alerted ON). LPN #1 stated; "I told ctor of Nursing). She told me When asked if it was difficult and Resident #107 apart,	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER	VINDSOR		2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	provide this writer with were conducted on 3/LPN #1 stated that q never written down. L way to prove that 15 is conducted on Reside  On 6/27/19 at 5:30 p. Administrator, ASM # the corporate nurse of of the above concerns  2. For Resident #82, investigate a resident between Resident #8 failed to prevent furth Resident #107.  2a. Resident #82 was 3/15/19 and readmitte that included but were without behavioral dis and high blood pressurecent MDS (minimur a quarterly assessment reference #82 was coded as be cognitive function on Mental Status Exam.  2b. Resident #107 was 11/28/18 with diagnos not limited to Wernick Hepatitis C, and altern #107's most recent M assessment was a quarker (assessment was a quarker) (assessment reference #107's most recent M assessment was a quarker) (assessment reference #107's most recent M assessment was a quarker) (assessment reference #107's most recent M assessment was a quarker) (assessment reference #107's most recent M assessment reference #107's most recent M assessment was a quarker) (assessment reference #107's most recent M assessment was a quarker)	then asked if she could then the 15 minute checks that 16/19 for Resident #107, 15 minute checks were PN #1 stated there was no minute checks were nt #107 on 3/6/19.  m., ASM #1, the 2, the DON and ASM #3, consultant were made aware stated to resident altercation 2 and Resident #107; AND the potential abuse from a sadmitted to the facility on the ed on 5/9/18 with diagnoses the not limited to dementia the sturbance, muscle weakness the edition of the second was the made of 5/21/19. Resident ing severely impaired in the Staff Interview for the sadmitted to the facility on the sadmitted to the facility on the second of 5/21/19. Resident ing severely impaired in the Staff Interview for the sadmitted to the facility on the set that included but were	F	610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C 06/27/2019
NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR				STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 610	impaired in cognitiv Assessment for Me #107 was coded as (activities of daily liv only with walking.  Review of Resident the following nursin "resident attempting roommate was obset trying to make him lobserved at this tim  The next note dated following: "placed of made aware of incident revealed the following resident yelling from CNA (Certified Nursionserved this resident make him lay down (Responsible Party PA (Physician's Ass Supervisor and ADO Nursing) made awar  Review of the facilit incidents) revealed to the OLC (Office of and other state age An investigation con incident.	e function of the Staff Intal Status exam. Resident Ibeing independent with ADL Iving) and requiring supervision  #82's clinical record revealed Ig note dated 6/24/19: Ig to get out of bed and Ierved hitting him in the face Interved hitting him in the face Interve	F 61		
	made of Resident #	0 p.m., an observation was 107. He was up eating lunch roommate (Resident #82). e left unattended.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	· /	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _	B. WING		C <b>06/27/2019</b>	
	NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPLICATION OF THE PROPERTY OF THE APPLICATION	IOULD BE	(X5) COMPLETION DATE	
F 610	Continued From pag	e 81	F 6	10			
	made of Resident #1 Resident #82's lap.  On 6/25/19 at 2:21 p conducted with CNA if she were to see a CNA #5 stated that s residents, deescalate the residents. CNA # report the incident to then gave an examp #107 had hit his roor approximately 1:45 p reported this to her of #5 stated that she ha nurse. When asked ensure Resident #82 #107, CNA #5 stated ensure that they wer same time. When as morning, CNA #5 sta working until 3 p.m. above observations confirmed that the re during this time. Whe made aware of resid CNA #5 stated that re	p.m., an observation was 07. He was wiping food off  .m., an interview was #5. When asked the process resident hit another resident, he would separate the ethe situation and redirect is stated that she would her charge nurse. CNA #5 is and stated that Resident inmate the day prior at it.m. and that she had harge nurse (LPN #1). CNA it written a statement for her what staff were doing to it was safe from Resident it that they were trying to e not in their room at the ked if she had worked that it witten the did and was CNA #5 was told about the during lunch. CNA #5 sidents were not separated en asked how CNAs were ent to resident altercations, jurses tell them in report.					
	On 6/25/19 at 2:25 preached for an interv	.m., LPN #1 could be iew.					
	Resident #82 was re (Director of Nursing) member) #2. ASM #	.m., the FRI and or Resident #107 and quested from the DON (ASM (administrative staff 2 stated that she didn't have vasn't aware of any resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495347	B. WING_			C 06/27/2019
NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/2//2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	Continued From pag	e 82	F 6	10		
F 610	to resident altercation and #82. ASM #2 sta administrator had sul go check.  On 6/25/19 at 5:20 p nurse stated that the made aware of the rebetween Resident #1 did not report this indagencies or initiate a there were no injurie had just in-serviced tabuse policy and we investigate abuse. At Administrator was us thought he didn't hav residents because the stated that they had ja private room to professional procession of the profession of th	the between Resident #107 atted that maybe the britted one and she would a.m., ASM #3, the corporate Administrator had been esident to resident altercation 107 and #82 on 6/24/19, but sident to the appropriate state in investigation because is. ASM #3 stated that she he Administrator on the int over when to report and SM #3 stated that the sing the old abuse policy and the to report and separate the ere were no injuries. ASM #3 stated that #107 to tect Resident #82.  I.m., this writer was able to I #1. When asked what had	F 6	10		
	and Resident #82, LI reported to her by the had slapped Resider	Detween Resident #107 PN #1 stated that it was CNA that Resident #107 of t#82. LPN #1 stated that t Resident #107 out of his				
	room but were unsuch they did q 15 minute When asked if she con LPN #1 stated that the down and she could this. LPN #1 stated the incident to the ADON stated that most of the was out of the room a activities with the act	ccessful. LPN #1 stated that checks on Resident #107. Duld provide those checks, he staff were not writing it not prove staff were doing that she had reported this and Administrator. LPN #1 he day 6/25/19, Resident #82 and at the table doing ivity assistant. LPN #1 was observations at lunch. When				

i ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495347	B. WING _			C <b>06/27/2019</b>
	NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			STREET ADDRESS, CITY, STATE, ZIP CO 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ODE	33/21/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI	ON SHOULD BE HE APPROPRIA	DATE
F to the contract of the contr	Resident #107 after #107, LPN #1 stated Resident #107 to a pathis was after this surely asking for a FRI, lone 6/27/19 at 12:00 conducted with ASM asked the process was abuse, or an allegation of the properties and start a gresidents and start a stated that the inciderand #82 was reported in the properties and #82 was reported in the properties and the properties and #82 was reported in the properties and the properties and the properties and the properties and what is a FRI regarding the incident that his DON had as a FRI regarding the incident to the OLC of asked why an invest mediately and what is a FRI regarding the incident #82 from Restated, "We (Administrated, "We (Administrate	2 was protected from being slapped by Resident that they just moved brivate room. When asked if rveyor had alerted the DON LPN #1 stated yes.  p.m., an interview was #1, the Administrator. When then it is reported to him that on of abuse had occurred tts, ASM #1 stated that he abuse that day to the	F6	510		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER	/INDSOR	•	23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622 SS=E	abuse policy.  On 6/27/19 at 5:30 p. Administrator, ASM # the corporate nurse of the above concern. Review of the facility's part, the following: "A becomes aware of an neglect or mistreatme whether alleged, suspreport the incident to Director of Clinical Se Executive Director, D Clinical Services Supprocedure for inciden reportingAlleged, suspreportingAlleged, suspreportingAlleged, suspreportingAlleged, suspreportingAlleged suspreportingAlleged suspreportingAlleged suspreportingOmbudsman and by state law. If a resident, the abusive contacted and approprevent further such the resident's behavior caposing a threat of har the resident will be different and Discharge CFR(s): 483.15(c)(1) Facility \$483.15(c) Transfer as \$483.15(c)(1) Facility	m., ASM #1, the 2, the DON and ASM #3, onsultant were made aware s. s abuse policy documents in my person who observes or incident of resident abuse, ent of resident belongings, bected or observed, must the Executive Director, ervices Immediately. The irector of Clinical Services or ervisor will initiate the t investigation and aspected or observed dy investigated by the d/or Director of Clinical epected or observed d immediately to d all other officials required dent abuses another resident's physician will be oriate action will be taken to behavior. If the abusive annot be controlled, thereby m to others in the facility, scharged." ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to		610			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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NAME OF D		495347	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/27/2019
NAME OF P	ROVIDER OR SUPPLIER			23352 COURTHOUSE HIGHWAY	
CONSULA	ATE HEALTH CARE OF W	/INDSOR		WINDSOR, VA 23487	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 622	discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the (B) The transfer or dis because the resident's sufficiently so the resiservices provided by (C) The safety of indirendangered due to the status of the resident; (D) The health of indirotherwise be endang (E) The resident has appropriate notice, to under Medicare or Medicare	at from the facility unless- scharge is necessary for the dithe resident's needs facility; scharge is appropriate 's health has improved ident no longer needs the the facility; viduals in the facility is ne clinical or behavioral ; viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party third party, including di, denies the claim and the ay for his or her stay. For a es eligible for Medicaid after or, the facility may charge a le charges under Medicaid; sto operate. of transfer or discharge the peal is pending, pursuant to pter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the furst document the danger or or discharge would pose.	F 62	1. Resident #32, #41, #65, #108 returned to the facility on 6/4/19 a been here ever since. Resident # longer resides at facility.  2. Residents who are transferred facility have the potential to be af A 30 day review of residents who transferred was in compliance. N issues were identified.  3. DON and or Designee will rest the staff to provide the care plant receiving provider at the time of transfer was completed by 08 d. The DCS and or designee will an audit of to ensure the care plant provided at the time of transfer to receiving facility twice weekly for a weekly times 4 and monthly time. The results will be reported to the Assurance Performance Improver Committee (QAPI) by the Executive Director monthly for 3 months for compliance and/or revision.  5. AOC: 08/06/2019	out of the fected. were o other ducate o the ansfer to 8/01/19. conduct is the 2 weeks, is 2 month. e Quality ment we

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		` ′	COMPLETED			
		495347	B. WING _			C 6/ <b>27/2019</b>
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 0	0/2//2013
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F 622	resident under any o in paragraphs (c)(1)( section, the facility mor discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include:  (A) The basis for the (i) of this section.  (B) In the case of parasection, the specific obe met, facility attern needs, and the service facility to meet the needs and the service facility to meet the needs and the service facility to meet the needs and the service facility of this section in (a) or (b) of this section in (b) of this section in (c) a physician when necessary under part this section.  (iii) Information provice facility in (b) All special instruction (c) Advance Directive (d) All special instruction (d) All special instruction (e) All other necessary of the resident's copy of the resident's copy of the resident's copy of the resident's copy in the resident's copy of the resident's copy in the resident's copy of the resident's copy of the resident's copy in the resident's copy of the resident's copy of the resident's copy in the resident's copy of the resident's copy in the resident's copy of the resident's copy in the resident's copy of the resident's copy	esfers or discharges a  If the circumstances specified  In (A) through (F) of this  I wast ensure that the transfer  I mented in the resident's  I ppropriate information is  I receiving health care  I the resident's medical record  I transfer per paragraph (c)(1)  I ragraph (c)(1)(i)(A) of this  I resident need(s) that cannot  I pts to meet the resident  I ce available at the receiving  I ped(s).  I ped (s).  I ped (s).  I per paragraph (c)  I ped (s).  I pe	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<b>.</b>	00/27/2013
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F 622	Continued From page	e 87	F 6	522		
F 022	any other documenta a safe and effective to This REQUIREMENT by: Based on staff intervand facility document failed to send a copy to include their goals (Resident #317, #32, after being transferred The findings included 1. The facility staff far #317's Plan of Care so care plan goals was so to the hospital on 04/000 originally admitted to Diagnosis for Reside limited to acute respitation of the current Minimum admission assessment Reference Date (ARI resident with a 15 outhe Brief Interview for indicating no cognitive The Discharge MDS 04/01/19-discharge model of the process of the current discharge model of the	ration, as applicable, to ensure ransition of care.  I is not met as evidenced riews, clinical record review tation review the facility staff of the Resident's care plan for six of 57 residents #41, #265, #65 and #108) d to the hospital.  It:  Id:  Id:  Id:  Id:  Id:  Id:  Id:		322		
