STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/03/20 through 03/05/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/03/20 through 03/05/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 90 certified bed facility was 87 at the time of the survey. The survey sample consisted of 26 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/14/20

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

Electronically Signed | 03/25/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to maintain the Resident dignity for 1 Resident (#7) in a survey sample of 26 Residents. The findings include: For Resident #7 the facility staff left Resident #7 dressed only in a hospital gown, no incontinence brief, no blanket or sheet and the door open and curtains open.	F 550	1. Resident # 7 was immediately checked to ensure proper attire in place to maintain dignity. Resident # 7 referred to speech therapy for chewing behaviors surrounding alternatives to chewing on clothing. 2. DON/designee will complete a review of current residents with behaviors to ensure proper recommendations are in place. 3. DON/designee will educate staff on	

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 550	Continued From page 2 Resident #7 a 79 year old man admitted to the facility on 7/28/14 with diagnoses of but not limited to diabetes, chronic kidney disease stage 2, major depressive disorder, dementia and contractures of multiple sites. Resident #7's most recent MDS (Minimum Data Set) labeled as a quarterly assessment, with an ARD (assessment reference date) of 12/9/19, coded Resident #7 as having a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. In the MDS section G - Functional Status the Resident is coded as requiring (4) Total dependence on staff with (2) one person physical assistance for bed mobility, dressing, toileting and personal hygiene. For transfers he is coded as requiring (4) Total dependence on staff with (3) Two person physical assistance as well as the use of mechanical lift. On 3/3/20 at 12:00 PM, this surveyor observed Resident # 7 in room with door open. The Resident was dressed only in a hospital gown no sheet or blanket covering him, heels up positioner in place and resident was laying on a cloth bed pad. It was visible from the hallway that the Resident did not have any incontinent brief on. Upon entering room observed the Resident chewing on his hospital gown, the left side of the gown was twisted up and wet where the Resident was chewing on it. On 3/3/20 at 12:04 PM an interview was conducted with LPN A, she stated that Resident A has "PICA." She stated that he chews on everything and that is why he is in bed with just	F 550	recognizing/reporting behaviors. DON/designee will educate staff on maintaining resident dignity. 4. DON/designee will audit behaviors for referrals weekly x4, then biweekly x4, then monthly x2, and reviewed in monthly QAPI. DON/designee will audit to ensure resident dignity maintained 10 residents per unit weekly x4, then biweekly x4, the monthly x2, and results will be reviewed in monthly QAPI x 3 months. 5. 4/14/2020.	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 550	Continued From page 3	F 550		

the gown and no brief on. She stated "He will eat the diaper if we put it on him." She further elaborated that the Resident was "care planned for it". She also stated that the Resident gets out of bed a couple of times a week. When asked if chewing on the gown was acceptable she stated that it was not and had the CNA assigned to him go and check on him.

On 3/4/20 at approximately 1:15 PM observation was made of Resident #7 lying in bed hospital gown on, no blanket or sheet covering the Resident and door open.

On 3/3/20 at approximately 2:00 PM a review of the care plan excerpts are as follows:
"FOCUS:
[Resident name redacted] has bladder incontinence r/t BPH (enlarged prostate), decreased mobility, Date initiated 11/22/18

INTERVENTIONS:
BRIEF USE: The resident uses disposable briefs. Change prn Date initiated 11/22/18"

"FOCUS:
[Resident name redacted] has behavior problem r/t depressive d/o [disorder], Dementia AEB [as evidenced by] refuses oob [out of bed] at times, refuses showers, talks to self, cursing at staff, refuses shave at times, refuses meds at times, refuses FSBS [Fasting Blood Sugar] at times, playing in BM at times, puts hands down his pants, stripping off his clothes, picking and tearing off the his brief, puts bed linens and his clothes in his mouth and refuses labs at times.

INTERVENTIONS:
"Brief off at bedtime and have absorbent pad

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 550	Continued From page 4 under him" Date initiated 12/1/19 On 3/4/20 during the end of day conference the DON was made aware of the issues and request was made for any screenings or evaluations for an alternative to chewing on clothing. The facility provided PT screening and PT notes, the Resident has no ST screening or evaluation for alternative to chewing behaviors. On 3/5/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 550		
F 558 SS=B	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to accommodate for individualized need and preference for two residents (Resident #78 and #2) in a sample size of 26 residents. This happened over multiple days. The findings included: 1. For Resident #78, the facility staff failed to provide a device so he could independently move himself up in bed.	F 558	1. Resident # 78, a new side rail assessment was completed on 3/5/20 and resident to use a less restrictive device to assist with bed mobility. Trapeze was placed. Resident #2, a new side rail assessment was completed on 3/6/20, and it was determined that side rails would assist with bed mobility and side rails were replaced. 2. DON/designee will review all side rail assessments for accuracy, and adjust accordingly.	4/14/20

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 558	Continued From page 5 Resident #78, a 69-year old male, was admitted to the facility most recently on 01/28/2020. Diagnoses included but not limited to displaced fracture of base of neck right femur, epilepsy, muscle weakness, heart failure, and end stage renal failure. Resident #78's most recent Minimum Data Set with an Assessment Reference Date of 02/21/2020 was coded as a quarterly review. The Brief Interview for Mental Status (BIMS) was coded as 14 out of possible 15 indicative of intact cognition. Functional status for bed mobility was coded as requiring limited assistance from staff meaning "resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance." On 03/03/2020 at approximately 12:00 PM, Resident #78 was observed awake lying in his bed. When asked if he had any concerns about the care he received at the facility, Resident #78 stated that he would prefer to have bed rails or something to grab on to so he could pull himself up in bed. When asked if he told staff, he stated that he told a therapist and "she said she would look into it." There were no side rails on Resident #78's bed. On 03/03/2020 at 3:30 PM, an interview with Employee E from the maintenance department was conducted. When asked about side rails on the bed, Employee E stated that "about three months ago" there was a concern about resident safety related to side rails and he was told to "remove all the side rails." Employee E then stated he also had to put most of the side rails back on due to complaints from family and residents.	F 558	3. DON/designee will re-educate licensed nursing staff regarding side rail assessments to ensure accurate completion. 4. DON/designee will audit side rail assessments for 100% of new admissions, weekly x4, biweekly x4, and monthly x2 and reviewed at monthly QAPI x 3 months. 5. 4/14/2020.	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 558	Continued From page 6	F 558		

On 03/03/2020 at approximately 4:00 PM, an interview with the administrator was conducted. When asked about the side rail policy, the administrator stated the process is to obtain a side rail assessment. The administrator also stated that if the resident was cognitively intact and "deemed to need side rails" then the resident would sign a consent and an order would be obtained to have side rails on the bed. When asked about cognition parameters, the administrator stated that residents with a BIMS of 12 or less "we question their ability to make the decision." The administrator stated residents would not get side rails "unless they were cognitively intact and have the upper body strength to use it to move themselves in bed." A copy of the side rail assessment for [Resident #78] was requested.

