	-	ID HUMAN SERVICES			FOR	M APPROVED
		MEDICAID SERVICES	1		OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		E SURVEY PLETED
		495347	B. WING		03	/26/2021
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	INDSOR		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
	survey was conducted 03/26/21. No correction	ness compliance with 42				
F 000		4 bed facility was 102 at the le survey sample consisted	F 000			
	survey was conducted Corrections are required CFR Part 483 Federa requirements. The Li	fe Safety Code w. No complaints were				
F 550 SS=D	102 at the time of the consisted of 35 curren closed record reviews	cise of Rights	F 550			5/7/21
	self-determination, an access to persons an	ght to a dignified existence, ad communication with and				
	§483.10(a)(1) A facilit with respect and dign	ry must treat each resident ity and care for each				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	_	TITLE		(X6) DATE
Electroni	cally Signed					04/12/2021

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 3352 COURTHOUSE HIGHWAY	<u> </u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	resident in a manner promotes maintenance her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The facil access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facili rights and to be supple exercise of his or her subpart. This REQUIREMENT by: Based on observatio staff interview, and fa facility staff failed to p for 1 Resident (Resid the survey sample.	and in an environment that be or enhancement of his or ognizing each resident's ity must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen	F	550	1. The facility staff failed to provide dignity and respect for one resident du wound care, by writing on the resident wound dressing after applying it to the residents' right upper buttock. Residen #47 not affected. ADON in-serviced o providing dignity during wound care or	s it n	

Facility ID: 0296

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/09/2021 RM APPROVED IO. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495347	B. WING		03/26/2021		
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	LATE HEALTH CARE OF WINDSOR			23	352 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	a 2	F 5	50			
	dignity and respect d		13	.50	3/26/2021.		
	upper buttock. The findings included Resident #47 was ad on 01/22/21. Diagnot to Pressure Ulcer of F 3 and Muscle Weakn The current Minimum Admission Assessme Reference Date (ARE resident with a 5 of a the Brief Interview for indicated Resident #4 daily decision making addition, the Minimum #47 as requiring exte persons for bed mobi one person for dressi Requires total depend assistance of one per of one person for toile Conditions, M0300 of resident was admitted ulcer. On 3/24/21 at 1:30 Pl the ADON (Assistant Administrative Staff) s	mitted to the nursing facility sis included but not limited Right Upper Buttock, Stage esses. • Data Set (MDS) an ent MDS with an Assessment D) of 01/28/21 coded the total possible score of 15 on • Mental Status (BIMS). This 47's cognitive abilities for g were severely impaired. In n Data Set coded Resident nsive assistance of two lity, extensive assistance of ing and personal hygiene. dence for eating with the rson and total dependence eting. Section M. Skin f the MDS indicates that d with a Stage 3 pressure			 Resident currently residing in the f that currently have wounds have the potential to be affected. A quality mo review will be conducted by the DON/Designee to ensure that dignity respect is maintained during wound o procedures. Licensed nursing staff will be educe by the DON/Designee on the policy f residents' rights on the resident havin right to have dignity and respect durin wound care Random wound observations will be conducted by the DON/Designee weekly x 6 weeks, to ensure that respect and dignity is maintained, during wound care. The results of the quality monitorin will be reported to the quality assurant committee team monthly for review at analysis. Date of Completion – May 7, 2021 	and and care ated or ng the ng g, nce nd	
	a black marker and p time and initial on the	ident's wound and then took roceeded to write the date,					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	VINDSOR			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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	was asked, when per do you usually write ti stated, "I usually do it On 3/24/21 at approxi debriefing was condu Administrator, The Re Services and with the concerning the above voiced. Protection/Manageme	forming wound care, when ne date, time and initial. She before I put it on her." imately, 3:00 PM a cted with the Facility egional Director of Clinical DON (Director of Nursing) issue. No comments were ent of Personal Funds		550			5/7/21
SS=D	 §483.10(f)(10) The remanage his or her finative right to know, in a facility may impose agfunds. (i) The facility must need deposit their personal resident chooses to d the facility, upon writter resident, the facility more resident's funds and hard account for the personal and account for the personal cestion. (ii) Deposit of Funds. (A) In general: Exception (A) In general: Exception (A) In general: Exception (B) of this section an interest bearing accounts, and that creates the fact that that the fact that that the fact that the fact that the fac	sident has a right to ancial affairs. This includes dvance, what charges a gainst a resident's personal of require residents to funds with the facility. If a eposit personal funds with en authorization of a nust act as a fiduciary of the hold, safeguard, manage, ersonal funds of the resident cility, as specified in this t as set out in paragraph (f)(n, the facility must deposit al funds in excess of \$100 in ecount (or accounts) that is the facility's operating edits all interest earned on at account. (In pooled be a separate accounting					