	complained of being weakness and had vo (unwitnessed).	dizzy, nauseous, extreme omited several times				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/27/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	On 06/25/19 at apprrequest was made to (DON) for evidence written information of to include their goals after being transferre 04/01/19. On the second process of the plan was sent when 04/01/19.  The Administrator, Experience of the findion of th	oximately 1:40 p.m., a of the Director of Nursing that the facility provided of Resident #317's care plants was sent prior to or shortly ed to the hospital on ame day at approximately stated, "I was unable to 317's clinical record the care discharged to the hospital on Director of Nursing and Clinical Services was and during a briefing on mately 3:40 p.m. The facility further information about the sailed to send Resident #32's en discharged to the hospital dimitted to the facility on and readmitted to the 19 and readmitted to the 9. Diagnoses included but Peripheral Vascular Disease is Mellitus. Resident #32's an assessment protocol) with perence Date of 04/05/2019 MS (Brief Interview for Mental andicating no cognitive tion, the Minimum Data Set as requiring set up help only sion with assistance of 1 for ent with bed mobility, transfer, dindependent with personal	F	522		

AND DUAN OF CORDECTION		PLE CONSTRUCTION  IG	(X3)	(X3) DATE SURVEY COMPLETED			
		495347	B. WING _			C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
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F 622	Director of Nursing (RN) Consultant wadocumentation that sent with Resident hospital on 06/13/2  On 06/25/2019 at a RN Consultant state educated to send the Plan goals with the hospital but they juth on 06/25/2019 at 2 conducted with the unable to provide defined hold Notice and Cawith (Resident namwas asked, "What a Nursing when send The DON stated, "I Bed Hold Notice and hospital and docum on 06/27/2019 at a pre-exit meeting the Registered Nurse of finding. The facility information about the series of the series	pproximately 12:00 p.m., the (DON) and Registered Nurse as asked, "Can you provide the Care Plan goals were #32 upon discharge to the 019?"  pproximately 1:00 p.m., the ed, "The Nurses have been he Bed Hold Notice and Care resident's on discharge to the st did not do it."  :45 p.m., an interview was DON and she stated, "I am ocumentation that the Bed are Plan goals were sent out e) to the hospital." The DON are your expectations of ing residents to the hospital?" expect the Nurses to send the d Care Plan goals to the ment in the Nurse Notes."  pproximately 6:15 p.m., at the e Administrator and the consultant was informed of the did not present any further	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			COMPLETED			
		495347	B. WING		06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 622	10/09/2018 was code problem and moderator daily decision made Minimum Data Set correquiring limited assist transfer, walk in room toilet use and supervector of Nursing (ICRN) Consultant was documentation that it sent with Resident #hospital on 06/22/20  On 06/25/2019 at ap RN Consultant stated educated to send the Plan goals with the reducated to send the Plan goals with the reducated with the Dunable to provide do Hold Notice and Carwith (Resident name was asked, "What ar Nursing when sendin The DON stated, "I ed Bed Hold Notice and hospital and docume On 06/27/2019 at ap pre-exit meeting the Registered Nurse Consultant made and pre-exit meeting the Registered Nurse Consultant made and moderate on the Registered Nurse Consultant moderate on the Registered Nur	dessment Reference Date of the door short-term memory tely impaired cognitive skills king. In addition, the coded Resident #41 as stance with bed mobility, in, walk in corridor, dressing, dision with eating and a proximately 12:00 p.m., the DON) and Registered Nurse asked, "Can you provide the Care Plan goals were the upon discharge to the 19?"  proximately 1:00 p.m., the di, "The Nurses have been as Bed Hold Notice and Care esident's on discharge to the tidd not do it."  15 p.m., an interview was don't and she stated, "I am cumentation that the Bed the Plan goals were sent out to the hospital." The DON to the hospital." The DON to the hospital." The DON to the hospital to the hospital?" Expect the Nurses to send the Care Plan goals to the untin the Nurse Notes."  proximately 6:15 p.m., at Administrator and the consultant was informed of the did not present any further	F 62	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495347	B. WING _			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CO 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ODE	33/21/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA	
F 622	#265's Plan of Care care plan goals were transfer-discharge to Resident #265 was on ursing facility on 11 04/08/19 and expired included but were not vascular Disease, Lous Subcutaneous Tissus The current Minimum MDS with an Assess of 03/06/19 coded the possible score of 15 Mental Status (BIMS impairment. The set Pressure Ulcers read for Pressure Ulcers read for Pressure Ulcers read for Pressure Ulcers also indicates that the Arterial Ulcers prese assessment dated 0 anticipated, resident An interview was con Practical Nurse (LPN approximately, 10:48 transfers-discharges paperwork is sent with being sent out to the that "we usually will (Medication Adminis Sheet, bed hold notic (Situation, Backgrour Recommendation) at On 6/27/19 at approximately.	siled to ensure that Resident Summary to include their e sent upon the hospital on 04/05/19.  Driginally admitted to the /12/18 and readmitted on don 04/12/19. Diagnoses of limited to, Peripheral ocal Infection of the skin and e and Venous Insufficiency.  In Data Set (MDS) a quarterly ment Reference Date (ARD) e resident with a 02 of a total on the Brief Interview for c), indicating severe cognitive oction M on the MDS under d as follows: Resident at risk as being "Yes". This section e resident has 2 Venous and nt. The Discharge MDS 4/05/19-discharge return re-admitted on 04/08/19.  Inducted with Licensed J #7 on 06/25/19 at 8 AM concerning Resident . She was asked "What the the resident when they are hospital." LPN #7 replied send out a copy of the MAR tration Record), the Face oce, E-Interact SBAR and, Assessment, and the History and Physical."	F	522		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495347	B. WING			C 06/27/2019
	ROVIDER OR SUPPLIER	111		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<u> </u>	00/2//2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 622	of Nursing) concerning Discharge/transfer no stated there is no not was sent to the hospit transferred.  An interview was compractical Nurse (LPN approximately, 12:22 transfers-discharges, paperwork is sent with being sent out to the that "we usually will seed (Medication Administ Sheet, bed hold notice (Situation, Backgrour Recommendation) and He was asked if the of He stated, "We don't was a sked what should have the above issue. The send care plan to the On 06/27/19 at approximately was conducted to the consultant, the Direction of the stated of the consultant, the Direction of the stated of the consultant, the Direction of the stated that the stated of the send care plan to the consultant, the Direction of the stated that the send care plan to the consultant, the Direction of the stated that the send care plan to the consultant, the Direction of the stated that the send care send that the send care send that the send care plan to the consultant, the Direction of the stated that the send care send that the send care sen	ducted with Licensed ) #1 on 05/16/19 at PM concerning Resident He was asked "What h the resident when they are hospital." LPN #1 replied end out a copy of the MAR ration Record), the Face e, Quality Assurance, SBAR ad, Assessment, ad the History and Physical." care plan is normally sent. send a care plan."  ducted with the ector of Nursing (DON) on ately 5:09 PM. They were ave been done concerning DON stated that "we will hospital with the resident."  eximately, 4:43 PM a pre-exit exited. Present were the Nurse tor Of Nursing, the Regional d the Administrator. They	F 62	22		
	discharge to the hosp 4/30/19.	plan goals were sent upon bital for Resident #65 on				
	Kesident #65 was ad	mitted on 3/24/18 and				

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 622	but not limited to Qua and Pressure Ulcers.  Resident #65's most (MDS) was a Quarter Reference Date (ARE Interview for Mental Spossible 15 indicating intact and capable of Resident #65's MDS revealed the following.  1. A Unplanned Disc MDS with an ARD of 2. A Entry MDS with Resident #65 Progres 18:52 (6:52 P.M.) was documented in part, a labs critical and called they said to send out Resident #65's Hospidated 5/4/19 was revipart, as follows:  Resident #65's Medic there was no docume comprehensive care the resident upon trand/30/19.  06/26/19 at 11:04 A.M. conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D. Resident #65's hospid and if there was any of the conducted with the D.	with diagnoses to include adriplegia, Failure to Thrive recent Minimum Data Set ly with an Assessment D) of 5/10/19. The Brief Status was a 15 out of a pather resident was cognitively daily decision making. history was reviewed and g:  harge-return anticipated 4/30/19. an ARD of 5/4/19. as Note dated 4/30/19 at serviewed and is as follows: Resident had d LTC (Physician Group) and resident emergency. hospital around 5:45. tal Discharge Summary fewed and is documented in seal Record was reviewed and entation to support that the plan goals were sent with insfer to the hospital on	F	622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 622	stated, "No I could n sent those documen to send the bedhold the time of transfer."  On 6/27/19 at approinformation was sharthe Director of Nursi Consultant. Prior to was shared.  6. The facility staff comprehensive care discharge for Resident #108 was of facility on 6/29/18 and diagnoses to include Bifida, Mild Intellectudisorder.  Resident #108's most (MDS) was an Annual Reference Date (AR Interview for Mental possible 15 indicating intact and capable of transfer in the country of the country o	tal The Director of Nursing of find anything to show we ts with him. Our process is policy and the care plan at eximately 3:30 P.M. the above red with the Administrator, and and the Corporate Nurse exit no further information failed to ensure plan goals were sent upon ent #108 on 11/29/18.  Driginally admitted to the and readmitted on 12/6/18 with the but not limited to Spina and Disabilities and Bipolar est recent Minimum Data Set all with an Assessment D) of 5/30/19. The Brief Status was a 15 out of a g the resident was cognitively f daily decision making.	F 6	22	
	A Quarterly Unpla anticipated MDS with     A Entry MDS with	anned Discharge-return h an ARD of 11/29/18. h an ARD of 12/6/18. gress Note dated 11/29/18 at as reviewed and is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495347	B. WING		06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR	2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	1 33/2/12310
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F 622	reported that resident bottle of wound clear room and resident at cleanser. Resident s and tried to kill herse to Name (Hospital) I in to transport reside manager notified and Resident #108's Med and there was no do comprehensive care the resident upon tra 11/29/18.  06/26/19 at 11:04 A. conducted with the E Resident #108's hos and if there was any that a care plan was transfer to the hospit stated, "No I could not sent those documents and the bedhold potime of transfer."  On 6/27/19 at approximformation was shared the Director of Nursin Consultant. Prior to was shared.  The facility policy title Notification and Right was reviewed and is follows:	A (Certified Nursing Assistant) at stated she drank a whole onser. Charge nurse entered dmitted to drinking wound stated she was depressed left. Called 911 in to transport ER (emergency room). 911 ant. Report called to ER. Unit is aware.  Idical Record was reviewed cumentation to support that plan goals were sent with insfer to the hospital on	F 622		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		495347	B. WING _		00	6/27/2019	
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	conducted according regulatory requirement Procedure: Transfer/I Documentation: Whe discharges a resident circumstances listed at that the transfer or distinct the resident's medical information is communication are institution *Comprehensive care Notice of Bed Hold Police Procedure in the procedure of the procedure in the proc	r (facility initiated) will be to Federal and/or State ints.  Discharge Requirements: en the center transfers or a under any of the above the facility will ensure scharge is documented in I record and appropriate inicated to the receiving or provider e plan goals.  Discharge Requirements: en the center transfers or and appropriate inicated to the receiving or provider e plan goals.  Discharge Requirements:	F 6				
SS=E	§483.15(d)(1) Notice nursing facility transfer the resident goes on nursing facility must puthe resident or reside specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, which paragraph (e)(1) of the resident to return; and (iv) The information sof this section.	bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to not representative that e state bed-hold policy, if resident is permitted to sidence in the nursing eayment policy in the state of this chapter, if any; y's policies regarding ich must be consistent with is section, permitting a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495347	B. WING _			06/	27/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CONSULA	ATE HEALTH CARE OF	WINDSOR		23	352 COURTHOUSE HIGHWAY			
CONSULA	AL HEALTH CARE OF	WINDSOK		W	INDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 625	Continued From pa	Continued From page 97			1. Resident #32 (readmitted on 6/1	8/19),		
	the time of transfer	of a resident for			#41(readmitted on 6/29/19),			
		nerapeutic leave, a nursing			#65 (readmitted on 5/4/19), #108			
		e to the resident and the ative written notice which			(readmitted on 12/6/18) and #317			
		on of the bed-hold policy			(readmitted on 06/04/19).			
	1 -	raph (d)(1) of this section.			2. All residents have the potential to	n he		
		his REQUIREMENT is not met as evidenced			affected. The facility will conduct a			
	by: Based on staff inte	rviews, facility documentation			of residents to ensure the resident of			
		record review the facility staff						
		of the Bed-Hold Policy upon			resident representative were given to			
		for five of 57 resident's			hold policy upon transfer to the loca	ı		
	transferred to the lo	, 41, 65 and 108) after being			hospital in the past thirty days was			
		ocal Hoophan			completed by 07/26/19.			
	The findings include	ed:			3. The DCS or designee will educa	ted		
	1 The facility staff	failed to provide the Resident			licensed staff on ensuring written			
		sentative a copy of the bed			information was provided to the resi	dent		
		scharge/transfer to the hospital			regarding bed hold upon transfer to	hospital		
		ent #317 was originally			to be completed by 08/01/19.			
		lity on 10/31/16. Diagnosis for uded but not limited to acute			4. The DCS or designee will ensure	e that		
	respiratory failure w				when residents are transferred to th			
	-				hospital the resident or resident			
		S assessments was dated for le return anticipated.			representative are is provided in wri	tina		
	04/01/19 - discharg	e return anticipated.			information regarding the bed hold	•		
	On 06/13/18, accor	ding to the facility's			• •			
		family request, Emergency			twice weekly for 2 weeks, weekly tir			
		d to transport Resident #317 to by Room (ER) due to resident			and monthly times 2 month. The res			
	_	g dizzy, nauseous, extreme			be reported to the Quality Assurance			
		vomited several times			Performance Improvement Committee			
	(unwitnessed).				(QAPI) by the Executive Director me	onthly		
	On 06/25/10 at ann	proximately 1:40 p.m., a			for 3 months for further compliance	and/or		
		to the Director of Nursing			revision.			