On 03/03/2020 at approximately 5:00 PM, an interview with certified nursing assistant A (CNA A) was conducted. CNA A verified she was familiar with the care for Resident #78. When asked about bed mobility, CNA A stated that Resident #78 needs one person assisting him when moving side-to-side in bed and he needs 2 people to move him up in bed. When asked about upper body strength, CNA A stated that Resident #78 has strength in his arms and added that he uses a slide board with transfers.

On 03/03/2020 at approximately 6:05 PM, an interview with Employee D, an occupational therapist, was conducted. When asked if Resident #78 was receiving therapy, Employee D referred to the electronic health record and stated that Resident #78 was discharged from physical therapy services on 02/26/2020 and discharged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 558	Continued From page 7	F 558		

from occupational therapy services on 02/12/2020. Employee D was asked about bed mobility and upper body strength for Resident #78 and she stated that Resident #78 was able to "roll on his side independently." When informed of Resident #78's preference for side rails to pull himself up in bed, Employee D stated that Resident #78 has the strength to do it and that he would benefit from having side rails. When asked if Resident #78 was at risk for strength decline, Employee D stated "Absolutely" and added that it is important to be independent and not rely on other people to move up in bed.

The facility staff provided a copy of Resident #78's side rail assessment on a document dated 02/17/2020 at 6:59 AM entitled, "Side Rail Evaluation." Excerpts of the complete assessment included the following sections and selections:
In Section F entitled, "Bed mobility", it was documented, "Will the bedrails(s) assist the resident in turning side to side/holding self to one side?" and "no" was selected. "Will the bed rail(s) assist the resident in moving up and down in bed?" and "no" was selected. "Will the bed rail(s) assist the resident in pulling self from laying to sitting position?" and "no" was selected. In Section J Part 1 entitled, "Recommendations", the option "Siderails not indicated" was selected.

On 03/04/2020 at 6:30 PM, the DON was informed [Resident #78] prefers side rails. The DON stated that the side rails assessment needs to be re-done and stated "I'll get him some side rails or a trapeze."

On 03/05/2020 at approximately 8:35 AM, Resident #78 was observed awake in his bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 558	Continued From page 8	F 558		

There were no side rails on the bed. When asked if the facility staff spoke to him about bed rails, Resident #78 confirmed that staff spoke with him and stated that they would be providing "something overhead."

On 03/05/2020 at 3:30 PM, the DON presented an updated side rails assessment dated 03/05/2020 at 8:00 AM entitled, "Side Rail Evaluation." Excerpts of the complete assessment included the following sections and selections: In Section F entitled, "Bed mobility", it was documented, "Will the bedrails(s) assist the resident in turning side to side/holding self to one side?" and "no" was selected. "Will the bed rail(s) assist the resident in moving up and down in bed?" and "no" was selected. "Will the bed rail(s) assist the resident in pulling self from laying to sitting position?" and "no" was selected. In Section J Part 1 entitled, "Recommendations", the option "Siderails not indicated" was selected. In Section J, part 2 entitled, "Comments", it was documented, "Discussed with resident request to have side rails, reviewed potential risks associated vs. [versus] benefits. Resident verbalizes understanding and states willing to use overhead trapeze as an alternative."

On 03/04/2020 at approximately 3:30 PM, the administrator and DON were notified of concerns and offered no further documentation or information.

2. For Resident #2 the facility staff failed the facility staff failed to provide a device so she could turn and get in and out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 558	Continued From page 9	F 558		

Resident #2 a 79 year old woman admitted to the facility on 6/27/19 with diagnoses of but not limited to metabolic encephalopathy, arthritis, dementia, hypertension, and unsteadiness on feet.

On 3/3/20 at 11:00 AM Resident # 2 was observed resting in bed eyes closed, dressed in hospital gown and had 1/4 side rail up.

On 3/3/20 at approximately 11:00 AM an interview was conducted with LPN H who stated that Resident #2 used the side rail safely to turn over in bed and to get up to a standing position and get her walker.

On 3/4/20 at approximately 8:50 AM the Resident was observed in bed resting with 1/4 side rail up.

On 3/4/20 at approximately 10:30 AM the Resident was observed awake and ready to get up. LPN C spoke to the Resident and asked her if she was ready to get up. Resident #2 was observed to safely use the side rail to turn in bed and hold on to the rail with both hands while going from sitting to standing before grabbing on to her walker.

On 3/4/20 at 11:45 AM an interview was conducted with LPN C who stated "I think all residents are dangerous with side rails. I've seen what they can do."