Facility ID: 0296

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES			FOF	RM APPROVED	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		495347	B. WING		0	3/26/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CONSUL	ATE HEALTH CARE OF W	/INDSOR		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 567	exceed \$100 in a non interest-bearing acco (B) Residents whose The facility must depo- funds in excess of \$5 account (or accounts) the facility's operating all interest earned on account. (In pooled a separate accounting f The facility must main not exceed \$50 in a m interest-bearing acco This REQUIREMENT by: Based on a facility re personal funds review interviews and facility staff failed to ensure f survey sample were a financial affairs/facility regards to a Covid St and Resident #14 was 9/12/18 with diagnose to Hypertension, Chro Disease and Congest The most recent MDS Resident #14 was a C ARD (Assessment Re Resident #14's BIMS Status) score was a 1	-interest bearing account, unt, or petty cash fund. care is funded by Medicaid: poit the residents' personal 0 in an interest bearing that is separate from any of accounts, and that credits resident's funds to that counts, there must be a for each resident's share.) tain personal funds that do oninterest bearing account, unt, or petty cash fund. is not met as evidenced ported incident, resident <i>y</i> , resident interviews, staff document review the facility that 2 of 35 residents in the allowed to manage their own <i>y</i> personal funds account in imulus Check, Resident #14 : admitted to the facility on es to include but not limited onic Obstructive Pulmonary tive Heart Failure. 6 (Minimum Data Set) for Quarterly Assessment with a efference Date) of 12/18/20. (Brief Interview for Mental 4 out of a possible 15 t was cognitively intact and	F 5	 67 1. Resident #14 and Resident #1 notified that audits of their stimulu were conducted. Both residents in of the findings, that an error had of and that funds had been returned individual RFMS accounts. 2. Audit of stimulus funds for all re completed utilizing report pulled fr report developed by Resident Fur Management System. The Execu Director, Regional Director Busine Office Manager, and Corporate Tr Fund Coordinator review the repo Follow up based on findings of au 3. Business Office team members educated regarding protection and tracking of Stimulus funds provide recurring basis. Corporate trainin conducted for all Business Office members: re: RFMS Stimulus Tra Report. 	s funds nformed occurred to their esidents om nd utive ess ust rt. dit. s will be d on a g team		

Facility ID: 0296

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CONSULA	CONSULATE HEALTH CARE OF WINDSOR						
0(0)15		ATEMENT OF DEFICIENCIES		~~~	/INDSOR, VA 23487 PROVIDER'S PLAN OF CORRECTION	1	(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 567	Continued From page	e 5	F	567			
	A Facility Reported In Office of Licensure at 8/13/20 was reviewed as follows: Report Date: 8/13/20 Resident involved: N Incident type: Reside Describe incident, ind taken: Stimulus payn trust accounts. Busin withdrew the funds at patient liabilities. Name of employee in Name (Previous BOM Employee action initia Office Manager suspe- investigation. Facility internal invest conducted/Reported Department Health)/0 Name and Title of Re Executive Director (P The facility's 5 day FF 8/19/20 was reviewed as follows: RE (regarding): Initia Incident: Allegation of resident funds. Investigation: On Auto conducted and it was the Center had funds stimulus payments at liabilities without the funds.	Acident (FRI) received at the and Certification (OLC on d and is documented in part, 200 ame (Resident #14) ent property misappropriated. cluding locations and action ments received in resident's mess Office Manager and applies to past due 200 201 201 201 201 201 201 201 201 201			 4. Stimulus funds will be monitored monthly utilizing reports pulled from reports developed by the Resident Fur Management System. The results of Quality Monitoring will be reviewed at monthly QAPI meeting for review, analysis, and further recommendation 5. Date of completion – May 7, 2021 	the	