		that the facility provided			5. AOC date: 08/06/2019			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C 06/27/2019		
	ROVIDER OR SUPPLIER	/INDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2//2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION		
F 625	Policy to the resident prior to or shortly after hospital on 04/01/19. approximately 2:04 punable to locate in Rethe bed hold policy witheir representative withospital on 04/01/19.  The Administrator, Di Regional Director of Conformed of the findin 06/27/19 at approximation did not present any furth findings.  2. The facility staff faor resident representative when discharge 06/13/2019.  Resident #32 was ad 01/26/2019. Resident hospital on 06/13/2019.  Resident #32 was ad 01/26/2019. Resident hospital on 06/13/2019.  On 06/25/2019 at approximation that the with or provided to Rethe to the hospital on 06/00 on 06/25/2019 at approximation that the with or provided to Rethe to the hospital on 06/00 on 06/25/2019 at approximation that the with or provided to Rethe to the hospital on 06/00 on 06/25/2019 at approximation that the deducated to send the	the Notice of Bed-Hold or resident representative r their transfer to the On the same day at .m., the DON stated, "I am esident #317's clinical record as issued to the resident or when discharged to the rector of Nursing and Clinical Services was g during a briefing on ately 3:40 p.m. The facility urther information about the illed to provide Resident #32 ative a written Bed Hold ged to the hospital on  mitted to the facility on at #32 was discharged to the 9 and readmitted to the .  proximately 12:00 p.m., the DON) and Registered Nurse asked, "Can you provide the Bed Hold Notice was sent the sident #32 upon discharge 13/2019?"  proximately 1:00 p.m., the later the sident #32 upon discharge 13/2019?"  proximately 1:00 p.m., the later the sident #32 upon discharge the sident #32 upon discharge the sident's on discharge to the	F 62	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	1 06/	2772019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	conducted with the D unable to provide doo Hold Notice and Care with (Resident name) was asked, "What are Nursing when sendin. The DON stated, "I estated Hold Notice and hospital and documer On 06/27/2019 at appre-exit meeting the A Registered Nurse Co finding. The facility dinformation about the 3. The facility staff fa #41's or resident reproduced Notice when discharge 06/22/2019.  Resident #41 was ad 05/06/2011 and discharge 06/22/2019. Diagnos limited to, Traumatic On 06/25/2019 at apprector of Nursing (IC) (RN) Consultant were documentation that the with Resident #41 upon 06/22/2019?"  On 06/25/2019 at appreciation of the stated educated to send the	5 p.m., an interview was ON and she stated, "I am cumentation that the Bed e Plan goals were sent out to the hospital." The DON e your expectations of g residents to the hospital?" expect the Nurses to send the Care Plan goals to the in the Nurse Notes."  Droximately 6:15 p.m., at Administrator and the insultant was informed of the id not present any further infinding.  illed to provide Resident resentative a Bed Hold	F	625			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED	
		495347	B. WING _			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/27/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 625	conducted with the Dunable to provide dor Hold Notice and Care with (Resident name was asked, "What ar Nursing when sendin The DON stated, "I e Bed Hold Notice and hospital and docume On 06/27/2019 at appre-exit meeting the Registered Nurse Cofinding. The facility of information about the 4. The facility staff far Policy was sent with the resident represer hospital on 4/30/19.  Resident #65 was ac readmitted on 5/4/19 but not limited to Qua and Pressure Ulcers.  Resident #65's Program 18:52 (6:52 P.M.) was documented in part, labs critical and called they said to send out Resident #65's Medical there was no documented was no documented was no documented was no documented.	t did not do it."  55 p.m., an interview was ON and she stated, "I am cumentation that the Bed e Plan goals were sent out to the hospital." The DON e your expectations of g residents to the hospital?" xpect the Nurses to send the Care Plan goals to the nt in the Nurse Notes."  proximately 6:15 p.m., at Administrator and the insultant was informed of the lid not present any further e finding.  alied to ensure a Bed Hold Resident #65 or provided to ntative upon discharge to the individual with diagnoses to include adriplegia, Failure to Thrive resident emergency.  The service wed and is as follows: Resident had d LTC (Physician Group) and resident emergency.  The hospital around 5:45.  The proximately 6:15 p.m., at the	F 6	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING			C <b>6/27/2019</b>
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 0	0/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 625	Resident #65's hospit if there was any docubedhold notice was stransfer to the hospital stated, "No I could not sent those documents to send the bedhold put the time of transfer."  On 6/27/19 at approxinformation was shared the Director of Nursin Consultant. Prior to example was shared.  5. The facility staff far Policy was sent with I	M. an interview was irector of Nursing regarding real discharge on 4/30/19 and mentation to support that a sent with the resident upon at The Director of Nursing of find anything to show we swith him. Our process is policy and the care plan at simately 3:30 P.M. the above ed with the Administrator, g and the Corporate Nurse exit no further information liled to ensure a Bed Hold Resident #108 or provided sentative upon discharge to	F 62	25		
	facility on 6/29/18 and diagnoses to include Bifida, Mild Intellectual Disorder.  Resident #108's Prog 20:09 (8:09 P.M.) was documented in part, a Behavior Note: CNA reported that resident bottle of wound clean room and resident ad					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495347	B. WING _			C <b>06/27/2019</b>		
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CO 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	DE .	39/21/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 625	Continued From pag	e 102 ER (emergency room). 911	F 6	625				
		nt. Report called to ER. Unit						
	and there was no do	lical Record was reviewed cumentation to support that s sent with the resident upon al on 11/29/18.						
	Resident #108's hos and if there was any	M. an interview was irector of Nursing regarding pital discharge on 11/29/18 documentation to support was sent with the resident						
	upon transfer to the I Nursing stated, "No I show we sent those	nospital The Director of could not find anything to documents with her. Our e bedhold policy and the						
	information was shar the Director of Nursir	kimately 3:30 P.M. the above ed with the Administrator, ng and the Corporate Nurse exit no further information						
	Notification and Righ	ed "Transfer/Discharge t to Appeal" revised 3/26/18 documented in part, as						
	initiated by the cente	discharges of residents, r (facility initiated) will be to Federal and/or State nts.						
		Discharge Requirements: en the center transfers or t under any of the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		PLETED
		495347	B. WING _			C / <b>27/2019</b>
	ROVIDER OR SUPPLIER	VINDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	circumstances listed that the transfer or disthe resident's medical information is communication is communication in communic	above the facility will ensure scharge is documented in I record and appropriate inicated to the receiving or provider information, including copies harge summary and other oplicable to ensure safe and care.  The facility is not met as evidenced in the comprehensive at a Compreh	F 6		arrent section A other  MDS the twice 4 and Its will be e by the months for	

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 104	F 6	41		
	(MDS) was an Annual Reference Date (ARI Interview for Mental apossible 15 indicating intact and capable of Under Section A 150 and Resident Review considered by the stanave serious mental disability or a related was coded as 0=No.  Resident #108's Conreviewed and is documented in particular for the considered by the stanave serious mental disability or a related was coded as 0=No.  Resident #108's Conreviewed and is documented in particular for the considered by its documented in particular for the conducted with MDS conducted with MDS regarding Resident #5/30/19 PASRR codi MDS Coordinator RN electronic medical reresident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental disability and RNS resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental resident did have a laccoordinator RN #2 serious mental reside	tual Disability: Intellectual tual Disability Spina Bifida  AM an interview was Coordinator RN #2 108's Annual MDS dated ng and if it was accurate. I #2 looked in the residents cord and noted that the				

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495347	B. WING _				C <b>27/2019</b>	
	ROVIDER OR SUPPLIER	/INDSOR	1	23	REET ADDRESS, CITY, STATE, ZIP CODE 352 COURTHOUSE HIGHWAY INDSOR, VA 23487	1 00	2172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	will do a modification  The Annual MDS that was reviewed and is a follows:  Under Section A 1500 and Resident Review considered by the state have serious mental in disability or a related was coded as 1=Yes.  A1510 Level II Pread Resident Review (PA 1: B. Intellectual Dis 1: C. Other related of the facility policy title was reviewed and is a follows:  Policy: The center constandardized, compressessments no less each resident includir collection of data regize	nder the PASRR section. I today."  It was modified on 6/27/19 documented in part, as  O Preadmission Screening Is the resident currently the level II PASRR process to llness and/or intellectual condition-Resident #108  mission Screening and SRR) Conditions: ability	F6	541				
F 656	On 6/27/19 at approx information was share the Director of Nursin Consultant. Prior to 6 was shared.	equired RAI (Resident ent).  imately 3:30 P.M. the above ed with the Administrator, g and the Corporate Nurse exit no further information  Comprehensive Care Plan	F€	356				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING			06/2	27/2019	
	ROVIDER OR SUPPLIER	/INDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		3352 COURTHOUSE HIGHWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656 SS=D	implement a compreh care plan for each respectives and timeframedical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that winder §483.2 (iii) Any services that winder §483.10, including treatment under §483.3 (iiii) Any specialized services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv) In consultation with resident's representation (A) The resident's prefuture discharge. Fact whether the resident's community was assess	ensive Care Plans cility must develop and lensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial lied in the comprehensive riprehensive care plan must lied in the to attain lied in the strict able psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not lesident's exercise of rights ling the right to refuse ling the right to refuse ling the nursing facility will PASARR la facility disagrees with the RR, it must indicate its lent's medical record. In the resident and the live(s)- lals for admission and leference and potential for lilities must document list desire to return to the lessed and any referrals to list and/or other appropriate	F	656	1. Resident #97 fall care plan was reviewed and updated with appropinterventions was completed on 062. All residents have the potential affected. MDS/designee will audit to care plans have been implemented current residents completed on data. MDS/designee will re-educate I team on patient centered care plandevelopment and implementation completed by ED on 07/18/19.  4. MDSC/designee will audit care to ensure fall care plans have been implemented twice weekly for 2 we weekly times 4 and monthly times. The results will be reported to the Assurance Performance Improver Committee (QAPI) by the Executiv Director monthly for 3 months for from compliance and/or revision  5. AOC date: 08/06/2019	riate 5/27/19. to be that fall d for te. DT as plans plans ceks, 2 month Quality nent e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING				27/ <b>2019</b>
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		1 001	2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation interview and clinical staff failed to develop for one of 57 resident Resident #97.  The facility staff failed on the comprehensive #97 was identified as The findings included Resident #97 was ad 05/27/2019. Diagnost limited to, Chronic Ol Disease and Diabete Minimum Data Set (No protocol) with an Ass 06/03/2019 was code Interview for Mental Standard Cognitive in Minimum Data Set or requiring total dependence and bathing, extended and bathing, extended and bathing with set of the Fall Risk Evaluation of the Fall Risk Evaluation.	in the comprehensive care in accordance with the h in paragraph (c) of this  It is not met as evidenced ons, resident interview, staff record review the facility of a comprehensive care plan at in the survey sample,  If to include care area 'falls' e care plan when Resident a fall risk.  It:  Imitted to the facility on sis included but were not costructive Pulmonary is Mellitus. Resident #97's MDS an assessment essment Reference Date of	F	656			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER	VINDSOR	•	23:	REET ADDRESS, CITY, STATE, ZIP CODE 352 COURTHOUSE HIGHWAY INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	was addressed in car On 06/27/2019 at 12: conducted with Regis Coordinator, and she #97 evaluated as a Fall Risk Fall Risk included on comprehensive care planted as a stated, "Yes it should was asked, "Who was was care planned?" Coordinator." RN #4 plan to include Fall Risk On 06/27/2019 at app pre-exit meeting the A Nurse Consultant was	no evidence that "Fall Risk" re plan.  155 p.m., an interview was stered Nurse (RN) #4, MDS was asked, "Is Resident all Risk?" RN #4 stated, k." RN #4 was asked, "Is Resident #97's plan?" RN #4 stated, "No I e plan." RN #4 was asked, care planned?" RN #4 be care planned." RN #4 s responsible for ensuring it RN #4 stated, "The MDS stated, "I will revise the care isk."  Droximately 6:15 p.m., at the Administrator and Registered informed of the finding.		656			
SS=D	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy	ensive Care Plans prehensive care plan must  7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE : COMPL	
			A. BOILDI			(	)
		495347	B. WING				27/2019
NAME OF P	ROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSIII	ATE HEALTH CARE OF	WINDSOP		23	3352 COURTHOUSE HIGHWAY		