On 3/5/20 at approximately 2:00 PM an interview was conducted with the maintenance director who denied that the Resident had bed rails. The Maintenance director was accompanied to the unit and the LPN G stated "she doesn't have the

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 558	Continued From page 10 side rails anymore, he took them off after you came in this morning." Resident #2's chart reflected that the Responsible family member had signed the "Informed consent for use of side rails" and the physician's order dated 2/13/20 was current and active. The last two "Side Rail Evaluations that were completed 9/17/19 and 12/27/19 both have boxes checked "side rails are recommended." On 3/5/20 at approximately 3:50 PM an interview was conducted with the Administrator. The Administrator stated that the corporate office thinks they should remove side rails from Residents who have a cognitive deficit. He stated that if the Resident cannot understand and sign for themselves they cannot have a bed rail. On 3/5/20 during the end of day meeting the Administrator was made aware of the concerns but no further information was provided.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 561	Continued From page 11 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review and facility documentation review, the facility staff failed to accommodate the needs of one Resident (Resident # 46) in a survey sample of 26 Residents. The Findings Include: 1. For Resident # 46, the facility staff failed to ensure the opportunity to vote on 3/3/2020. Resident #46 was admitted to the facility in 2018 with diagnoses that included, but were not limited to: Chronic Obstructive Pulmonary Disease, Diabetes, Gastroesophageal Reflux Disease, Chronic Congestive Heart Failure, and Hypertension. Resident #46's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/21/2020. The Brief Interview for Mental Status	F 561	1. Resident #46 missed opportunity to vote on Super Tuesday. Resident was told that for the next election he will be able to vote either at the Polls or absentee ballot. 2. Current residents that want to vote were notified they would be able to vote in the next election by either absentee ballot or through an in-person polling system. 3. Activities staff will be educated by Executive Director on voting policy and process for residents. 4. ED or designee will monitor the next 3 elections and deadlines that residents are able to vote and assure Activity staff followed the Voting Policy/Process to ensure residents that want to vote are able too. Findings will be discussed during monthly QAPI X3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 12	F 561	5. 4/14/2020	

(BIMS) coded Resident #46 at 15 out of 15, indicating no cognitive impairment. Resident #46 was coded as requiring limited assistance of 1 person for transfers, bed mobility, ambulation, dressing, and hygiene, and requiring setup and assistance of one staff person for eating.

Review of the clinical record was conducted on 3/3/2020 and 3/4/2020.

Review of the record revealed documentation that Resident # 46 had contractures and difficulty walking. Resident # 46 required assistance with ambulation. Resident # 46 was unable to go to the voting precinct without assistance.

On 3/4/2020 at 11:00 AM during the Group Interview, Resident # 46 complained of not being allowed to vote on the day before for Super Tuesday. Other residents stated they did not vote either.

On 3/4/2020 at 2:15 PM, an interview was conducted with Resident # 46 who stated the facility staff did not help the residents vote on the day before (3/3/2020). Resident # 46 reported the desire to vote during all elections.

On 3/4/2020 at 3:09 PM, an interview was conducted with the Activities Director who stated she was responsible for ensuring residents who wanted to exercise their right to vote were afforded the opportunity to do so. The Activities Director stated "usually, every year, residents are afforded the opportunity to vote through absentee ballots." The Activities Director stated "this year is the first year that residents did not get a chance to vote." She stated none of the residents voted during the Super Tuesday Election on 3/3/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 13	F 561		

The Activities Director stated a representative from the Board of Elections usually comes every year but did not do so this year. The Activities Director stated the issue this year was due to reduced staffing. She stated there was no part time help to get to voting. The Activities Director stated she felt really bad about it and it would not happen again.

On 3/4/2020 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The Administrator stated the Activities Director was responsible for making sure residents could vote. The Administrator stated he would find out what happened on the day before that caused the residents not to vote.

On 3/5/2020 at 10:45 AM, copies of facility documentation were presented.
Review of the policy on Voting revealed documentation of
Policy: The Community Life Director and/or Social Services Director will provide access to the necessary material and means to vote all residents wishing to do so in local, state and federal elections.
Procedure:
1. On admission, residents' voting information will be obtained and documented in the medical record.
2. The Community Life Director and Social Services Director will review necessary tasks and assume responsibility for accomplishment of the voting process.
3. The Community Life Director and Social Services Director will establish contact with the Board of Supervisors of Elections, securing from them:
a. change of address forms,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 14	F 561		

b. dates of elections,
c. deadlines for registration,
d. absentee ballots and their required due dates,
e. any voting material available for the visually and hearing impaired, and
f. a list of polling places and times.
4. The Community Life Department and Social Services staff will inform residents of upcoming elections in the time frame necessary for them to execute their vote through:
a. daily announcements,
b. Resident Council,
c. posters,
d. the center newsletter,
e. current events discussions, and
f. one-to-one visits.
5. Community Life Department and Social Services staff will supply residents wishing to vote with the material and means necessary to cast and deliver their ballot to the Board of Elections in the appropriate time frame.
6. Community Life Department and Social Services staff may arrange for voting assistance in any necessary capacity with nonpartisan volunteer services.
7. Community Life Department and Social Services will assist Resident Council with any voting necessary."

Copies of a Certified Mail receipt to the Secretary of the Electoral Board and emails to and from the Administrator and the Activities Director were presented. Review revealed the Certified Mail receipt was dated November 4, 2019 and the emails regarding voting were from April 2018.

On 3/5/2020 during the end of day debriefing, the facility Administrator and Director of Nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 561	Continued From page 15 informed again of the findings. The Administrator stated facility staff should help to ensure that all residents who want to vote have the opportunity to vote. No further information was provided.	F 561		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 16 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, the facility staff failed to ensure a clean comfortable home environment for two residents (Residents # 65 and # 46) in a survey sample of 26 residents. This happened over multiple days. The Findings Include: 1. For Resident # 65, the facility staff failed to fix a hole in the wall behind the door across from the bed. During the initial tour on 3/3/2020, a large hole was observed behind the door to the room where Resident # 65 resided. The hole measured approximately 8 inches wide and 3 inches tall. On 3/4/2020 at 10:30 AM, an interview was conducted with Resident # 65 who stated she didn't like seeing the hole behind the door. Resident # 65 stated she complained about it a few weeks before but the Maintenance Director "works on his own schedule." Resident # 65 stated there had been a hole in the wall behind her bed that was not fixed for several weeks. Resident # 65 stated the hole behind the bed was even more upsetting than the hole behind the	F 584	1. Resident #65 and #46 holes in walls were fixed on 3/06/2020 2. Resident rooms were audited for holes or maintenance needs on 3/25/20. Follow up based on findings. 3. Maintenance Director was educated by Executive Director on maintenance repairs being performed in a timely manner. 4. Executive Director or designee will perform round rooms in the facility daily for 4 weeks then weekly for 4 weeks and 1X a month for 3 months to monitor for repairs needed in resident rooms. Findings will be discussed during monthly QAPI X3 months 5. 4/14/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17	F 584		

door. Resident # 65 stated the hole behind the door was obvious when the door was half open or closed.