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DICAID SERVICES						APPROVED 0.0938-0391
PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
495347	B. WING				03/2	26/2021
		STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
225		23352 C	OURTHOUSE HIGH	WAY		
SOR		WINDS	OR, VA 23487			
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		(X5) COMPLETION DATE
	F 5	67				
erventions: Previous BOM) was oletion of investigation. Previous BOM) was was refunded \$831.00. from his stimulus check tely 2:00 P.M. a phone with Resident #14 ulus Check and asked if documents for the past due balances. , I haven't signed now I got any money." a phone interview was bus Executive Director. Director was asked about oriation of funds he 2020. The previous , "I was contacted by ause Resident #14's egards to the account (previous BOM) was ager at the time and we investigation. There e stimulus check was Corporate had said we mulus for past due us BOM) had received I told not to use the had been authorized by of attorney. We also Ils with corporate and ney was to be used for						
	A95347 SOR ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ERVENTIFYING INFORMATION) EVENTIFYING INFORMATION) Previous BOM) was Netion of investigation. Previous BOM) was vas refunded \$831.00. from his stimulus check ely 2:00 P.M. a phone with Resident #14 flus Check and asked if documents for the past due balances. I haven't signed ow I got any money." A phone interview was us Executive Director. irector was asked about priation of funds he 2020. The previous "I was contacted by ause Resident #14's gards to the account (previous BOM) was ger at the time and we investigation. There e stimulus check was Corporate had said we nulus for past due s BOM) had received told not to use the had been authorized by of attorney. We also	IDENTIFICATION NUMBER: A. BUILDIN 495347 B. WING SOR ID SOR ID ENT OF DEFICIENCIES ID ST BE PRECEDED BY FULL PREFIX DENTIFYING INFORMATION) F 50 Previous BOM) was Previous BOM) was Jetion of investigation. Previous BOM) was Vas refunded \$831.00. F 50 from his stimulus check Past due balances. I haven't signed In a phone with Resident #14 Previous BOM or a sked if documents for the Past due balances. I haven't signed I haven't signed ow I got any money." Iphone interview was us Executive Director. irector was asked about oriation of funds he 2020. The previous 2020. The previous "I was contacted by ause Resident #14's gards to the account (previous BOM) was ger at the time and we investigation. There e stimulus check was Corporate had said we mulus for past due s BOM) had received told not to use the had been authorized by <td>IDENTIFICATION NUMBER: 495347 B. WING SOR STREET 23352 C WINDS ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) Frevious BOM) was letion of investigation. Previous BOM) was vas refunded \$831.00. from his stimulus check ely 2:00 P.M. a phone with Resident #14 lus Check and asked if documents for the past due balances. I haven't signed ow I got any money." I phone interview was us Executive Director. irector was asked about priation of funds he 2020. The previous "I was contacted by ause Resident #14's gards to the account (previous BOM) was ger at the time and we investigation. There e stimulus check was Corporate had said we nulus for past due s BOM) had received told not to use the had been authorized by of attorney. We also Is with corporate and hey was to be used for</td> <td>IDENTIFICATION NUMBER: 495347 B. WING SOR STREET ADDRESS, CITY, STA 23352 COURTHOUSE HIGH WINDSOR, VA 23487 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) FREFIX TAG FRECEDED BY FULL FREFX (EACH CORREC CROSS-REFEREN D FF 567 F</td> <td>IDENTIFICATION NUMBER: A BUILDING 495347 B. WING SOR STREETADDRESS, CITY, STATE, ZIP CODE SOR 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487 ENT OF DEFICIENCIES STEE PRECEDED BY FULL STEE PRECEDED BY FULL PREFIX ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOLD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Previous BOM) was leiton of investigation. PE F 567 Previous BOM) was leiton of investigation. F F 567 Previous BOM) was leiton of investigation. F S07 Previous BOM) was leiton of investigation. F S07 Previous BOM) was leiton of investigation. F S07 Previous BOM) was us as refunded \$831.00. from his stimulus check ID ID ely 2:00 P.M. a phone with Resident #14 flus Check