CONSULA	TIE HEALIH CARE OF	WINDSOR		W	/INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	(E) To the extent practice resident and the resident and the An explanation must medical record if the and their resident renot practicable for the resident's care plan (F) Other appropriate disciplines as deternor as requested by (iii)Reviewed and reteam after each assements. This REQUIREMEN by:  Based on staff intereview, and clinical determined that facing care plan after resident review, and clinical determined that facing care plan after resident Residents #5, #107  1. Facility staff failed a sexual encounter Resident #5 and Resident #5 and Resident to reside occurred between Ferson #107.  The findings included 1a. Resident #5 was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was followed to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination in the sident was 6/20/18 with diagnol limited to Pick's Disciplination was 6/20/18 with disciplination was 6/20/18 with disciplination was 6/20/18 with disciplination was 6/20/18 with disciplination was 6/20/18 wi	ad and nutrition services staff. acticable, the participation of a resident's representative(s). at be included in a resident's a participation of the resident appresentative is determined the development of the  attention to professionals in mined by the resident's needs the resident. Avised by the interdisciplinary the sament, including both the a quarterly review  AT is not met as evidenced arview, facility document arecord review, it was allity staff failed to revise the altent to resident altercations for as in the survey sample, and #7.  and to revise the care plan after and occurred between asident #107 on 3/6/19.  at to revise the care plan after and physical altercation had aresident #7 and Resident	F	357	1. Resident # 5 no longer resides facility. Resident #107 and #7 care have been revised regarding the paltercations.  2. All residents have the potential affected. MDS will audit current recare plans to be sure they have be revised when resident altercations was completed by 07/29/19.  3. MDS or designee will reeducate team on revision of patient centered plans was completed 07/18/19.  4. MDS or designee will audit that plans have been revised when altercations occurred twice weekly 2 weeks, weekly times 4 and monto times 2 month. The results will be reported to the Quality Assurance Performance Improvement Commit (QAPI) by the Executive Director of for 3 months for further compliance and/or revision  5. AOC date: 08/06/2019	e plans revious to be sident een occur el IDT ed care care for chly	

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
	495347	B. WING			C <b>6/27/2019</b>
NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WI	NDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	, <u> </u>	<u> </u>
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
set) assessment was a an ARD (assessment in Resident #5 was coder impaired in cognitive further on the BIMS (Brief Interexam. Resident #5 was extensive assistance for ADLs (activities of daily bed mobility and transform with walking.  1b. Resident #107 was 11/28/18 with diagnose not limited to Wernicke Hepatitis C (3), and alt Resident #107's most of data set) assessment with an AF date) of 6/25/19. Resident #107 was conwith ADL (activities of supervision only with was review of Resident #5 nursing note that document abuse on 3/6/19. The form "Reported to this writere #5) in room (number of Rewith paints (sic) down a each others. Made DO aware. Instructed by Diapart."	cent MDS (minimum data a quarterly assessment with reference date) of 3/11/19. It das being severely unction scoring 99 out of 15 erview for Mental Status) is coded as requiring rom one staff member with y living) such as dressing, fers; and supervision only se that included but were est encephalopathy (2), ered mental status. Frecent MDS (minimum was a quarterly RD (assessment reference dent #107 was coded as aired in cognitive function of for Mental Status exam. Ided as being independent daily living) and requiring walking.  It's clinical record revealed a mented possible sexual following was documented: In that resident (Resident #5's room) was sident #107's room). Seen as well as lips touching to N (Director of Nursing) in ON to keep resident's	F 68	57		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	COMPLETED
		495347	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 657	Review of Resident # Review of Resident plan dated 12/12/18 6/25/19, failed to resident plan dated 12/12/18 6/25/19, failed to resident plan dated 12/12/18 6/25/19, failed to resident plan date at 5:37 conducted with LPN when both sexual elements when asked the properties of the situation and resident date and instration. When coordinator was, LF (Director of Nursing When asked what ware resident is abused stated that q (every conducted for three tracking record. What staff, i.e. nursing aid aware of resident to stated that nurses a report. When asked if the constant of the serve as a guide when asked if the confirmation of the stated, "It should be p.m., LPN #1 confirmation of the stated, "It should be p.m., LPN #1 confirmation of the sident #107's can the 3/6/19 incident.	effect the above incident #5 and Resident #107.  #107's comprehensive care 8 with the latest revision on effect the above incident #5 and Resident #107.  p.m., an interview was 1 #1, the nurse who worked necounters had occurred. Occess if she were to see residents in the facility, LPN would remove the victim from port the abuse to en asked who her abuse PN #2 stated that the DON 1) was the abuse coordinator. Was usually put into place after 15 min) checks are usually days and recorded on a en asked how other clinical des and nurses are made 10 resident abuse, LPN #1 and nursing aides are given 11 the purpose of the care plan, purpose of the care plan was 15 to care for the residents. Care plan should be updated esident altercation, LPN #1 and nursing aides are given 15 the purpose of the care plan was 16 to care for the residents. Care plan should be updated esident altercation, LPN #1 and nursing aides are given 16 the purpose of the care plan was 16 to care for the residents. Care plan should be updated esident altercation, LPN #1 and nursing aides are given 16 the purpose of the care plan was 17 to care for the residents. Care plan should be updated esident altercation, LPN #1 are updated. Ton 6/26/19 at 6:57 med that Resident #5's and 17 the purpose of the care plan was 18 to care plan swere not revised after 18 the purpose of the care plan was 18 the purpose of the care	F 65	57	
	interview was cond	oximately 3:00 p.m., an ucted with ASM (administrative ne Director of Nursing. When			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		495347	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ı	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	stated that the purpounderstand the care psychosocial needs, anything related to caimportant for the care #2 stated that it was. was updated for reside ASM #2 stated that it victim and the aggrescare plan should be resident altercation, be updated to monitochanges after an incithe incident. When at the care plans, ASM own kardex that be at the care plan was upcare plans were updated to monitochanges after an incithe incident. ASM #2 revise the care plan care plans were updated the incident. ASM #2 revise the care plan.  On 6/27/19 at 5:30 p. Administrator, ASM #4 the corporate nurse of the above concern (1) "Pick's disease is characterized by a sl deterioration of behallanguage. People with abnormal substances nerve cells in the dar Pick bodies contain a called tau. This prote but people with Pick's amount or type of this	is the care plan, ASM #2 se of the care plan was to for each resident such as use of devices (splints) or are. When asked if it was e plan to be accurate, ASM When asked if the care plan dent to resident altercations, would be updated for the asor. When asked why the updated after a resident to ASM #2 stated that it should or for any psychosocial dent and to alert staff about sked if CNAs have access to #2 stated that they had their utomatically updated once dated. ASM #2 stated that ated immediately following stated that all nurses can  a.m., ASM #1, the #2, the DON and ASM #3, consultant were made aware as.  a neurological condition owly progressive	F6	57		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495347	B. WING	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	433347	D. W		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	27/2019
CONSULA	ATE HEALTH CARE OF W	VINDSOR			3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	cks-disease.  (2) "Wernicke's encer brain disorder caused (vitamin B1). It may redictary deficiencies, publication disorders, or the effect deficiency causes dath the deficiency causes dath alamus and hypothermia, low bloomuscle coordination (was obtained from The Health. https://www.ninds.nih/Wernicke-Korsakoff  (3) Hepatitis C- Hepaliver. Chronic hepatitis infection. If it is not trailifetime and cause se including liver damag liver), liver cancer, and spreads through contisomeone who has Hotthrough -Sharing drug needle with someone who has Hotthrough -Sharing drug needle with someone who has tates, this is the monget hepatitis CGetting an accidentation was used on someone happen in health care-Being tattooed or pie were not sterilized after who has HCV	chalopathy is a degenerative of by the lack of thiamine esult from alcohol abuse, prolonged vomiting, eating cts of chemotherapy. B1 mage to the brain's alamus. Symptoms include ion problems, coma, od pressure, and lack of (ataxia)." This information he National Institutes of all composed in Institutes of a long-lasting eated, it can last for a rious health problems, e, cirrhosis (scarring of the lad even death. Hepatitis C lact with the blood of CV. This contact may be so or other drug materials as HCV. In the United est common way that people all stick with a needle that le who has HCV. This can	F	657			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED	
		495347	B. WING _			C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		33/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	come in contact with such as razors or todal Being born to a modal Having unprotected HCV." This informational Institutes of https://medlineplus.com/situtes.com/s	are items that may have another person's blood, othbrushes ther with HCV sex with someone who has son was obtained from The F Health.  gov/hepatitisc.html.  It to revise the care plan after at physical altercation had esident #7 and Resident  admitted to the facility on sees that included but were not with Lewy Bodies (1), is, and high blood pressure. The ecent MDS (minimum data as a quarterly assessment with at reference date) of 3/13/19. The ded as being severely a function scoring 06 out of a sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the sees that included but were seed to the facility on the seed	F 6	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495347	B. WING _			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP C 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ODE	33/2//2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF  X (EACH CORRECTIVE ACT  CROSS-REFERENCED TO 1  DEFICIENCE	FION SHOULD BI THE APPROPRIA	DATE
F 657	note dated 6/1/19 tha "alteration (sic) with in mouth by resident. RPA (Physician's Assis (DON-Director of Number 1974). Review of Resident #6/1/19 revealed the find with (Resident #7's). separated at this time made aware."  Review of the facility incidents) revealed the tothe appropriate stamanner. The FRI date following: "(Name of Resident #7 in mouth Staff immediately separated at the following: "(Name of Resident #7) was plated (Name of Resident #7) was plated the following: "(Name of Resident #7) winvestigation has been follow up to the FRI of following: "(Name of Observed walking up sitting at a table wither (Resident #7). Staff if two residents. (Name visible injuries and nowere noted."	#7's nursing notes revealed a at documented the following: resident. was (sic) hit in the IP (Responsible Party) and stant) made aware. don ring) notified."  #107's nursing notes dated following note: "altercation Hit resident in mouth. staff it. Placed call to RP and PA  FRIS (facility reported for a timely led 6/1/19 documented the Resident #107) punched for no unknown reason. Coarated residents. (Name of for no unknown reason.	F	657		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		OMPLETED	
		495347	B. WING			C 06/27/2010	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487		06/27/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 657	plan dated 12/12/18 6/25/19, failed to re between Resident a  On 6/27/19 at apprent interview was cond staff member) #2, the asked the purpose stated that the purpunderstand the care psychosocial needs anything related to important for the care #2 stated that it was updated for resident altercation be updated to mone changes after an in the incident. When the care plans were up the incident and the supplemental to the care plans were up the incident. ASM # revise the care plan resident #107 and not revised after the Facility policy titled	t #107's comprehensive care 8 with the latest revision on eflect the above incident #5 and Resident #107.  oximately 3:00 p.m., an ucted with ASM (administrative he Director of Nursing. When of the care plan, ASM #2 obse of the care plan was to e for each resident such as s, use of devices (splints) or care. When asked if it was are plan to be accurate, ASM s. When asked if the care plan sident to resident altercations, to the would be updated for the essor. When asked why the e updated after a resident to a, ASM #2 stated that it should iter for any psychosocial incident and to alert staff about asked if CNAs have access to M #2 stated that they had their automatically updated once updated. ASM #2 stated that dated immediately following #2 stated that all nurses can in. ASM #2 confirmed that Resident #7's care plan was a altercation on 6/1/19.	F 6	57			
	revise the compreh changing goals, pre resident and in resp	g: "Review, update and/or lensive care plan based on eferences, and needs of the bonse to current interventions n of each OBRA MDS					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495347	B. WING _			06/	27/2019
	ROVIDER OR SUPPLIER	/INDSOR		2	STREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658 SS=E	team shall ensure the resident needs and the toward attaining or ma practicable physical, it well-being."  (1) Lewy Bodies Dem (LBD) is a disease as deposits of a protein obrain. These deposits chemicals in the brain can lead to problems behavior, and mood of the most common of information was obtain Institutes of Health. https://www.nia.nih.gomentia.  Services Provided McCFR(s): 483.21(b)(3) Comproduced CFR(s): 483.21(b)(3) CFR	needed. The interdisciplinary plan of care addresses an lat the plan is oriented aintaining the highest mental and psychosocial  entia- "Lewy body dementia sociated with abnormal called alpha-synuclein in the called Lewy bodies, affect in whose changes, in turn, with thinking, movement, Lewy body dementia is one causes of dementia." This ned from The National cov/health/what-lewy-body-de leet Professional Standards or arranged by the facility, in mprehensive care plan, standards of quality.  It is not met as evidenced int investigation, observation, taff interviews, facility declinical record review, the follow professional standards		657			
	The facility staff fa	iled to follow the physician					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING				07/0040