2. For Resident # 46, the facility staff failed to fix a large hole in the wall behind the door.

Resident #46 was admitted to the facility in 2018 with diagnoses that included, but were not limited to: Chronic Obstructive Pulmonary Disease, Diabetes, Gastroesophageal Reflux Disease, Chronic Congestive Heart Failure, and Hypertension.

Resident #46's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/21/2020. The Brief Interview for Mental Status (BIMS) coded Resident #46 at 15 out of 15, indicating no cognitive impairment. Resident #46 was coded as requiring limited assistance of 1 person for transfers, bed mobility, ambulation, dressing, and hygiene, and requiring setup and assistance of one staff person for eating.

On 3/3/2020 at 12:34 PM during the initial tour of the facility, a large hole was observed behind the door of the room where Resident # 46 resided. The hole was large and gaping. Resident # 46 was not in the room during the initial observation.

On 3/4/2020 at 11:15 AM during another observation, Resident # 46 was observed sitting in a wheelchair in the room. When asked if there were any problems with the room, Resident # 46 pointed and stated there was a hole in the wall behind the door to the room. Resident # 46 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18	F 584		

"I don't like it". Resident # 46 stated the facility staff was aware of the hole in the wall but it had not been fixed yet.

On 3/4/2020 at 2:30 PM, an interview was conducted with the Maintenance Director who stated he was aware that there were holes in some of the walls "generally behind the doors" but he was a "one man show." The Maintenance Director stated he was the only person working in the Maintenance department at the time of survey and had to prioritize the projects that needed to be repaired. The Maintenance Director stated his first priority was for the safety of the residents in the facility. He stated the facility Administrator had been trying to hire someone for the last year and a half to help to stay on top of all of the repairs needed for the walls. The Maintenance Director stated a temporary person was hired a few weeks prior that helped to patch and paint holes on some of the units. The Maintenance Director stated that the rooms on the skilled care unit were easier to keep control of because the rooms would be empty at times. He stated the long term care unit was harder to keep a handle of repairs. The Maintenance Director stated that sometimes as fast as repairs were completed, another hole was in that same area in a short period of time. He stated it was constant work needed to stay on top of the problem.

On 3/4/2020 during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. The Administrator stated "within a week, facility repairs should be completed. We have a part time position available at this time. The Administrator stated "one month prior, the facility had a temporary part time employee who "was hired to patch and paint"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 584	Continued From page 19 the holes in the walls. No further information was provided.	F 584		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide respiratory care according to the professional standards of care for two Residents (Residents # 44 and # 46) in a survey sample of 26 residents. The findings include: 1. For Resident # 44, the facility staff failed to administer oxygen at the rate as ordered by the physician. During the initial tour of the facility on 3/3/2020 at 12:26 PM, Resident # 44 was observed sitting up in bed with oxygen infusing at 1.5 liters per minute via nasal cannula. ON 3/3/2020 at 12:51 PM, after concluding the initial tour, the surveyor went to the nurses station to ask for assistance in Resident # 44's room. An interview was conducted with LPN (Licensed	F 695	1. Resident #44, 02 rate was immediately verified, and increased to 2L/NC. Resident # 46, nebulizer, mask, and humidifier bottle for 02 was immediately replaced and mask placed into plastic bag. 2. Flow rate on residents receiving 02 was checked and verified to ensure rates were correct on 3/3/20-3/4/20. Current residents with nebulizer treatments were audited to ensure they were properly stored in bags on 3/3/20. Current residents with humidifier bottles were checked on 3/3/20 to ensure they have been changed in the last 7 days. 3. DON/designee will educate licensed nursing staff on procedure of changing 02 tubing and humidifier bottles per policy and procedure. DON/designee will	4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 695	Continued From page 20 Practical Nurse) A who stated she was not assigned to work with Resident # 44 but could help. LPN A went to Resident # 44's room with the surveyor, looked at the oxygen concentrator and stated the oxygen was infusing at 1.5 liters per minute. When asked how much oxygen was ordered by the physician, LPN A stated she would check the physicians orders and come back to inform the surveyor. LPN A stated Resident # 44 had an order for oxygen as needed and that she did not receive it often. On 3/3/2020 at 12:57 PM, LPN A reported that the Physicians order was for 2 liters per minute. LPN A stated she was going to change the oxygen immediately to the correct dosage. Review of the clinical record was conducted on 3/3/2020. Review of the Physicians Orders revealed an order for Oxygen As Needed PRN 2L (2 liters) via NC (nasal cannula) every 8 hours as needed for Shortness of Breath Order status: Active, Order date 9/2/2019, Review of the Care plan revealed Focus: _____(Resident # 1) has oxygen therapy related to Respiratory failure, Congestive Heart Failure, AEB (as evidenced by) Shortness of breath at times Date initiated: 1/16/2020 Goal: The resident will have no s/sx [signs or symptoms] of poor oxygen absorption Dated initiated: 1/16/2020, Revision on 1/29/2020 Interventions included:	F 695	educate licensed nursing staff on procedure to store all nebulizer masks or treatment apparatus in plastic bags. DON/designee will re-educate licensed nursing staff to ensure 02 flow rate is set as ordered. 4. DON/designee will audit 10% of residents per unit weekly x4, biweekly x4, and monthly x2 for 02 flow rate, proper storage of nebulizer treatment apparatus, and timely changing of 02 tubing and humidifier bottles. Results will be reviewed at monthly QAPI x 3 months. 5. 4/14/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 21	F 695		

Check pulse ox every shift as ordered Dated initiated: 1/16/2020, Revision on 1/29/2020
Oxygen Settings: O2 (oxygen) via NC (nasal cannula) 2L/min PRN (as needed) for SOB (shortness of breath)

Another Focus Area:
_____(Resident # 1) has altered respiratory status/difficulty breathing related to Asthma, Respiratory failure, Congestive Heart Failure Shortness of Breath

Goal: The resident will have minimal risk of complications related to Shortness of Breath through the review date
Dated initiated: 1/16/2020, Revision 1/24/2020

Interventions included: Oxygen Settings: O2 (oxygen) via NC (nasal cannula) 2L/min PRN (as needed) for SOB (shortness of breath)

On 3/3/2020 during the end of day debriefing, the Administrator and Director of Nursing were informed of the observation of oxygen being administered at the wrong dosage during the initial tour. The Director of Nursing stated the nurses should follow Physicians Orders and administer oxygen at 2 Liters per minute as needed as ordered.