and asked if documents for the past due balances. I havent signed ow I got any money." ID ID up hone interview was us Executive Director. irector was asked about priation of funds he 2020. The previous BOM) was ger at the time and we mivestigation. There a stimulus check was Coroporate had said we mulus for past due s BOM) had received told not to use the nad been authorized by of atomey. We also Is with corporate and rey was to be used for ID</td> <td>IDENTIFICATION NUMBER: A. BUILDING COMP 495347 B. WING 03// SOR STREET ADDRESS, CITY, STATE, ZIP CODE 2332 COURTHOUSE HIGHWAY SOR STREET ADDRESS, CITY, STATE, ZIP CODE 2332 COURTHOUSE HIGHWAY STOP DEFICIENCIES ID PREPX PROVDER'S PLAN OF CORRECTION SHOULD BE STOR FRECENCED BY FULL ID PREPX CROBS-REFERENCED TO THE APROPRIATE DEFICIENCY) SentTrYING INFORMATION) TAG CROBS-REFERENCED TO THE APROPRIATE DEFICIENCY) Previous BOM) was F 567 erventions: F 567 reventions: F 567 erventions: F 567 erventions: F 567 vith Resident #14 Jus Check and asked if documents for the past due balances. I haven't signed ow I got any money." I phone with Resident #14 Jus Check and asked if Gocuments for the past due balances. I past due balances. I haven't signed ow I got any money." I'' was contacted by agers to the account (previous BOM) was gers to the account (previous BOM) was gers to the account</td>	IDENTIFICATION NUMBER: 495347 B. WING SOR STREET 23352 C WINDS ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) Frevious BOM) was letion of investigation. Previous BOM) was vas refunded \$831.00. from his stimulus check ely 2:00 P.M. a phone with Resident #14 lus Check and asked if documents for the past due balances. I haven't signed ow I got any money." I phone interview was us Executive Director. irector was asked about priation of funds he 2020. The previous "I was contacted by ause Resident #14's gards to the account (previous BOM) was ger at the time and we investigation. There e stimulus check was Corporate had said we nulus for past due s BOM) had received told not to use the had been authorized by of attorney. We also Is with corporate and hey was to be used for	IDENTIFICATION NUMBER: 495347 B. WING SOR STREET ADDRESS, CITY, STA 23352 COURTHOUSE HIGH WINDSOR, VA 23487 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) FREFIX TAG FRECEDED BY FULL FREFX (EACH CORREC CROSS-REFEREN D FF 567 F	IDENTIFICATION NUMBER: A BUILDING 495347 B. WING SOR STREETADDRESS, CITY, STATE, ZIP CODE SOR 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487 ENT OF DEFICIENCIES STEE PRECEDED BY FULL STEE PRECEDED BY FULL PREFIX ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOLD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Previous BOM) was leiton of investigation. PE F 567 Previous BOM) was leiton of investigation. F F 567 Previous BOM) was leiton of investigation. F S07 Previous BOM) was leiton of investigation. F S07 Previous BOM) was leiton of investigation. F S07 Previous BOM) was us as refunded \$831.00. from his stimulus check ID ID ely 2:00 P.M. a phone with Resident #14 flus Check and asked if documents for the past due balances. I havent signed ow I got any money." ID ID up hone interview was us Executive Director. irector was asked about priation of funds he 2020. The previous BOM) was ger at the time and we mivestigation. There a stimulus check was Coroporate had said we mulus for past due s BOM) had received told not to use the nad been authorized by of atomey. We also Is with corporate and rey was to be used for ID	IDENTIFICATION NUMBER: A. BUILDING COMP 495347 B. WING 03// SOR STREET ADDRESS, CITY, STATE, ZIP CODE 2332 COURTHOUSE HIGHWAY SOR STREET ADDRESS, CITY, STATE, ZIP CODE 2332 COURTHOUSE HIGHWAY STOP DEFICIENCIES ID PREPX PROVDER'S PLAN OF CORRECTION SHOULD BE STOR FRECENCED BY FULL ID PREPX CROBS-REFERENCED TO THE APROPRIATE DEFICIENCY) SentTrYING INFORMATION) TAG CROBS-REFERENCED TO THE APROPRIATE DEFICIENCY) Previous BOM) was F 567 erventions: F 567 reventions: F 567 erventions: F 567 erventions: F 567 vith Resident #14 Jus Check and asked if documents for the past due balances. I haven't signed ow I got any money." I phone with Resident #14 Jus Check and asked if Gocuments for the past due balances. I past due balances. I haven't signed ow I got any money." I'' was contacted by agers to the account (previous BOM) was gers to the account (previous BOM) was gers to the account