	ROVIDER OR SUPPLIER	VINDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY //INDSOR, VA 23487	U6/2	27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	right below the knee *incision) and skin teal #55.  2. The facility staff fa orders and administer (Below the Knee Amp 3. The facility failed the elimite cream for Res The findings included  1. Resident #55 was facility on 01/24/19. If included but are not like amputation. Reset (MDS-an assess Assessment Reference the resident with an 115 on the Brief Intervit (BIMS), indicating most impairment. In addition conditions) was coded surgical wound care.  An interview was condo/25/19 at approximations and "the nurses are reas ordered by the document of the strength of the	ent of the following wounds: *amputation site (surgical r to right elbow for Resident  siled to follow physician r treatments to a right BKA outation) for Resident #32.  to justify treatment with sident #465.  d:  originally admitted to the Diagnosis for Resident #55 imited to Right below the esident #55's Minimum Data ment protocol) with an ce Date of 04/26/19 coded 11 out of a possible score of iew for Mental Status oderate cognitive on, under section M (Skin d for surgical wounds with  ducted with Resident #55 on ately 4:13 p.m. The resident not changing my dressings ctor." The resident stated, sing will go 4 to 5 days d (pointing to surgical o)."	F	658	<ol> <li>Resident # 55, #32 and #465 no resides at the facility.</li> <li>All residents have the potential to affected. DCS or designee will revie all current resident treatments are administered as ordered was compl by 07/29/19.</li> <li>DCS or designee will reeducate licensed staff on ensuring treatment administered per physician order was completed by 08/01/19.</li> <li>DCS or designee will audit the TMMD orders to ensure residents are receiving treatments as ordered twice weekly for 2 weeks, weekly times 4 monthly times 2 month. The results reported to the Quality Assurance Performance Improvement Committed (QAPI) by the Executive Director months for further compliance and/or revision.</li> <li>AOC date: 08/06/2019</li> </ol>	o be w that eted  ts are as  AR and ce and will be	
	(TAR) for June 2019 r treatment orders:	revealed the following					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		00/2//2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 658	saline, apply *Algis and stump shrinker right stump care (si review of the clinical evidenced there we indicating the surgistreatment was not co 06/17/19.  -Apply skin prep to site every shift for so 06/20/19). Further June 2019 evidence nurse; indicating the 12:00 p.m., on the and 6/24/19.  Review of the Treat (TAR) for May 2019 treatment orders:  -Apply *Santyl ointramputation topically treatment (start dat of the clinical reconthere were no initial surgical wound carnot completed at 12 days: 5/06, 5/07, 5/5/16, 5/18, 5/19, 5/5/29/19.  -Cleanse skin tear saline, pat dry, app with dry dressing d 05/03/19). Further	lee stump: cleanse with normal lite, cover with foam dressing r, change every other day for lart date 06/13/19). Further all record for June 2019 ere no initials by the nurse; cal wound care (right stump) completed at 9:00 a.m., on right above the amputation extin protection (start date: review of the clinical record for ed there were no initials by the eatment was not completed at following days: 6/21, 6/22, 6/23 extment Administration Record every shift for wound e: 05/02/19). Further review d for May 2019 evidenced lis by the nurses, indicating the extraction (right stump) treatment was 2:00 p.m., on the following 108, 5/09, 5/11, 5/12, 5/14, 21, 5/23, 5/25, 5/26, 5/28 and 10 to right elbow with normal ly bacitracin ointment, cover aily until healed (start date: review of the clinical record for ed there were no initials by the	F 65	8		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER	VINDSOR	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	05/06, 05/07, 05/08, 05/15, 05/16, 05/18 at An interview was compractical Nurse (LPN approximately 2:14 phas holes (having mittreatment was not do On 06/27/19 at approximaterview was conduct "There should never Administration Recorstated, "If there are hwhich means the meadministered or the total An interview conduct (DON) on 06/27/19 at The surveyor asked your nurses related to she replied, "I expect physician orders as with The Administrator, Director of informed of the findin 06/27/19 at approximation of the findings.  The facility's policy titiand Wound (Effective Overview: To provide skin at risk, implement	a.m., on the following days: 05/09, 05/11, 05/12, 05/14, and 05/19/19.  Iducted with Licensed ) #2 on 06/29/19 at .m., who stated, "If the TAR asing initials) then the ne."  Indication the Medication of (MAR) or TAR." She oles on the MAR or TAR, dication was not reatment was not done."  Indication was not reatment was not done."  Indication was not done.  Indication was n	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С	
		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER TE HEALTH CARE OF W	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	worsening of/prevention  Process to include but-License Nurse to repto the physician/pract resident/responsible produced in the physician pract resident/responsible produced in the physician progress towards goal management meeting.  Definitions:  *Amputation is the repto surgery or they occur the body (https://medlineplus.g.)  *Algisite is a calciumforms a soft, gel that a contact with wound extremely the proven benefits of http://www.smith-neplect.  *Santyl is used to help ulcers. Collagenase is helping to break up at tissue. This effect ma and speed up your bot (antibiotics <a href="http://www.webmd.co.biotics-myths-facts">http://www.webmd.co.biotics-myths-facts</a> .  Complaint deficiency.	n, healing and decrease on of pressure ulcer.  It not limited to: port changes in skin integrity itioner and party and document in the eness of interventions, and als during the care grand as needed.  Impoval of a body part, either cur by accident or trauma to pov/ency/article/007365.htm).  It alginate dressing which absorbs when it comes into exudate. Algisite helps utilize from from the mount of the mou	F	658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2/12010	
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F 658	01/26/2019. Reside facility on 06/18/201 were not limited to, and Type 2 Diabete Minimum Data Set (an Assessment Refewas coded with a B Status) score of 15 impairment. In addicoded Resident #32 with eating, supervistoilet use, independ dressing, bathing ar hygiene with assistation 006/25/2019 at a printerview was conducted that he had of his right BKA (Be the nursing staff havin 2 weeks.	dmitted to the facility on ent #32 was readmitted to the 9. Diagnoses included but Peripheral Vascular Disease is Mellitus. Resident #32's fan assessment protocol) with erence Date of 04/05/2019 IMS (Brief Interview for Mental indicating no cognitive tion, the Minimum Data Set is as requiring set up help only sion with assistance of 1 for ent with bed mobility, transfer, and independent with personal	F 658			
	On 06/26/2019 at 9: observed Licensed wound care on Resi wound was observe with some depth, no incision line of the received Review of Resident 06/26/2019 revealed	216 a.m., the surveyor Practical Nurse #2 provide ident #32's right BKA. The ad to be an open clean area by drainage and located on the esident's Right BKA.  #32's clinical record on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	VINDSOR	:	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 658	with an end date of 0 follows: Right BKA g Aquacel Ag and Alley Shrinker one time a c Right Lower Limb. R Administration Record dated to start on 05/2 06/18/2019 to the Rig available spaces for (05/25, 05/26, 05/27, 06/04, 06/05, 06/08, 06/16, 06/17, 06/18) were blank. Review revealed Resident # hospital on 06/13/20 06/18/2019. There we vidence that treatme 05/25, 05/26, 05/27, 06/04, 06/05, 06/08, The Order Summary dated 06/20/2019 with and read as follows: Cleanse with NS (No with foam dressing C wound care. Review Administration Record dated to start on 06/2 only had documentated 06/26/2019. Spaces 06/25/2019 were blank Review of Nurse Prodocumentation indicated to 16/2019. No of that treatments were 06/23, 06/24 and 06/24 and 06/25/2019.	art Date on 05/25/2019 and 16/18/2019 and read as rently cleanse, pat dry apply ryn Daily and then apply day related to cellulitis of deview of the Treatment order 25/2019 and to end on 19th BKA had 25 total documentation. 17 spaces 05/28, 05/29, 05/31, 06/02, 06/09, 06/11, 06/14, 06/15, had no documentation, they of Nurse Progress Note's 32 was discharged to the 19 and returned on 19th and 19th	F 658			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	' '	OMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487		06/27/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	#2 and she was asked space on the Treatment mean?" LPN #2 stattreatment was not do that it was done."  On 06/27/2019 at appre-exit meeting the Nurse Consultant was The facility did not preabout the finding.  3. The facility staff content was the facility of the	nsed Practical Nurse (LPN) ed, "What does an empty eent Administration Record ted, "It indicates that the one or the nurse did not click  proximately 6:15 p.m., at Administrator and Registered as informed of the finding. resent any further information  ould not justify treatment with sident #465's bilateral legs.  admitted to the nursing facility noses that included of the brain, peripheral //D), cellulitis of right and left is, history of blood clots of the left upper extremity, high sity and venous insufficiency. On Not Resuscitate (DNR) n. Resident #465 was cal hospital on 5/25/18 and plications in wound healing tepsis. He was readmitted to on 6/3/18. The resident was ervices on 8/27/18 and	F 65	58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	IDER OR SUPPLIER	WINDSOR	:	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1002.720.10	
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the experience of the control of the	ne care plan dated sident had impaired tremities related to ascular wounds. To sident was that the bunds would show the goals set for the ball included adminited adminited actions as ordered to the resident refuses and try again. The construction of scale ovided to the resident action of scale ovided to the resident action of the factorial lower leg expression of the factorial lower leg expression of the factorial form of the factorial factorial form of the factorial factor	otion on and off the unit.  15/18/18 identified the ed skin integrity to lower of cellulitis, lymphedema and the goal set by the staff for the ed cellulitis and vascular of signs of healing. Some of of resident to accomplish this of interventions and if of treatments/interventions, wait of treatments/interventions, wait of the physician and if of treatments/interventions, wait of the physician and if of treatments/interventions, wait of the physician and if of treatments/interventions, wait of treatments/interventions/interven	F 658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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PREFIX (EAC	H DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE	(X5) COMPLETION DATE
with scable treatment of this order. This is son in my prog (attending find this verification physician, confirms the Complaint F 684 SS=E \$483.25 Quality of applies to a facility residence accordance practice, the son in my prog (attending find this verification works by prof scables (https://www_cream/art  The facility 8/22/17 incompropriate shall sign of verification physician, confirms the Complaint F 684 Quality of Gapplies to a facility residence accordance practice, the son in my prog (attending find this verification physician).	m includes sor symposith elimiter. This had the thing outers notes on the sort of the thing outers and the thing outers. Permethrics. Permethrics. Permethrics. Permethrics and the thing outers of the order of transciples. Deficiency of the thing of the	ed elimite. He had no issues of the state would require e. I have no recollection of o have been ordered in error. It of the blue. I have nothing is and I do not see anything in is name) progress notes. I e."  In is a topical cream used to ethrin is a neurotoxin that nerves in respiratory muscles neir death the net.com/permethrin-topical ethed Physician's Orders dated ders are transcribed to all IAR, TAR, etc.). The nurse ers upon completion or ription. The attending actitioner reviews and		658		

CENTER	S FOR WEDICARE &	WIEDICAID SERVICES				OIVID IVO	<u>. 0936-039 i</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE	
		495347	B. WING			06/2	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF	WINDSOR			3352 COURTHOUSE HIGHWAY		
				W	/INDSOR, VA 23487		
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F 684	facility staff failed to medications and trea in the survey sample 1. The facility staff fawith medications as 2. The facility staff for Resident #465.  3. The facility staff for Resident #465.  3. The facility staff for Resident #6 was a 2/7/18 with diagnose diabetes, long terms depression, anxiety, hyperlipidemia, and to provide physician anti-anxiety medicat Resident #6 was ass Minimum Data Set (las having minimum glasses. In the area resident was assess the area of Brief Inter (BIMS) indicating no Resident #6 was assess Activities of Daily Livenia and treat the same and the same	view and staff interviews, the provide physician ordered atments for 3 of 57 residents e, Resident #6, #465, & #265.  alled to provide Resident #6 ordered by the physician.  alled to provide wound care  alled to provide treatment for rewound for Resident #265.  d:  re-admitted to the facility on es which included type two cuse of insulin, dysphagia, congestive heart failure, COPD. The facility staff failed ordered insulin and ion to Resident #6.  sessed on a Quarterly MDS) dated June 12, 2019 hearing difficulty and wears of Cognitive Patterns this ed as having scored a 15 in erview for Mental Status cognitive impairment. sessed in the area of ring (ADL's) as requiring	F	684	1. Resident #6, #265 and #465 no reside at the facility. 2. All residents have the potential to affected. DCS or designee will review residents are receiving medication at treatments as ordered by the physic No other residents were affected. 3. DCS or designee will re-educate staff on administering medications at treatments as ordered by the physic completed by 08/01/19. 4. DCS or designee will audit MD of ensure residents are receiving medications are receiving medications. The results will be resulted to the Quality Assurance Performant Improvement Committee (QAPI) by Executive Director monthly for 3 medications are for further compliance and/or revisions. AOC date: 08/06/2019	o be ew that and cian. nursing and cian was orders to ication eekly for ally eported nce the onths	
	transfer and dressing one person physical	up only in the areas of g with limited assistance; with assist in the area of toileting. ations this resident was a lnsulin injections,					

A 495347  B. WING
STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487  T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)  F 684  ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 684  IS ARREST ADDRESS, CITY, STATE, ZIP CODE  2352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487  IC (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 684  IS ARREST ADDRESS, CITY, STATE, ZIP CODE  2352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487  IC (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  IN THE PROPERTY OF THE APPROPRIATE DEFICIENCY  IN THE PROPERTY OF THE PROPERTY OF THE APPROPRIATE DEFICIENCY  IN THE PROPERTY OF TH
BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 684
ndicated: betes mellitus and will have no betes. Interventions- dered by doctor. effects and iety medication care for discomfort or anti-anxiety therapy.