At the time of exit, a copy of the facility policy on Respiratory Therapy had not been presented.

No further information was provided.

2 . Resident #46, facility staff failed to store a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 22	F 695		

nebulizer mask in a sanitary manner according to professional standards of practice and failed to change the sterile water on the oxygen concentrator every 7 days. During the initial tour of the facility on 3/3/2020, Resident #46's mask attachment for the nebulizer was observed, uncovered sitting on Resident #46's night stand and the sterile water bottle for humidification on the oxygen concentrator was dated 2/24/2020.

Resident #46 was admitted to the facility in 2018 with diagnoses that included, but were not limited to: Chronic Obstructive Pulmonary Disease, Diabetes, Gastroesophageal Reflux Disease, Chronic Congestive Heart Failure, and Hypertension.

Resident #46's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/21/2020. The Brief Interview for Mental Status (BIMS) coded Resident #46 at 15 out of 15, indicating no cognitive impairment. Resident #46 was coded as requiring limited assistance of 1 person for transfers, bed mobility, ambulation, dressing, and hygiene, and requiring setup and assistance of one staff person for eating.

Review of the clinical record was conducted on 3/3/2020 and 3/4/2020.

Resident #46's room was observed during initial tour of the facility on 3/3/2020 at 12:34 p.m. At that time, it was noted that Resident # 46 had a Nebulizer on the nightstand by the bed. The mask attachment for the nebulizer was observed sitting, uncovered, on Resident # 46's nightstand. The mask and tubing were dated 3/1/2020. There was an oxygen concentrator next to the bed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 23	F 695		

a sterile water bottle for humidification attached. The label on sterile water bottle was dated 2/24/2020. There was nasal cannula tubing attached to the sterile water bottle and dated 3/1/2020.

On 3/3/2020 at 12:52 p.m., an interview was conducted with Licensed Practical Nurse (LPN) A regarding nebulizer treatments. LPN A stated that nebulizer equipment should always be kept in a bag when not in use. LPN A also stated all respiratory equipment, such as nebulizer masks and oxygen tubing, were supposed to be changed weekly by the night shift. LPN A stated she was unsure of which night the respiratory equipment was changed but knew the night shift should do it weekly, at least every 7 days. LPN A stated that sometime the nursing staff had to change the respiratory equipment more often if there were problems with infection control such as the equipment was on the floor or uncovered. LPN A stated she would tell the nurse working with Resident # 46 about the issues with the respiratory equipment.

On 3/3/2020 at 2:30 p.m., an interview was conducted with LPN B who stated the equipment had been changed, dated and covered in plastic bags. LPN B stated respiratory equipment should be changed weekly and that nebulizer masks should be kept covered when not in use.

The next day, on 3/4/2020, it was noted that the nebulizer tubing and mask had been replaced, and were in a Ziploc bag dated 3/4/2020. The sterile water bottle and tubing were dated 3/3/2020.

Review of the Physicians Orders revealed orders:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 24 Oxygen Settings: O2 (oxygen) PRN (as needed) for SOB (shortness of breath) 2L/min (2 Liters per minute) via NC (nasal cannula) to keep oxygen above 92% Order Date 1/4/2017 Change nebulizer mask and O2 tubing every Saturday every night shift every Saturday for Hygine [sic] Order Date 3/30/2017 On 3/4/2020 during the end of day debriefing, the facility administrator and Director of Nursing were informed of the findings of the opened sterile water container attached to the oxygen concentrator and dated 2/24/2020 and the uncovered nebulizer mask sitting on the nightstand. The Director of Nursing stated the respiratory equipment should be changed every 7 days and the nebulizer mask should be covered when not in use. Copies of the care plan, Physicians Orders and facility policy on Respiratory Therapy were requested. The next day, 3/4/2020, it was noted that the sterile water bottle and tubing were dated 3/3/2020. The nebulizer mask was in a bag and dated 3/3/2020. Review of the Physicians Orders revealed orders: Oxygen Settings: O2 (oxygen) PRN (as needed) for SOB (shortness of breath) 2L/min (2 Liters per minute) via NC (nasal cannula) to keep oxygen above 92% Order Date 1/4/2017 Change nebulizer mask and O2 tubing every Saturday every night shift every Saturday for Hygine [sic] Order Date 3/30/2017"	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 25 The Administrator and Director of Nursing again were informed of the findings at the end of day meeting on 03/04/2020. The Director of Nursing stated the opened bottle of sterile water should have been changed at least every 7 days and that the of 2/24/2020 was more than 7 days when observed on tour on 3/3/2020. The Director of Nursing also stated the nebulizer mask should be covered when not in use. At the time of exit, a copy of the facility policy on Respiratory Therapy had not been presented. No further documentation was provided.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 758	Continued From page 26 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation and clinical record reviews the facility staff failed to ensure Residents were free from unnecessary psychotropic medications for 1 Resident (#5) in a survey sample of 26 Residents. There findings include: For Resident #5 the facility staff failed to address the Pharmacy recommended Gradual Dose	F 758	1. Resident #5 pharmacy recommendation was immediately given to the Nurse Practitioner to be addressed. 2. DON/designee will review current residents for documented GDR or documentation stating no GDR recommended. 3. Regional Director of Clinical Services	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 758	Continued From page 27 Reduction (GDR). Resident #5 a 75 year old woman admitted to the facility on 12/5/15 with diagnoses of but not limited to chronic kidney disease stage III, generalized anxiety disorder, bipolar disorder, major depressive disorder, diabetes and dementia. Resident #5's last MDS (minimum data set) with an ARD (assessment reference date) of 12/9/19, a quarterly assessment coded the Resident as having a BIMS (brief interview of mental status) score of 13 indicating mild cognitive impairment. On 3/5/19 the Aspen program selected this Resident as an unnecessary medication review. Upon review of the clinical record it was discovered that on 11/11/19 the pharmacy recommendation read: "Comment: Forward to psych if appropriate. [Resident #5] receives two or more anxiolytic medications concomitantly Lorazepam and Buspirone Hydrochloride, Last psych note suggests that Ativan [Lorazepam] undergo a GDR once Buspar [Buspirone Hydrochloride] has stabilized her anxiety. Recommendation: Please reduce lorazepam with the end goal of discontinuation while concurrently monitoring for reemergence of target behaviors and or withdrawal symptoms. Rationale for recommendation: Duplicate anxiolytic therapy can have additive central nervous system effects and complicates the regimen." "[signature of pharmacist redacted] the date signed was 11/11/19"	F 758	will educate DON on process of pharmacy recommendations to ensure all pharmacy recommendations are addressed timely. DON/designee will educate licensed nursing staff on process of gradual dose reductions. 4. DON/designee will audit residents on psychotropic medication for last GDR monthly x4. DON/designee will audit all pharmacy recommendations for timely review monthly x4. Results will be reviewed at monthly QAPI x 3 months. 5. 4/14/2020.	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 758	Continued From page 28 (The MD signature was left blank) On 2/21/20 the pharmacy recommendation read: "REPEATED RECOMMENDATION FROM 11/11/19- Please respond promptly to assure facility compliance with Federal regulations. Comment: Forward to psych if appropriate. [Resident #5 name redacted] receives two or more anxiolytic medications concomitantly Lorazepam and Buspirone Hydrochloride, Last psych note suggests that Ativan [Lorazepam] undergo a GDR once Buspar [Buspirone Hydrochloride] has stabilized her anxiety. Recommendation: Please reduce lorazepam with the end goal of discontinuation while concurrently monitoring for reemergence of target behaviors and or withdrawal symptoms. Rationale for recommendation: Duplicate anxiolytic therapy can have additive central nervous system effects and complicates the regimen." "[signature of pharmacist redacted] the date signed was 02/21/20" (The MD signature was left blank) On 3/5/20 at approximately 3:30 PM an interview was conducted with the DON who submitted a psych note from 1/9/20 which did not address a GDR. On 3/5/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770		4/14/20