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/09/2021 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY
		495347	B. WING		_	03/2	26/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
CONSULA	TE HEALTH CARE OF W	INDSOR		23352 COURTHOUSE HIG	GHWAY		
				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 CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 567	it, she said she did do Name (previous BOM being told and trained do with the stimulus n to terminate her. We back the resident's m Director of Business O audit of all resident's m Director of Business O audit of all resident's m On 3/25/21 at 9:58 A. conducted with the Of Resident #14's stimul Ombudsman stated, " resident's family (Res facility took money fro check without permiss spoke with the Name Director) who agreed office manager to che On 8/14/20 Name (pro called and told me an facility by the Adminis was determined that to money from the stimu permission from the re power of attorney. Th on the resident's bill a stimulus check was u amount. Name (previ agreed to replace the the resident."	ad no answer why she did o it but didn't know why. I) said she remembered I about what to do and not to noney. Corporate said I had terminated her and paid oney. The Regional Office Services did a 100% who got stimulus checks at was found Name we money taken as well. titutes misappropriation of M. a phone interview was mbudsman regarding us check. The 'I received a call from the ident #14) alleging that the om the resident's stimulus sion. I called the facility and (previous Executive to get with his business eck on the stimulus check. evious Executive Director) audit was done at the trator and the BOM and it the BOM had in fact taken fulls check without getting esident or the resident's here was a past due amount and the money from the sed to pay that past due ious Executive Director) funds that were taken from	F 56	57			
		A.M. a phone interview was aveling Business Office					