19 included: Novolin Pen-injector (insulin) brazepam tablet 0.5 et by mouth twice a 1). Iministration Record dicated on March 6, 7 pension (70/30) 100 as ordered.  March 2019 indicated am 0.5 mg was not  Inne 2019 indicated on
ministration Record dicated on March 6, 7 pension (70/30) 100 as ordered.  March 2019 indicated am 0.5 mg was not  me 2019 indicated on din 70/30 100 units dered.  me 2019 indicated on

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495347	B. WING				27/ <b>2019</b>
	ROVIDER OR SUPPLIER	VINDSOR	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
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F 684	Diabetes Mellitus with awaiting pharmacy.  A Nursing Progress in (12:50) indicated: "Instruction of the continuing to monitor."  A Nursing Progress in (19:16) medication didelivery.  During an interview of Resident #6, she state ran out several times past weekend. I get in are short of staff, I hat and change my own is the Director of Nursin Nurse Consultant the #6 medications were stated insulin is available have gone in the state DON stated, staff show medication more time. Pharmacy Policy indicating: Back order Ordered-too-soon not Drug-drug interaction Formulary changes; Any other communication medication to item was 2. Resident #465 was	e morning related to type 2 in Diabetic Neuropathy,  ote dated June 21 2019 sulin not available; pharmacy elivered today. MD aware  ote dated June 21, 2019 d not arrive during afternoon  in 6/25/19 at 2:45 P.M. with ed, " My medications have  Back in March and just this my insulin twice a day. They we to make up my own bed sheets."  in 6/26/19 at 11:15 A.M. with g (DON) and Regional y were asked why Resident not available. The DON able on site and staff should box and got her insulin. The build have ordered the elly.  cated: " If any order is not communication slip restifications; s;	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	VINDSOR		233	EET ADDRESS, CITY, STATE, ZIP CODE 52 COURTHOUSE HIGHWAY NDSOR, VA 23487	1 00,	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	vascular disease (PV lower limb with sepsi the deep veins of the blood pressure, obes Resident #465 was do hospital on 5/25/18 a complications in wou sepsis. He was readi on 6/3/18. The reside services on 8/27/18 a 9/2/18.  The admission Minimassessment dated 5/with a score of 11 outhe Brief Interview for indicated he was more for daily decision marked to have vascular sessed totally dependently dependently and locomod. The care plan dated resident had impaired extremities related to vascular wounds. The resident was that the	of the brain, peripheral (D), cellulitis of right and left s, history of blood clots of left upper extremity, high sity and venous insufficiency.  Ilischarged to the local and admitted due to admitted to the nursing facility ent was placed on hospice and expired in the facility on the management of the state of the staff for the cellulitis, lymphedema and the goal set by the staff for the cellulitis and vascular	F	584			
	the goals set for the goal included adminimedications as order the resident refuses and try again.	red by the physician and if treatments/interventions, wait ment Administration Records in through discharge on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495347	B. WING		06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487	, 33.220.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 684	for bilateral leg cellu 2018.  -Sixty-five blanks on to eight individual we back of knee, left an leg, left lateral malle left foot and top of ri 2018.  -Forty-one blanks or to eight individual we back of knee, left an leg, left lateral malle left foot and top of ri August 2018.  On 6/27/19 at 11:20 conducted with Lice #5. There were no not that provided direct his stay in the nursing remembered Reside often refused treatmentry by the nurse o would either indicates.	ge 131 the TAR related to treatment litis for the month of May  The TAR related to treatment counds that included the left dright dorsal foot, left lateral colus, right medial lower leg, ght foot in the month of July  The TAR related to treatment counds that included the left dright dorsal foot, left lateral colus, right medial lower leg, ght foot in the month of  The TAR related to treatment counds that included the left dright dorsal foot, left lateral colus, right medial lower leg, ght foot in the month of  The TAR with a lower leg, and the count was available for interview care for the resident during and facility. LPN #5 stated she can the target that the the resident refused the contact of the resident refused the resident refused the contact of the resident refused the resident refused the contact of the resident refused the resident refused the resident refused the contact of the resident refused the refused	F 684	DEFICIENCY)		
	If the legend for othe was required. LPN # past that we could n TAR or on the Medic (MAR) before leavin not documented, it v  On 6/27/19 at 1:25 p shared with the Dire DON stated it was the	er was entered, a nurses note 45 stated, "We were told in the ot leave any blanks on the cation Administration Record g our shift because if it was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	WINDSOR	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487	1 00/2//2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 684	stated blanks were rand gave the indicat provided. The DON refused treatment, b  No further information survey exit on 6/27/1/2  Complaint Deficience 3. Resident #265 was nursing facility on 11 04/08/19. The resident therefore a closed reduced to, Peripheral Vascut the skin and Subcuta Insufficiency.  The quarterly Minimus Assessment Reference oded the resident was sore of 15 on the B Status (BIMS), indicating impairment. Section read as follows: Resulters as being "Yes that the resident had present.  According to the Phy 2019, Resident #268 following wound care Extremity (BLE) with cover wounds with x wrap with kerlix ever	ain a reason for not ent or medication. She not an acceptable practice, ion the treatment was not said, "I want to say he ut I can't prove it."  on was provided prior to 19.	F 684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495347	B. WING			06/	27/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			3352 COURTHOUSE HIGHWAY		
				V	VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	from dialysis late. The provide wound care endocumentation of white to the wound clinic.  The review of the Rescomprehensive care process: Resident has bilateral lower extrement (Peripheral Vascular I Wound Care Clinic as	e oncoming nurse did not e oncoming nurse did not e oncoming nurse did not either. There was no ch days Resident #265 went esident #265's colan included the following:  a Venous Stasis Ulcer of the eities relating to PVD Disease). Interventions:	F	684			
		tions as ordered to promote dly Treatment and Boot as ordered. the potential for skin s: Weekly skin					
	and vascular wounds Interventions: Anticipa pain relief and respon complaint of pain. Mo care.  Focus: The resident h Extremities. Intervent Report to MD signs a  On 06/26/19 at appro interview was conduct Nurse (LPN) #2 conce She was asked if she	ate the resident's need for and immediately to any nitor for pain during wound has cellulitis of the Lower ions: Monitor Document and nd symptoms of delirium.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	COMPLETED
		495347	B. WING		C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	00/2//2019
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 684	she was the wound vascular disease an an unnaboot that co of wound treatment had vascular wound care 3 days a week nurses." "Resident wound on her leg." towards the end of oral and topical paid day she passed aw  On 06/26/19 at appinterview was cond Assistant) CNA #12 could elaborate on end she was confus was being attacked She would talk strallegs and they stayed drainage. When as #12 stated "Yes; or	ound care at the wound clinic, care nurse. "The resident had not poor circulation. She had ould only be taken off on days" She stated that Resident ds on her legs. "I did wound" "Other days were up to the was initially admitted with one "She was in a lot of pain her life." The nurses gave her n medications. "I was here the	F 68	34	
	conducted with the concerning Resider stated that the assicare because resid her shift at 3:30 PM have provided wou QAPI (Quality Assu Improvement) it because residually and the Regional Nurse Coshould have been conurse should have	PM an interview was Regional Nurse Consultant at #265's wound care. She gn nurse did not do the wound ent was at dialysis. She ended at the evening nurse should and care but she didn't. "We did arance and Performance cause it wasn't done" The ansultant was asked what alone? She responded, "The adone it." "There is no nursing dicating wound care was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C <b>06/27/2019</b>	
	ROVIDER OR SUPPLIER	/INDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	33/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	)N
F 684	interview was conduct Consultant, the Direct Nurse Consultant and were debriefed on the Complaint Deficiency	eximately, 4:43 PM a pre-exit ted. Present were the Nurse for of Nursing, the Regional the Administrator. They above concerns.	F 684	1. CNA #5 and LPN #1 were educ	ated on	
F 692 SS=D	(Includes naso-gastric both percutaneous en percutaneous endosce enteral fluids). Based comprehensive assessensure that a resident §483.25(g)(1) Maintai of nutritional status, significant demonstrates that this preferences indicate of the percentage of the percent	nutrition and hydration. c and gastrostomy tubes, idoscopic gastrostomy and opic jejunostomy, and I on a resident's esment, the facility must t- ins acceptable parameters uch as usual body weight or a range and electrolyte esident's clinical condition is is not possible or resident	F 692	o6/26/19 to ensure residents receisupplements as ordered.  2. All residents have the potential that affected. DCS or designee will review residents are receiving supplement ordered by the physician. No other residents were affected.  3. DCS or designee will educate not staff on administering supplements ordered by the physician; was comby 08/01/19.  4. DCS or designee will audit to entered twice weekly for 2 weeks, we will advice the product of the physician of	or be sew that s as sursing as pleted sure s as	
§483.25(g)(3) Is offered there is a nutritional proportion orders a there are the REQUIREMENT by:  Based on staff interviews the facility stars.		etion and health;  ed a therapeutic diet when roblem and the health care rapeutic diet.  is not met as evidenced rews, and clinical record		times 4 and monthly times 2 month results will be reported to the Quali Assurance Performance Improvem Committee (QAPI) by the Executive Director monthly for 3 months for fu compliance and/or revision  5. AOC date: 08/06/2019	. The ty ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		C 06/27/2019	
	ROVIDER OR SUPPLIER	VINDSOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION	
F 692	Continued From pag	e 136	F 692			
	one of 57 Residents (Resident #63).	in the survey sample				
	The facility staff faile supplement, Mighty 9	d to provide the nutritional Shake, on 6/25/19.				
	The findings included	1:				
	9/27/18 and readmitt	iginally admitted to the facility ed on 4/19/19. The current eimer's Dementia and				
	(MDS) assessment v reference date (ARD resident as not havin Brief Interview for Me interview coded the r	) of 5/09/19 coded the g the ability to complete the ental Status (BIMS). The staff esident with long and short ms as well as severely				
	#63 was observed si lunch. The lunch tray Resident #63 was ob not eating until 12:43 Assistant (CNA) #5 v resident with feeding	oximately 11:42 AM Resident titing at a table waiting for its arrived at 11:56 AM. Its asserved touching her food but its PM when Certified Nursing walked over to assist the its assistance. Resident #63 resisted. At its PM the resident's tray was oble.				
	the Resident's tray fr if the resident had ea stated, "No she neve her." Surveyor stated Resident #63 was or	wed shortly after removing om the table. She was asked ten anything. The CNA #5 or does but I tried to feed I that she noticed that ally fed for a few minutes. The per does eat anything."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	1 00/2//2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 692	receive a supplement She stated "Yes." She Resident didn't receive replied, "Dietary didn't replied, "Dietary didn't receive replied, "Dietary didn't receive replied, "Dietary didn't Resident #63 nutrition issues. She stated the med-Pass supplement A review of the Hosp tolerated, Thickened included: "Mighty She On 6/27/19 at approximaterview was conducted to the kitch on 06/27/19 The dieprovide a copy of Resident not receive their was confirmed that meal ticket."  On 6/27/19 at approximaterview was conducted to dietary for the should you have don called to dietary for the Nurse was also asket.	#5 does Resident #63 tal shake with her meals. he was then asked why the we her shake today; She 't put it on the tray."  view was conducted with urse (LPN) #1 concerning hal needs and weight loss hat Resident #63 receives a hat at 9 AM, 1 PM, and 5 PM.  ice care plan read: "Diet as liquids." The Doctor's order ake with every meal."  kimately, 9:00 AM an heted with the Other Staff She was asked if a Resident hutritional shake on their tray  she responded, "The staff hen and we'll bring it."  tary manager was asked to sident #63's meal ticket and he "Mighty Shake was on  kimately 10:15 AM an heted with LPN #8 concerning higher nutritional shake with honded, "We try to coach her he Mighty Shake or went to	F 69	92	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 501251			(	С
		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER	/INDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	able to feed self with assistance. It also sta monitored at meal tim	plan stated that Resident is	F	692			
F 727 SS=D	interview was conducted Consultant, the Direct Nurse and the Admin		F.	727			
	must use the services least 8 consecutive he \$483.35(b)(2) Except paragraph (e) or (f) or must designate a reg director of nursing on \$483.35(b)(3) The director as a charge nurse on average daily occupa This REQUIREMENT by:  Based on facility info Complaint investigatic Competent Nurse Stainterviews, the facility	when waived under If this section, the facility Is of a registered nurse for at ours a day, 7 days a week.  when waived under If this section, the facility istered nurse to serve as the a full time basis.  ector of nursing may serve ly when the facility has an ncy of 60 or fewer residents. It is not met as evidenced  rmation obtained during the on, Sufficient and offing task, and staff staff failed to staff an N) for at least 8 consecutive					

			(X3) DATE : COMPI	LETED			
		495347	B. WING _			06/2	27/2019
NAME OF PI	ROVIDER OR SUPPLIER		'	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
001101111	TE !!E 4 ! T!! 0 4 DE 0E !!	WINDOOD		23	352 COURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF V	VINDSOR		W	INDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					1. The facility has reviewed its proc	edures	
F 727	Continued From page 139  1. The facility staff failed to staff an RN, for at		F 7	27	to ensure RN is utilized 8 Hrs per d	ay	
					and that the DON may not serve as	а	
	least 8 consecutive h				charge nurse completed on 07/18/19	9.	
		f Nursing as a charge nurse			2. All residents have the potential to	be	
	with a resident census greater than 60.				affected. The facility will ensure that		
	2 The facility staff fa			is utilized 8 hours per day and that t			
	The facility staff failed to ensure RN coverage eight hours in a twenty-four hour period on				DON may not serve as a charge nui		
	4/14/18, 4/15/18 and 6/24/18.				3. ED or designee will educate nurs		
					· ·	•	
	The findings included	l:			leadership that and RN (Register Nu	,	
	A review of the as work schedules from April				must be utilized 8 hours a day and t	ne	
		6, 2019, were reviewed			DON may not be utilized as a charg-	e nurse	
	_	ner review of the Registered			was completed by 07/26/19.		
	, ,	coverage. During the			4. ED or designee will audit the sch	edule	
		ed schedule for 06/16/19 it			to ensure an RN is utilized 8 hours a	a dav	
		of Nursing (DON) worked ne floor nurse passing			and a DON is not utilized as a charg	-	
		rrent census on 06/16/19			twice weekly for 2 weeks, weekly tin		
		concluded there was no RN					
		rse other than the DON for			and monthly times 2 month. The res		
	at least 8 nours cons	ecutive hours on 06/16/19.			be reported to the Quality Assurance		
	An interview was con	ducted with the DON on			Performance Improvement Committ	ee	
	06/26/19 at approxim	ately 10:50 a.m. The DON			(QAPI) by the Executive Director mo	onthly	
		06/16/19 from 7a (a.m.)-7p			for 3 months for further compliance	and/or	
		irse but there was another			revision.		
		ne supervisor/charge nurse." The as worked scheduled with			5. AOC date: 08/06/2019		
		After the DON reviewed			0. 7.00 date. 00/00/2010		
		ule she stated, "Oh, RN #5					
	called out for the 7a-7	7p shift, on the Blue Unit."					
		"Was there a RN supervisor					
	/charge nurse in the f	•					
		ed "No." The surveyor					
		onsider supervisor/charge					
	_	there is a census of 60 or					
	rureater? She reblied	. "The facility is 114 beds		- 1			I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER	/INDSOR	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 727	The Administrator, Dir Regional Director of Conformed of the finding 06/27/19 at approximation of the findings.  The facility staff fa (Registered Nurse) of twenty-four hour period 6/24/18.  During review of the frequency failed to ensure there consecutive hours a conformation of 6/27/19 at 10:45 at (DON) stated they have mandate for RN cover the federal regulation review of the as work that there was no RN	of considered a rise when the facility has a so."  rector of Nursing and Clinical Services was g during a briefing on ately 3:40 p.m. The facility orther information about the siled to ensure RN overage for eight hours in a pid on 4/14/18, 4/15/18 and accility's staffing for N) coverage, the facility was an RN for at least 8 day seven days a week on	F	727			
F 755 SS=D	CFR(s): 483.45(a)(b)( §483.45 Pharmacy So The facility must prov	edures/Pharmacist/Records (1)-(3) ervices ide routine and emergency to its residents, or obtain	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495347	B. WING		06/2	27/2019	
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	§483.70(g). The faci personnel to adminis permits, but only und a licensed nurse.  §483.45(a) Procedure pharmaceutical servithat assure the accur dispensing, and adminicologicals to meet the services of the provision of the facility.  §483.45(b)(1) Provide aspects of the provision the facility.  §483.45(b)(2) Establication and disposition of the provision of th	lity may permit unlicensed ter drugs if State law ler the general supervision of les. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident.  Consultation. The facility in the services of a licensed les consultation on all ion of pharmacy services in lishes a system of records of on of all controlled drugs in able an accurate lenines that drug records are in count of all controlled drugs riodically reconciled.  To is not met as evidenced lent (Resident #6) in the residents.  Sility staff failed to ensure ailable for administration per	F 75	1. Resident #6 medication orders or reviewed by DCS and medication is currently available.  2. All residents have the potential that affected. An audit was completed to ensure current residents have medicated available as ordered was completed by 07/29/19.  3. DCS or designee will educated Innursing staff on quality monitoring of medication rooms to ensure that or medications are available; was completed by 07/19.  4. DCS or designee will audit MAR ensure residents are receiving insulorazepam as ordered; twice weekly weeks, weekly times 4 and monthly 2 month. The results will be reported Quality Assurance Performance Improvement Committee (QAPI) by Executive Director monthly for 3 medications are one of the province of the p	to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495347	B. WING		C 06/27/2019		
	WINDSOR					
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
Continued From pag	ne 142	F 75	5			
2/7/18 with diagnose heart failure, hyperlip diabetes, dysphagia long term use of insure Resident #6 was ass Minimum Data Set (I as having minimum glasses. In the area resident was assess the area of Brief Inte (BIMS) indicating no Resident #6 was ass Activities of Daily Liv supervision with settransfer and dressing one person physical In the area of Medicassessed as receiving anti-anxiety and anti-A Care Plan dated 3 "Focus-Resident #6 neuropathy. Goal-Recomplications related Diabetes medication Monitor-document for effectiveness. An amplan indicated-Goal	es that included congestive bidemia, COPD, type two depression, anxiety and ulin.  sessed on a Quarterly MDS) dated June 12, 2019 hearing difficulty and wears of Cognitive Patterns this ed as having scored a 15 in review for Mental Status cognitive impairment. Sessed in the area of ring (ADL's) as requiring up only in the areas of gwith limited assistance with assist in the area of toileting. ations this resident was ang Insulin injections, depressant medications.  /25/19 indicated: has diabetes mellitus and esident will have no do to diabetes. Interventions- as as ordered by doctor. For side effects and ti-anxiety medication care.					
as ordered by physic Physician orders dat 70/30 flex pen Suspunit/ml (milliliters) (in	cian. red 6/10/19 indicated: Novolin ension Pen-injector 100 isulin).					