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 770	Continued From page 29 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation and clinical record review and in the course of an investigation the facility staff failed to provide laboratory services that were timely for one (resident #133) of 26 sampled residents. The findings included: For Resident #133 the facility staff failed to obtain STAT bloodwork as ordered. Resident # 133 an 82 year old woman admitted to the facility on 11/21/19 with diagnoses of but not limited to acute and chronic respiratory failure, chronic renal failure Stage 3, pain in legs, unsteady on feet, hypertension, Alzheimer's dementia, COPD (Chronic Obstructive Pulmonary Disease) and a history of falls with hip fracture. The Resident's code status was DNR. Resident #133's most recent MDS with an ARD (Assessment Reference Date) of 11/21/19 coded Resident #133 as having a BIMS (Brief Interview of Mental Status) score of 3 indicating severe cognitive impairment. On 3/4/20 at approximately 3:00 PM a review of	F 770	1. Resident #133 has been discharged from the facility. 2. DON/designee will audit current stat lab orders since 3/1/20 for documentation of timely collection. Findings will be followed up as needed. 3. DON/designee will educate licensed nursing staff on procedure for obtaining stat labs. 4. DON/designee will audit current stat labs weekly x4, biweekly x4, and monthly x2 to ensure timely collection. Results will be reviewed at monthly QAPI x 3 months. 5. 4/14/2020.	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 770	Continued From page 30	F 770		

the clinical record was conducted and it was discovered that Resident #133 had been hospitalized for a repair of a fractured hip.

The progress notes revealed the Resident was admitted with blood pressures that fluctuated between 117/66 on 11/21/19 to 143/82 on 11/26/19. It continued to steadily rise until on 11/29/19 her blood pressure was 165/68 at 2:45 PM. At this time LPN G entered the following note:

"Resident arouse [sic] when staff call her name or touch to arouse resident offered meds refuse [sic] to wake up and take meds appeared very tired and noted leaning to the left side, NP [name redacted] in facility made aware that resident was in bed and in w/c [wheel chair] with eyes closed throughout the day and refuse to eat during meals, received verbal order to D/C Ativan."

At 11:06 AM on 11/30/19 LPN D entered a note in the chart stating that "New orders noted for Stat Blood work, CBC, CMP, ProBNP [ProBNP is a cardiac biomarker test to detect heart stress and damage] Clysis D 5 1/2 NS [Clysis is fluids administered subcutaneously] at 60 cc/hr."

At 8:36 PM LPN D entered a note that "Lab results in awaiting on the on-call."

A review of the progress notes revealed no notes reflecting what time the lab was drawn and or sent out to the lab.

Lab report reveals "Collection Date & Time: 11/30/19 at 4:15 PM."

On 3/5/19 in an interview with the DON she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 770	Continued From page 31 asked what her definition of STAT was and she stated "within an hour." When asked then the order to obtain labs STAT should have been completed by 12:06 PM on 11/30/19 she answered yes. On 3/5/20 during the end of day meeting the Administrator was made aware of the concerns no further information was provided.	F 770		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide food prepared to conserve appearance for one resident (Resident #69) in a sample size of 26 residents. The findings included: For Resident #69, the facility staff failed to provide grits at his preferred consistency on 3/05/2020. Resident #69, a 53-year old male, was admitted to the facility on 09/24/2016. Diagnoses included	F 804	1. Resident 69 receiving grits at desired consistency. Dietary Staff Employees I and H provided 1:1 education on preparation of grits. 2. Residents that eat grits were asked about their preference on 3/23/2020 and preferences updated. 3. Dietary Cooks educated by Dietary Manager on reading recipes, following recipes and correct if needed to serve food/grits at proper consistency. 4. Dietary Manager or designee will	4/14/20