Facility ID: 0296

If continuation sheet Page 8 of 71

STATEMENT OF DEFICIENCIES (M) DENTIFICATION NUMBER: (A) MULTIPLE CONSTRUCTION (M) CONSTRUCTION AND PLAN OF CORRECTION 495347 B: WINC 03/26/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 2332 COURTHOUSE HIGHWAY 03/26/201 CONSULATE HEALTH CARE OF WINDSOR STREET ADDRESS, CITY, STATE, ZP CODE 2332 COURTHOUSE HIGHWAY 03/26/201 MIND OF PROVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 2332 COURTHOUSE HIGHWAY 03/26/201 MIND OF PROVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 2332 COURTHOUSE HIGHWAY 03/26/201 MIND OF CORRECTION (STATE EPRECEDED BY FULL TOG IEACH DEFICIENCY MITS EPRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) IP PREFX TAG PROVIDERS IN AN OF CORRECTION (EACH CORRECTION SHOULD BE CORRECTION ADDIE) 00 F 567 Continued From page 8 F 567 F 567 F 567 O N 3/25/21 at 10/28 A31.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 S31.00 was pulled out of the account from the stimulus check was deposited in the account. The Traveling BOM attel at 19 would have expected Name (previous BOM) to have met with the resident #14 stimulus money and personal fund account. The Wind personal fund account. The Wind personal fund account. The Wind personal fund account. The woney should not have benetobalance. The money should not have benetobal			ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 11/09/202 ORM APPROVEI NO. 0938-039		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE CONSULATE HEALTH CARE OF WINDSOR (X) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MIST BE PRECEEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OEFICIENCY MIST BE PRECEEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CORRECTION (EACH OEFICIENCY MIST BE PRECEEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG F 567 Continued From page 8 Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of \$120,0.0. On 6/1/20 \$831.00 was pield out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/1/3/20 the resident did have a past due balance of \$1408,00." On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The With the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. When I asked Name (previous BOM) who she removed the funds without written permission she said she had spoken to the family. The funds should have newer been pulled before the written authorization was received. A second resident (Resident#100) was also found on the auditivities funds	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,				(X3) DATE SURVEY COMPLETED		
23322 COURTHOUSE HIGHWAY WINDSOR, VA 23487 CMUID TWO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC.IDENTIFYING INFORMATION) ID PREXX TWO PROVIDERS PLAN OF CORRECTION (EACH OPERCENCE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Or PREXX TWO F 567 Continued From page 8 Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of \$1200.00. On 6/1/20 \$831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of \$1408.00." F 567 On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The With the resident did have a past due balance of \$1408.00." F 567 On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The With the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission she said she had spoken to the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the autithrea stimulus funds East additional should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit			495347	B. WING				03/26/2021		
CONSULATE HEALTH CARE OF WINDSOR WINDSOR, VA 23487 (X4)10 PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC WIST ER RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH DEFICIENC WIST ER RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH DEFICIENC WIST ER RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH DEFICIENCY) ID (EACH DEFICIENCY) ID (EACH DEFICIENCY) F 567 Continued From page 8 Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of \$1200.00. On 6/1/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of \$1408.00." F 567 On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. When I asked Name (previous BOM) was heremoved the funds without written permission she said she had spoken to the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit where stimulus funds was received. A second resident (Resident#100) was also found on the audit where stimulus funds	NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE				
(Mi) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG POUDDERE PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL (EACH DEPICENCY DI STOLD SECURITY REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG POUDDERE PLAN OF CORRECTION (EACH DEPICENCY) O COME (EACH DEPICENCY) F 567 Continued From page 8 Manager regarding Resident #14's person fund account on 4/30/20 in the amount of \$1200.00. On 61/120 \$831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of \$1408.00." F 567 On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The Vice President did have a past due balance of \$1408.00." On 3/25/21 at 10:28 A.M. a phone interview was conducted with the vice president of Nevenue Cycle regarding Resident #14's timulus money and personal fund account. The Vice President is of the back balance. The money should not have been touched without receiving written permission. When I asked Name (previous BOM) wis he removed the funds without written permission she said she had spochen to the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#140) was also found on the audit where stimulus funds and on the audit where stimulus funds			INDSOR	23352 COURTHOUSE HIGHWAY		2 COURTHOUSE HIGHWAY				
Preferix TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG IEACH CORRECTURE ACTION SHOULD BE CROSS-REFENCED TO THE APPROPRIATE DEFICIENCY COMMUNICATION F 567 Continued From page 8 Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of \$1200.00. On 6/1/20 \$831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident diff as timulus money and personal fund account. The Vice President of Revenue Cycle stated, " would have expected Name (previous BOM) have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permissions he said she had spoken to the family. The travel the funds without written permission she said she had spoken to the family about using the stimulus funds and sent an authorization was never returned by the family. The funds in the account from the stimulus funds account in a returned stamped envelop, but the authorization was never returned by the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit where stimulus funds President of merceived stamped envelop, but the authorization was received. A second resident (Resident#100)	CONSULF				WIN	IDSOR, VA 23487				
Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of \$1200.00. On 6/1/20 \$831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 \$831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of \$1408.00." On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permissions. When I asked Name (previous BOM) why she removed the funds without written permissions he said she had spoken to the family about using the stimulus funds and sent an authorization in a returned stamped envelop, but the authorization was never returned by the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit where stimulus funds	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE		
had been removed without authorization." A signed statement dated 3/25/21 by the Regional Director of Business Office Services was reviewed and is documented in part, as follows: I received an email regarding a complaint filed by	F 567	Manager regarding R account. The Traveli resident's stimulus ch account on 4/30/20 in On 6/1/20 \$831.00 w by Name (previous B payment. On 9/8/20 resident as a reverse 8/13/20 the resident of of \$1408.00." On 3/25/21 at 10:28 A conducted with the V Cycle regarding Resident and personal fund ac Vice President of Rev have expected Name met with the resident signed permission to from the stimulus for money should not have receiving written perm Name (previous BOM funds without written spoken to the family funds and sent an au stamped envelop, but returned by the family never been pulled be was received. A secon was also found on the had been removed w A signed statement d Director of Business of reviewed and is docu	A.M. a phone interview was decer cost credit. On did have a past due balance A.M. a phone interview was ice President of Revenue dent #14's stimulus money count. The venue Cycle stated, "I would (previous BOM) to have (POA and to have received use the funds in the account the back balance. The ve been touched without nission. When I asked 1) why she removed the permission she said she had about using the stimulus thorization in a returned t the authorization was never (. The funds should have fore the written authorization ond resident (Resident#100) e audit where stimulus funds ithout authorization."	F	567					