	SUMMARY S (EACH DEFICIENCE REGULATORY OR REGULATORY OR Resident #6 was re- 2/7/18 with diagnose heart failure, hyperlip diabetes, dysphagia long term use of inst Resident #6 was ass Minimum Data Set (I as having minimum glasses. In the area resident was assess the area of Brief Inte (BIMS) indicating no Resident #6 was ass Activities of Daily Liv supervision with set- transfer and dressing one person physical In the area of Medica assessed as receivin anti-anxiety and anti  A Care Plan dated 3 "Focus-Resident #6 neuropathy. Goal-Re complications related Diabetes medication Monitor-document for effectiveness. An an plan indicated-Goal- adverse reactions re Interventions-admini as ordered by physic  Physician orders dat 70/30 flex pen Suspo- unit/ml (milliliters) (in	PROVIDER OR SUPPLIER  ATE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER  ATE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 142  F 75:  Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses that included congestive heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin.  Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.  Resident #6 was assessed in the area of Activities of Daily Living (ADL's) as requiring supervision with set-up only in the areas of transfer and dressing with limited assistance with one person physical assist in the area of toileting. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.  A Care Plan dated 3/25/19 indicated: "Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor-document for side effects and effectiveness. An anti-anxiety medication care plan indicated-Goal-At risk for discomfort or adverse reactions related to anti-anxiety medications as ordered by physician.  Physician orders dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unit/ml (milliliters) (insulin).	ATE HEALTH CARE OF WINDSOR  SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 142  Resident #6 was re-admitted to the facility on 2/7/18 with diagnoses that included congestive heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin.  Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Conglitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #6 was assessed in the area of Conglitive Patterns this resident was assessed as first in the area of Conglitive impairment. Resident #6 was assessed in the area of tolleting. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.  A Care Plan dated 3/25/19 indicated: "Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor-document for side effects and effectiveness. An anti-anxiety medication care plan indicated-Goal-Nt risk for discomfort or adverse reactions related to anti-anxiety medications as ordered by physician.  Physician orders dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unithm (millilliters) (insulin).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	(MAR) dated March and 11th Novolin 70/units was not adminishered as orded A review of the MAR on March 21, 2019 Ladministered as orded A review of a MAR of June 20, and 21 201 was not administered 23, 2019 Lorazepam administered as orded A Nursing Progress indicated: Novolin 70 subcutaneously in the Diabetes Mellitus with awaiting pharmacy.  A Nursing Progress (12:50) indicated: "In notified 6/21: to be decontinuing to monito A Nursing Progress (19:16) medication of delivery.  During an interview of Resident #6, she star an out several times past weekend ( June insulin twice a day"	e a day.  Ition Administration Record 2019 indicated on March 6, 7 30 Suspension (70/30) 100 Indicated as ordered.  Idated March 2019 indicated Iorazepam 0.5 mg was not ered.  Idated June 2019 indicated on Idated Jun	F	755			

PRINTED: 07/12/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495347	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	450347	B. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	27/2019
	TE HEALTH CARE OF W	/INDSOR		2	3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760 SS=D	Nurse Consultant the #6 medications were stated insulin is availated have gone in the statt DON stated, staff show medication more time. Pharmacy Policy indicated processes and process	g (DON) and Regional y were asked why Resident not available. The DON able on site and staff should box and got her insulin. The uld have ordered the ly.  cated: " If any order is not communication slip rs- iffications; s; ation explaining the reason a as not delivered." If Significant Med Errors  are that its- nts are free of any significant  is not met as evidenced ew and staff interviews, the insure two of 57 residents cant medication errors.  led to ensure Resident #6 hysician's order.  led to ensure that Resident lin per physician's order.  e-admitted to the facility on		755			
		e-admitted to the facility on swhich included congestive					

NAME OF PROVIDER OR SUPPLIER		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 23322 COURTHOUSE HIGHWAY WINDSOR, VA 23487   CALL DEFICIENCY MIST BE PRÉCEDED BY FULL TAG			495347	B. WING		
CONSULATE HEALTH CARE OF WINDSOR   WINDSOR, VA 23487	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/21/2013
WINDSOR, VA 23487  (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 760 Continued From page 145 heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin. The facility staff failed to provide physician ordered insulin and anti-anxiety medications to Resident #6.  Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In the area of Medications this resident was assessed as receiving insulin injections, anti-anxiety and anti-depressant medications.  A Care Plan dated 3/25/19 indicated: Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications as ordered by doctor. Monitor- document for side effects and effectiveness. An anti-anxiety medication care plan indicated- Goal - At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions-administer Anti-Anxiety  Interventions-  Diabetes Provincer Record To the APPROPRIATE (EACH CORRECTIVE ACTOR SHOULD BE (EACH CORRECTIVE ACTOR ST				:	23352 COURTHOUSE HIGHWAY	
F 760  Continued From page 145 heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin. The facility staff failed to provide physician ordered insulin and anti-anxiety medications to Resident #6.  Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In the area of Medications, anti-anxiety and anti-depressant medications.  A Care Plan dated 3/25/19 indicated: Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no compilications related to diabetes. Interventions- Diabetes medications as ordered by doctor. Monitor-document for side effects and effectiveness. An anti-anxiety medication care plan indicated- Goal - At risk for discomfort or adverse reactions Shoul. Be CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1. Resident #6 and #32 medication orders were reviewed by DCS and MD was notified and medication supplements are available. 2. All residents have the potential to be affected. An audit was completed to ensure that current residents are receiving their medications as ordered by the physician; was completed by 7/29/19. 3. DCS or designee will educate licensed nursing staff to administer medications as ordered was completed by 08/01/19. 4. DCS or designee will audit MARS to ensure residents are receiving insulin as ordered; twice weekly for 2 weeks, weekly times 4 and monthly times 2 month. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly. Interventions- administer Anti-Anxiety	CONSULA	ATE HEALTH CARE OF V	VINDSOR	,	WINDSOR, VA 23487	
heart failure, hyperlipidemia, COPD, type two diabetes, dysphagia, depression, anxiety and long term use of insulin. The facility staff failed to provide physician ordered insulin and anti-anxiety medications to Resident #6.  Resident #6 was assessed on a Quarterly Minimum Data Set (MDS) dated June 12, 2019 as having minimum hearing difficulty and wears glasses. In the area of Cognitive Patterns this resident was assessed as having scored a 15 in the area of Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In the area of Medications this resident was assessed as receiving Insulin injections, anti-anxiety and anti-depressant medications.  A Care Plan dated 3/25/19 indicated: Focus-Resident #6 has diabetes mellitus and neuropathy. Goal-Resident will have no complications related to diabetes. Interventions-Diabetes medications are ordered by doctor. Monitor- document for side effects and effectiveness. An anti-anxiety medication care plan indicated- Goal - At risk for discomfort or adverse reactions related to anti-anxiety therapy. Interventions-administer Anti-Anxiety  The Resident #0 and ADD was notified and medication and supplements are available.  2. All residents have the potential to be affected. An audit was completed to ensure that current residents are receiving their medications as ordered by the physician; was completed by 7/29/19.  3. DCS or designee will educate licensed nursing staff to administer medications as ordered by 08/01/19.  4. DCS or designee will audit MARS to ensure residents are receiving insulin as ordered; twice weekly for 2 weeks, weekly times 4 and monthly times  2 month. The residents and supplements are available.  2. All residents have the potential to be affected. An audit was completed to ensure that current residents are receiving their medications as ordered by 7/29/19.  3. DCS or designee will audit MARS to ensure residents are receiving insulin inspections, anti-anxiety and anti-depressant medications as ordered by 08/01/19.  4. DCS or designee w	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION
medications as ordered by physician.  Physician order dated 6/10/19 indicated: Novolin 70/30 flex pen Suspension Pen-injector 100 unit/ml (milliliters) (insulin). Lorazepam tablet 0.5 mg (milligram) give one tablet by mouth twice a day.  A review of a Medication Administration Record (MAR) dated March 2019 indicated on March 6, 7 and 11th Novolin 70/30 Suspension (70/30) 100	F 760	heart failure, hyperlip diabetes, dysphagia, long term use of insul provide physician ord medications to Resident #6 was assed Minimum Data Set (Mas having minimum higlasses. In the area of resident was assessed the area of Brief Inter (BIMS) indicating no area of Medications that as receiving Insulin in anti-depressant medications related Diabetes medications Monitor- document for effectiveness. An antiplan indicated-Goal adverse reactions related Diabetes medications as order. Physician order dated 70/30 flex pen Susper unit/ml (milliliters) (instablet by mouth twice A review of a Medicat (MAR) dated March 2	idemia, COPD, type two depression, anxiety and lin. The facility staff failed to lered insulin and anti-anxiety ent #6.  lessed on a Quarterly MDS) dated June 12, 2019 learing difficulty and wears of Cognitive Patterns this ed as having scored a 15 in liview for Mental Status cognitive impairment. In the his resident was assessed lijections, anti-anxiety and cations.  25/19 indicated: less diabetes mellitus and sident will have no to diabetes. Interventions- less as ordered by doctor. In side effects and li-anxiety medication care - At risk for discomfort or lated to anti-anxiety therapy. Ister Anti-Anxiety led by physician.  d 6/10/19 indicated: Novolin linsion Pen-injector 100 linsion Pen-injector 100 linsion Administration Record line March 6, 7  littory and line was a service of the ser	F 760	orders were reviewed by DCS and was notified and medication and supplements are available.  2. All residents have the potential affected. An audit was completed ensure that current residents are retheir medications as ordered by the physician; was completed by 7/29.  3. DCS or designee will educate I nursing staff to administer medicates as ordered was completed by 08/04. DCS or designee will audit MA ensure residents are receiving insordered; twice weekly for 2 weeks weekly times 4 and monthly times 2 month. The results will be report the Quality Assurance Performance Improvement Committee (QAPI) be Executive Director monthly. for 3 months for further compliance and/or revision.	to be to receiving ne /19. ricensed rations 01/19. RS to receiving ne y the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495347	B. WING _	B. WING		C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	<u>'</u>	33/21/23 10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	Continued From pag	ue 146	F 7	60		
		dated March 2019 indicated orazepam 0.5 mg was not ered.				
	June 20, and 21 201	_				
	A Nursing Progress note dated March 6, 2019 indicated: Novolin 70/30 Flexpen 100 unit subcutaneously in the morning related to type 2 Diabetes Mellitus with Diabetic Neuropathy, awaiting pharmacy.					