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 804	Continued From page 32 but not limited to paraplegia, chronic kidney disease, major depressive disorder, and generalized anxiety disorder. Resident #69's most recent Minimum Data Set with an Assessment Reference date of 02/17/2020 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for eating was coded as requiring supervision - oversight, encouragement, or cueing from staff. On 03/05/2020 at approximately 8:45 AM, Resident #69 was observed awake in bed. The breakfast tray was on the tray table within reach of Resident #69. Resident #69 lifted the lid off his breakfast meal to show that he poured his grits out from the bowl to the plate to demonstrate how watery the grits were. Resident #69 stated, "I can't eat this." Resident #69 also stated he prefers grits to be a thicker consistency than what was served. Resident #69 also stated that he feels upset and disrespected and he feels like the staff doesn't care about him due to the quality of food that is served; namely, how the grits were served this day. Resident #69 also stated that he has told the staff about this before but it doesn't make a difference. On 03/05/2020 at 9:55 AM, an interview with Licensed Practical Nurse E (LPN E) caring for Resident #69 was conducted. When asked about Resident #69's grits, she stated she saw they were watery this morning. When asked if they appeared palatable, LPN E stated "Yes, some people like them watery." When asked if [Resident #69] preferred them watery, she stated, "No, he likes them thicker."	F 804	monitor grits daily when served for 6 weeks to ensure proper consistency of grits are served to residents and ensure cook corrected consistency prior to serving to residents. Findings will be discussed monthly in QAPI x 3 months. 5. 4/14/2020	

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F 804	Continued From page 33	F 804		

A copy for the recipe for grits used by the dietary cook was requested and the facility provided a document entitled, "Cereal, Hot (Oatmeal, Grits)." The following headers and options were documented:
Portion size: 6 oz/ld [ounce/ladle]
Servings: 1
Ingredient: water
Amount: 1-1/4
unit: cup

Ingredient: cereal, grits
Amount: ½
unit: srv [serving]

Under the header "Procedures", it was documented, "Prepare hot cereals according to separate recipes [sic] instructions." Under the header, "Notes", Part 2, it was documented, "Note: Liquid and thickener measurements are approximate and slightly more or less may be required to achieve desired pureed consistency."

On 03/05/2020 at 1:50 PM, an interview with Employee I from dietary and Employee H, the dietary cook, was conducted. When asked about the recipe for grits provided by the facility, Employee I stated that is just for one serving. Employee I provided a copy of their document entitled, "Production Counts." Employee I stated this informs the cook how many servings of grits need to be made on any given day. Employee I stated that for this day, the cook needed to make 70 servings of grits. When Employee H was asked about her process for preparing grits, Employee H stated she fills the long steam table pan about "1/4 the way up the pan" with water and then adds the entire 5-pound bag of grits to

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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F 804	Continued From page 34 it. Employee H stated she will then add butter and add water or grits to make the consistency "not too loose, not too thick." When asked about the ratio of water to grits, she stated she did not measure it. Employee I provided a bag of grits used by the facility and the instructions on the side of the bag to make one serving was ¼ cup of grits in 1 cup water. When asked if everyone is served grits the same consistency, she stated, "yes." When asked if a resident had a preference for different consistency, Employee I stated that residents' preferences are on their food preference assessment. A copy of the food preference assessment for Resident #69 was requested and the facility staff provided a document entitled, "Diet History and Food Preference." Resident #69's preference for consistency of grits was not addressed on the assessment. A physician's order dated 02/20/2020 documented, "Regular diet, Regular texture, Regular/thin liquids consistency." In summary, Resident #69's grits were not prepared according to his personal preference. There was conflicting information with the recipe for grits provided by the facility and the recipe on the grits bag. Also, the cook did not prepare grits according to either recipe ratio and did not measure ingredients. On 03/05/2020 at approximately 3:30 PM, the administrator and DON were informed of findings and they offered no further information or documentation.	F 804		
F 880	Infection Prevention & Control	F 880		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 880 SS=D	Continued From page 35 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 880	Continued From page 36 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement an effective infection control & isolation program concerning handwashing during medication pour and pass, and for 3 specific Residents (Residents #284, 70, and #72) in a survey sample of 26 residents. The findings included:	F 880	1. Resident #284. Employee F was immediately reeducated on infection control and proper cleaning procedures. Employee RN A was provided 1:1 education on immediate peer redirection if improper cleaning/disinfecting is observed. Resident #70 need for isolation was immediately reviewed with provider and the provider discontinued the isolation due to resident having formed stool.	

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	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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

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F 880	Continued From page 37 1. For Resident #284, contact isolation precautions were not maintained for a Resident with a communicable infection. On 3-4-2020 at 10:00 a.m., surveyors observed the following incident; An isolation cart was in the hallway by the door of Resident #284. The cart held personal protective equipment (PPE) to be worn by staff entering the room because of a communicable infection in the room. The cart included gloves, gowns, and biohazardous waste red trash bags in a clear rolling cart with 3 drawers. There was a sign which read see nurse before entering. The Registered charge nurse (RN-A) was in the hallway, as was the Activities Director (Employee F), and the physical therapy (PTA) assistant. The PTA was donning a yellow gown, and gloves, and entered the room, leaving the door open. The PTA went over to the Resident who was laying in bed and introduced herself and told her she was going to get the Resident's picture for her clinical record. The PTA touched the Resident, the Resident's bed, and the over bed table, while helping the Resident to sit up. The PTA then returned to the door where employee F was standing. Employee F handed the PTA a tablet type electronic device measuring approximately 8 inches by 11 inches, and the PTA carried it into the room wearing the same gloves and took a picture of the resident using the tablet. The PTA then returned the device to employee F, into her bare hands. At that time employee F and RN A were asked if they noticed a problem with the interaction which	F 880	Resident #7, LPN D was immediately provided 1:1 education on hand hygiene and infection control. 2. DON/designee will audit nursing staff for proper hand hygiene and infection control during medication administration. Current residents on isolation were assessed to ensure proper precautions/ signage in place for infection control. Findings will be followed up. 3. DON/designee will reeducate staff on proper isolation technique to include cleaning of devices and equipment entering and leaving isolation rooms. Staff will be reeducated to peer check immediately if seeing improper infection control practices, and on proper hand hygiene. 4. DON/designee will observe/audit infection control practice and hand washing with 10 employees weekly x4, biweekly x4, and then monthly x2. DON/Designee will observe/audit staff entering and exiting isolation rooms to ensure proper infection control practices are followed weekly x4, biweekly x4, and then monthly x2. DON/designee will observe 3 medication passes weekly x 4 weeks biweekly x4, and then monthly x2 to ensure infection control maintained. Results will be reviewed at monthly QAPI x 3 months. 5. 4/14/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 880	Continued From page 38	F 880		

had just taken place. RN-A stated yes, that the tablet needed to be cleaned, and Employee F stated "no problem" and proceeded to the medication administration cart at the end of the hallway which was being used by another nurse to administer medications.