Facility ID: 0296

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	Contractorion		A. BUILDI	NG _			
		495347	B. WING			03/	26/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE 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 SC 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
F 567	(Resident #14's) according they were used for convame (previous BOM) to support the use of the BOM) said the daught consent, and she had sign and send back. She had contacted the asking why she had not had she wouldn't answer of that she should not had she had the written and this was the process. said, "I'm sorry, I know concluded my audit of account and based or the funds be returned family notified of the convert date is documented in part." The facility policy title Tracking Report " date is documented in part. Coronavirus stimulus to pay an outstanding balance without writter resident or responsibil permission must be keep financial file. The facility policy title and Responsibilities."	ducted an audit of Name bunt and discovered that ast of care. I contacted I) and requested the backup funds. Name (previous ter has given verbal d mailed her the forms to Name (previous BOM) said e daughter numerous times not sent back the forms, but or return her calls. I told her ave moved the funds until uthorization and she knew Name (previous BOM) w I should have waited.". I f Name (Resident#14's) n my findings, instructed that to his account and resident butcome. I then conducted a dents that received stimulus d "Stimulus Payment ed 9/2020 was reviewed and t, as follows: monies are not to be used I AR (accounts receivable) en permission from the le party. This written ept in the resident's Rights effective 1/2007 was mented in part, as follows:	F	567			
		eeds: nancial affairs and to not be					

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 567	facility. On 3/25/21 at 3:00 P. debriefing with the Ad Nursing and the Regi Services the above in to exit no further infor 2. Resident #100 wa 11/26/2019 with diagr limited to Diabetes Me Major Depressive Dis The most recent MDS Resident #100 was a a ARD (Assessment F Resident #100's BIMS Status) score was a 1 indicating the residen capable of daily decis The facility's 5 day FF 8/19/20 was reviewed as follows: RE (regarding): Initia Incident: Allegation of resident funds. Investigation: On Aug conducted and it was the Center had funds payments and applied without the resident's Findings: Upon comp	M. during a pre-exit Iministrator, the Director of onal Director of Clinical formation was shared. Prior mation was provided. s admitted to the facility on noses to include but not ellitus, Hypertension and order. 6 (Minimum Data Set) for Quarterly Assessment with Reference Date) of 3/8/21. 5 (Brief Interview for Mental 5 out of a possible 15 t was cognitively intact and sion making. 8 Investigation dated a and is documented in part, I Report 8/13/2020 of misappropriation of gust 14, 2020 an audit was determined that residents at withdrawn fro their stimulus d to past due liabilities	F	567			
	Actions and On-Goin	g Interventions:					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING				03/26/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR	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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 567	 On 8/12/2020 Nan suspended pending c On 8/19/2020 Nan terminated, Name (Resident#1 This is the amount tal without authorization. On 3/24/21 at approxi- interview was conduct regarding her Covid S she had signed any fa money to be used for Resident #100 stated papers. Can you tell received because this about it." On 3/25/21 at 9:13 A. conducted with the pr The previous Executive Resident #100's misa reported to OLC on 8. Executive Director stat done and the stimulus permission. Corporat the Covid stimulus for Regional Director of E a 100% audit of all re- checks and one other (Resident #100) to ha What happened cons funds." On 3/25/21 at 10:07 A conducted with the Tr Manager regarding R account. The Travelin 	ne (Previous BOM) was completion of investigation. ne (Previous BOM) was 100) was refunded \$644.34. ken from her stimulus check imately 10:15 A.M. a phone ted with Resident #100 Stimulus Check and asked if acility documents for the any past due balances. , "I haven't signed any me how much money I a is the first I have heard M. a phone interview was evious Executive Director. ve Director was asked about ppropriation of funds he /19/2020. The previous ated, "there was an audit as check was used without the had said we couldn't use r past due balances. The Business Office Services did sident's who got stimulus r resident was found Name ave money taken as well. titutes misappropriation of	F	567	7		