	(12:50) indicated: "Ir	note dated June 21 2019 nsulin not available; pharmacy lelivered today. MD aware r."				
		note dated June 21, 2019 lid not arrive during afternoon				
	Resident #6, she staran out several times past weekend. I get	on 6/25/19 at 2:45 P.M. with sted, "My medications have s. Back in March and just this my insulin twice a day. They ave to make up my own bed sheets."				
	the Director of Nursi Nurse Consultant th #6 medications were stated insulin is avai	on 6/26/19 at 11:15 A.M. with ng (DON) and Regional ey were asked why Resident not available. The DON lable on site and staff should t box and got her insulin. The				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILES	_		(	
		495347	B. WING			06/	27/2019
	ROVIDER OR SUPPLIER	/INDSOR		2	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	received, check for a indicating: Back order Ordered-too-soon not Drug-drug interaction Formulary changes; Any other communicate medication to item was 2. Resident #32 was 01/26/2019. Resident hospital on 06/13/2015 were not limited to, Pand Type 2 Diabetes  Resident #32's Minimassessment protocol) Reference Date of 04 BIMS (Brief Interview 15 indicating no cogn On 06/25/2019 at app. Resident #32 stated, Nurses don't give me  On 06/26/2019 a review not of the Physician Order Resident #32 has an Pen-Injector 100 Unit Glargine) Inject 50 Ur morning related to Ty Unspecified Complicate 06/18/2019 with a States.	cated: "If any order is not communication slip "S- idifications; s; ation explaining the reason a as not delivered." admitted to the facility on t #32 was discharged to the 9 and readmitted to the . Diagnoses included but eripheral Vascular Disease Mellitus.  The with an Assessment /05/2019 was coded with a for Mental Status) score of itive impairment.  Droximately 5:00 p.m., "There are times that the my insulin."  The wof Resident #32's Clinical following:  Summary revealed that order for Lantus SoloStar	F	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495347	B. WING				27/2019
	ROVIDER OR SUPPLIER	VINDSOR		STREET ADDRESS, O 23352 COURTHOUS WINDSOR, VA 23			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Review of the Physici that Resident #32 had SoloStar Pen-Injector Glargine) Inject 50 un evening related to Tyl Unspecified Complica 06/18/2019 with a Star Review of the MAR of 106/21, 06/22 and 06/22 and 06/24 Review of the Physici that Resident #32 had Solution 100 Unit/ML Inject 15 unit subcutat to Type 2 Diabetes M Complications was or Start Date of 06/19/20 revealed blank space at 4 p.m., 06/22 at 8 at 4 p.m. and 06/24/20 Review of the Physici that Resident #32 had Solution 100 Unit/ML Inject as per sliding s 300 - 349 = 4 units; 3 subcutaneously befor related to Type 2 Dial Unspecified Complica 06/18/2019 with a Star Review of the MAR re 06/21 at 11 a.m., 06/2 and 06/24/2019 at 4 printerview was conductive was	ian Order Summary revealed d an order for Lantus 100 Unit/ML (Insulin hit subcutaneously in the pe 2 Diabetes Mellitus with ations was ordered on art Date of 06/19/2019. Ian Order Summary revealed is an order for Humulin R (Insulin Regular Human) ineously with meals related relitus with Unspecified redered on 06/19/2019 with a 2019. Review of the MAR is for 06/21 at 11 a.m., 06/21 a.m., 06/22 at 11 a.m., 06/22 at 11 a.m., 06/22 in order for Humulin R (Insulin Regular Human) ineously with meals related relitius with Unspecified redered on 06/19/2019 with a 2019. Review of the MAR is for 06/21 at 11 a.m., 06/22 in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in order Summary revealed d an order for Humulin R (Insulin Regular Human) in o	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		C 06/37/2040
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 760	concern of not receivid DON stated, "(Reside hospital frequently. Whe refuse his insulin?" was asked, "What are Nurses administering Insulin's?" The Direct expect the Nurses to ordered and documer insulin they should do DON was asked, "Withe MAR indicate?" Timedication was not githat she had been toled.	Ing his insulin at times. The ent name) goes out to the vas he out at the hospital, did of the Director of Nursing expour expectations of the and documenting tor of Nursing stated, "I administer insulin's as and the Interest of the Mark." The mat does a blank space on the DON stated, "That the liven." The DON also stated diff the Nurse documents that there he some of the	F 7	60	
F 761 SS=D	period of 06/21/2019 there was no evidenchis insulin or was out  On 06/27/2019 at appre-exit meeting the ANURSE Consultant was The facility did not preabout the finding.  Label/Store Drugs an CFR(s): 483.45(g)(h)(c)  §483.45(g) Labeling of Drugs and biologicals	proximately 6:15 p.m., at administrator and Registered in informed of the finding. The esent any further information discontinuous discontinuo	F 7	61	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
				_			
		495347	B. WING _			06/2	27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF V	WINDSOR			3352 COURTHOUSE HIGHWAY		
	_			W	VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					1. The medication cart on blue uni	t was	
F 761	Continued From pag	e 150	F7	761	locked and secured on 6/25/19. Th		
	§483.45(h) Storage o	of Drugs and Biologicals			expired influenza vials stored in the	als stored in the	
		-			refrigerator in the medication room		
§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					green unit were disposed of on 06/	26/19.	
		•			2. All residents have the potential	to be	
				affected. An audit was completed t	o		
	personnel to have ac	cess to the keys.			ensure all medication carts were lo	cked	
	§483.45(h)(2) The facility must provide separately				and secured on 06/25/19. An audit	was	
locked, permanently affixed compartments for				completed to ensure medications in	1		
	_	drugs listed in Schedule II of			medication refrigerators are not ex	oired on	
		Orug Abuse Prevention and and other drugs subject to			06/26/19. No other issues identified	ı.	
	abuse, except when	the facility uses single unit			3. The DCS and or designee will e	ducate	
		ution systems in which the			the License staff on ensuring medic	cations	
	be readily detected.	nimal and a missing dose can			that are expired are destroyed and	that	
	·	T is not met as evidenced			medication carts are locked and se	cured	
	by:	an ataff intension, and facility			when not supervised; was complet	ed	
		on, staff interview, and facility was determined that facility			by 07/26/19.		
	staff failed to secure	medications on one of four			4. The DON and or designee will a	udit	
		medication cart on the blue nsure one of two medication			medication storage observation twi	ce	
	I .	n expired biologicals; the			weekly for 2 weeks, weekly times 4	and	
	green unit medication				monthly times 2 month. The results		
	4 Facility staff failed	to analyze the weedingtion			reported to the Quality Assurance		
		to ensure the medication was locked when it was left			Performance Improvement Commi	ttee	
	unattended.				(QAPI) by the Executive Director m		
	O The feetile	iled to dispess of southings			for 3 months for further compliance		
	_	iled to dispose of multiple Is stored in the refrigerator in			revision	3.13,01	
		located on the Green Unit.			5. AOC date: 08/06/2019		
	The findings in the				0. 7.00 date. 00/00/2019		
	The findings include:						
	1. On 6/25/19 at 11:	20 a.m., the medication cart					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONST		(X3) DATE COMP	SURVEY PLETED
			A. BOILDI			,	С
		495347	B. WING			06/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
CONSIII	TE HEALTH CARE O	WINDSOR		23352 CC	DURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF	WINDSOR		WINDSO	DR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	The keys to the me cart. Licensed Pract the nurse's station cart. LPN #5 then with the cart unlock medication cart was approximately 14 miletary staff was observed hallway near the medication cart with was also observed hallway near the medication cart back to the medication cart back to the medication cart should be confirmed that her she had given her brought over a resibeing transferred to the medication cart stated that it should did not have acces When asked if som top of her medication them can." When residents who coull LPN #5 stated, "Yee On 6/27/19 at appring a miletary stated that it should did not have acces when asked if som top of her medication them can." When residents who coull LPN #5 stated, "Yee On 6/27/19 at appring a miletary staff."	edication cart sat on top of the walked away from the station ked and keys on the cart. The selft unattended for ninutes. During this time, oserved going by the high the meal trays. A resident ambulating up and down the edication cart. At 11:34 a.m., not Director of Nursing) locked at At 11:37 a.m., LPN #5 came attion cart.  7 a.m., an interview was N #5. When asked how the bould be left when not attended, the cart should be locked. Her keys should also be in her top of the cart. LPN #5 cart was left unlocked but that keys to a nurse who had dent's medication who was on her unit. When asked why at should be locked, LPN #5 do be locked so that residents is to medications or narcotics. The residents could reach the contact, LPN #5 stated, "Some in asked if she had a lot of do ambulate around the unit, is:"  OXIMATELY S.30 p.m., ASM from member) #1, the	F	761			
	· ·	1 #2, the DON (Director of #3, the consultant were made					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION  NG	(X3)	DATE SURVEY COMPLETED
		495347	B. WING _			C <b>06/27/2019</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	ı	06/27/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SHOOL) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	Dating of Medication Needles," document "Facility should ensure Facility staff, as define possession of the ket codes, or combination storage areas. Store locked compartment of No further information 2. On 06/26/19 at an inspection was made medication storage of Nurse #10 (LPN). The vaccines with a total date of 06/20/19 were asked would you not vaccines? She responsified out."  On 06/27/19 at approximate of Nursing concerning the vaccines. She was a stop giving residents stated that they give September to April. Sind of the expired fluton on 06/27/19 at approximate of the properties of Med Calobserved that the medication of Medication o	Storage and Expiration is, Biologicals, Syringes and is in part the following: are that only authorized ined by Facility should have eys, access cards, electronic ins which open medication all drugs and biologicals in s"  In was presented prior to exit.  In was presented provide presented prior to exit.  In was presented provide presented prior to exit.  In was presented provide presented prese	F 7	761		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	495347	B. WING _		1	C / <b>27/2019</b>	
NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF W	INDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	·		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	BE	(X5) COMPLETION DATE	
walked past the nurse surveyor and informed had been left unattend appeared unlocked. H pushed the lock inward that he would tell their unlocked. The Administ should have been done should have been locked. On 06/27/19 at approximaterview was conduct Practical Nurse) on the cart being unlocked. Subusy giving out trays to the consultant, the Direct Nurse Consultant and were debriefed on the consultant stated "I the those vaccines."  F 880 SS=D CFR(s): 483.80(a)(1)(3)  §483.80 Infection Control The facility must establing fection prevention and designed to provide a comfortable environment development and transidiseases and infection program.	AM, the facility Administrator is station, stopped by the did that the medication cart ded for a few minutes and it le went over to the cart and did to lock the cart and stated nurse that she left her cart strator was asked what he? He stated "The cart ked."  I wimately 3:16 PM an ted with LPN #2 (Licensed e Blue Unit concerning her She stated that she was to her residents.  I wimately, 4:43 PM a pre-exit ted. Present were the Nurse or Of Nursing, the Regional the Administrator. They above concerns. The nurse ought that I had discarded a Control 2)(4)(e)(f)  Introl Dilsh and maintain an and control program safe, sanitary and ent and to help prevent the smission of communicable his.		380			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			
		495347	B. WING _			06/2	27/2019
	ROVIDER OR SUPPLIER  ATE HEALTH CARE OF W	/INDSOR		23	TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY FINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable distaff, volunteers, visite providing services unarrangement based us conducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whore communicable disease reported; (iii) Standard and transto be followed to prevention (iv) When and how is communicable disease reported; (iv) When and how is communicable disease resident; including but (A) The type and durate depending upon the initial involved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstances must prohibit employed disease or infected skeep contact with residents contact will transmit the staff of the	IPCP) that must include, at ving elements:  em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards;  a standards, policies, and ogram, which must include,  ellance designed to identify ble diseases or can spread to other impossible incidents of se or infections should be insmission-based precautions tent spread of infections; polation should be used for a troot limited to: atton of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the se under which the facility ees with a communicable kin lesions from direct is or their food, if direct	F	380	1. Resident #10 wound was covered Resident did not have any adverse 2. All residents have the potential to affected. An audit was completed to ensure treatments were applied as ordered; was completed by 07/29/13. The DCS and or designee will ensure the licensed staff on ensuring treatments are completed as ordered; was comby 08/01/19.  4. The DON and or designee will as residents to ensure treatments are inplace as ordered, twice weekly for 2 weekly times 4 and monthly times 2. The results will be reported to the CAssurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for fur compliance and/or revision.  5. AOC date: 08/06/2019	reaction to be g. g. ducate ments hpleted ssess in weeks month. Quality ent	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		495347	B. WING		,	C 06/27/2019
	ROVIDER OR SUPPLIER	WINDSOR		STREET ADDRESS, CITY, STATE, ZIP CODE 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		3012112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	§483.80(a)(4) A systidentified under the force corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual re The facility will condul PCP and update the This REQUIREMENT by:  Based on observation facility staff failed to a practices, increasing illnesse and disease survey sample (Resident #10's left lownship included Resident #10's left lownship included Resident #10 was or 02/07/18. Resident #10	em for recording incidents acility's IPCP and the ken by the facility.  Idle, store, process, and is to prevent the spread of view.  Let an annual review of its ir program, as necessary.  T is not met as evidenced ons and staff interviews the follow infection control the chances of infection, for one of 57 residents in the dent #10.)  Id to cover an open wound on over extremity in a timely  Id:  Id:  Id:  Id:  Id:  Id:  Id:  Id	F 88	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING				C <b>27/2019</b>
NAME OF PROVIDER OR SUPPLIER  CONSULATE HEALTH CARE OF WINDSOR			•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY VINDSOR, VA 23487		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 880	an uncovered wound as she was sitting. The tell (Licensed Practice)  On 06/25/19 at 11:33 exposed on Resident  On 06/25/19 at 1:35 lexposed. When approse will just put a Baruntil after medication resident will remove leading to the didn't have necessive of the didn't have nece	oximately 10:30 AM, oxerved showing activity staff on her left lower extremity he staff commented, "I will all Nurse-LPN#1)."  AM the area was still the #10's left lower extremity.  PM the area was still oached, the nurse stated and-Aid on Resident's left leg pass. She also stated that ther dressing.  Eximately, 2:11 PM LPN #1 or the above resident because ssary supplies.  Eximately 2:24 PM wound an Resident's Left Lower Leg cedure tolerated well by	F	880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495347	B. WING			C 06/27/2040	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  23352 COURTHOUSE HIGHWAY  WINDSOR, VA 23487			06/27/2019	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	impairment to the ski the left lower leg. Go: minimal complication left lower extremity the Interventions Reads: physician orders.  The physician's order lower left ulcer with docalmoseptine cream mepilex. Plain foam we Extremity from toes to profore one time a dark lower leg ulcer.  On 06/26/19 at approximate a control of the uncovered area of extremity yesterday, wait as long as she down the uncovered area of extremity in the uncovered area of extremity yesterday, wait as long as she down the uncovered area of extremity in the uncovered area of extremity yesterday.  On 06/26/19 at approximate there were not treatment cart." "I every consultant, Director of Nurse Consultant and the skill of the sk	s Resident has actual no relating to venous ulcer to al: Resident will have is relating to venous ulcer of strongh the review date. Complete wound care per in summary stated to clean ermal wound cleanser, apply around wound cover with wrap (LLE) Left Lower on 1 inch below knee 3 layers are every Wednesday for inch below knee 3 layers are every Wednesday for eximately 10:19 AM an acted with LPN #1 concerning on the Resident's left lower She was asked why did she id before coverings on the estated, "It took a while no dressings on the entually covered it."	F8	80			