The medication nurse was in another resident's room administering medications, and was unaware of the infection control breach. Employee F laid the tablet on top of the cart and pulled an alcohol pledget (normally used to clean skin prior to an injection) out of a bulk box of many individually wrapped pledgets with her bare hands. She opened the individually wrapped 2 inch by 2 inch square gauze pledget impregnated with alcohol, and began to rapidly wipe the tablet in a haphazard manner, for approximately 5 seconds.

Employee F never applied gloves, and then proceeded back out of the nursing unit with the tablet in her bare hands, which had not been properly disinfected, and never washed her hands. RN-A did not try to stop employee F, and at that point it is unknown where the tablet or Employee F went, and what she touched.

RN-A was asked what kind of isolation Resident #284 required, and she stated "Contact precautions for C-Diff". RN-A stated the she was herself a "labor pool employee, and only here when needed." RN-A stated she would follow employee F and have her wash her hands, and clean the tablet with the correct disinfecting agent.

On 3-4-2020, the clinical records were reviewed for Resident #284. The Resident had been

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F 880	Continued From page 39	F 880		

admitted the day before, on 3-3-2020, after a hospitalization. Diagnoses included; sepsis from urinary tract infection, multiple myeloma, gastrointestinal bleeding, and Clostridium Difficile infection diagnosed (2-28-2020), and contracted while in the hospital 4 days before admission to the skilled nursing facility. The Resident was currently receiving Vancomycin antibiotic administration for the Clostridium Difficile in the skilled nursing facility.

Resident #284's most recent admission assessment, and baseline care plan were reviewed, and revealed that the Resident was completely dependant on staff for all activities of daily living. The Resident was on 3 liters of oxygen via a nasal cannula continuously and was generally weak, and unable to move her extremities. Resident #284 was documented as having no memory deficits and was able to make all daily life decisions.

On 3-4-2020 at 5:00 p.m., at the end of day debrief, the Administrator and the DON (director of nursing) were notified of above findings. The DON stated, "they (staff) told me." The DON stated the CDC (Centers for Disease Control) as their professional standard resource for all isolation and infection control needs.

On 3-5-2020 at 5:00 p.m., at the end of day debrief, the Administrator and the DON supplied the guidance used in the facility for infection control, and isolation requirements sent from their Medical Director. The title was "Healthcare Associated Infections." "Strategies to Prevent Clostridioides Difficile (CDI) infection in Acute Care Facilities." The reference document was from the CDC. The reference document revealed

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F 880	Continued From page 40	F 880		

at item #3 heading; "Perform Environmental Cleaning to Prevent CDI." Under the heading it read; "Perform daily cleaning of CDI patient rooms using a C. Difficile sporicidal agent (EPA list K agent)." The document goes on to say that the patient care environment, high touch surfaces, and all shared equipment must be disinfected using the EPA list K agent sporicidal prior to use with another patient.

2. For Resident #70, contact isolation precautions were not maintained for a Resident with a communicable infection.

Resident #70 was admitted on 12-5-2019. The Resident had a current diagnosis of recurrent Clostridium Difficile (C-dif). The Resident was able to use a walker and wheel chair for ambulation.

The clinical record was reviewed to include physician's orders. The review revealed that the Resident was currently receiving Vancomycin antibiotic for recurrent C-dif.

The Resident's room was visited from the hallway on 3-5-2020 at 11:00 a.m., by surveyors and found to have the door open with the Resident laying on top of the bed reading. There was no infection control cart outside of the door, and no signage to indicate there was an infection in the room.

LPN-E (licensed practical nurse) was approached at the nursing station and asked if Resident #70 had any kind of isolation precautions. She stated

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F 880	Continued From page 41 yes, she was on contact precautions for C-diff. LPN-E was asked why there was no PPE (personal protective equipment) such as gowns, gloves and biohazard trash bags at the room. She stated "It should be, someone may be refilling it, I will get a cart down there immediately. On 3-5-2020 at 5:00 p.m., the Administrator and DON were made aware of the findings. They stated no further information was available. 3. For Resident #7, the facility staff failed to administer medications in a manner to prevent the spread of infection. The facility staff did not exercise proper handwashing technique. Resident #7 was a 79 year old. Resident #7's diagnoses included Chronic Kidney Disease, Diabetes Mellitus-Type 2, Hypertension, and Heart Failure. On 3/5/20 at 5:00 P.M., an observation was conducted of medication administration as Licensed Practical Nurse D was administering medications to Resident #7. LPN D poured the following medications into a cup: Aspirin 81 MG-1 tab., Lasix 40 MG-1 tab, and Potassium 20 MG-1 tab. LPN D then stated that she didn't have enough water in her pitcher to administer the medications. She then went into the medication room, touched the door with her bare right hand both when entering and then leaving the room. She also touched the faucet with her bare right hand when turning the water	F 880		

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F 880	Continued From page 42	F 880		

on, and then off after filling the pitcher. LPN D then returned to the medication cart and used her bare right hand to pick up a drinking cup, and filled it with water. Her fingers were near the top rim of the cup. She then entered Resident # 7's room, and sat the cup of water, along with the cup of medications down on the bedside table.

LPN D then went to the sink and washed her hands for only 7 seconds before rinsing them. She then administered Resident #7's medications using the contaminated cup of water.

When asked to describe the appropriate handwashing technique, LPN stated that she didn't know how long she should have washed her hands, but stated that she'd appreciate learning the information.

On 3/5/20 a review was conducted of facility documentation, revealing a Handwashing policy dated 11/30/14. An excerpt read, "An essential component of infection control is hand washing." The policy did not state the amount of time hands should be washed before rinsing.

Handwashing guidance is provided at CDC.gov/handwashing:

"Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
Scrub your hands for at least 20 seconds.
Rinse your hands well under clean, running water.
Dry your hands using a clean towel or air dry them."

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F 880	Continued From page 43 On 5/5/20 at approximately 4:00 P.M., the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 880		