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM APPE MB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		3) DATE SURVE COMPLETED	
		495347	B. WING				03/26/202	21
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CONSULA	TE HEALTH CARE OF W	/INDSOR						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE COM				
F 567	account on 4/29/20 in On 7/22/20 \$644.34 v by Name (previous Bi payment. On 9/8/20 \$ resident as a reverse 8/13/20 the resident of of \$2624.79." On 3/25/21 at 10:28 A conducted with the Vi Cycle regarding Resid and personal fund acc Vice President of Rev have expected Name met with the resident/ signed permission to from the stimulus for the money should not hav receiving written perm have never been pulle authorization was rec The facility policy title Tracking Report" date is documented in part Coronavirus stimulus to pay an outstanding balance without writter resident or responsibli permission must be k financial file. The facility policy title and Responsibilities" reviewed and is docum	 the amount of \$1200.00. vas pulled out of the account OM) as a care cost \$644.34 was refunded to the care cost credit. On did have a past due balance A.M. a phone interview was ce President of Revenue dent #100's stimulus money count. The renue Cycle stated, "I would (previous BOM) to have POA and to have received use the funds in the account the back balance. The ve been touched without hission. The funds should ed before written eived. d "Stimulus Payment ed 9/2020 was reviewed and t, as follows: monies are not to be used (AR (accounts receivable)) en permission from the le party. This written ept in the resident's effective 1/2007 was mented in part, as follows: 	F	567	7			

Facility ID: 0296

If continuation sheet Page 13 of 71

				CONSTRUCTION	OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		03/26/2021		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CONSULA	TE HEALTH CARE OF V	VINDSOR		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 SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLET		
F 567	Continued From page	e 13	F 567				
	required to deposit yo facility.	our funds with the nursing					
	Nursing and the Regi	Iministrator, the Director of onal Director of Clinical formation was shared. Prior					
F 574 SS=D	Required Notices and	Contact Information	F 574		5/7/21		
	writing (including Bra language he or she u (i) Required notices a The facility must furni description of legal rig (A) A description of the personal funds, under section; (B) A description of the procedures for estable including the right to resources under sect Security Act. (C) A list of names, a email), and telephone State regulatory and resident advocacy gro Survey Agency, the S State Long-Term Car protection and advoc	(meaning spoken) and in ille) in a format and a nderstands, including: is specified in this section. is to each resident a written ghts which includes - ne manner of protecting r paragraph (f)(10) of this					
	in long-term care faci agency for informatio	lities, the local contact n about returning to the ledicaid Fraud Control Unit;					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE			
		495347	B. WING			03/	/26/2021		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
CONSULA	ATE HEALTH CARE OF W	INDSOR		23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			BE	(X5) COMPLETION DATE		
F 574	(D) A statement that t complaint with the Sta concerning any suspe- federal nursing facility not limited to resident exploitation, misappro- in the facility, non-cor- directives requirement information regarding (ii) Information and co- and local advocacy of not limited to the Stat Long-Term Care Omb (established under se Americans Act of 196 U.S.C. 3001 et seq) a advocacy system (as as established under Disabilities Assistance 2000 (42 U.S.C. 1500 (iii) Information regard eligibility and coverag (iv) Contact informatio Disability Resource C Section 202(a)(20)(B) Act); or other No Wro (v) Contact informatio Control Unit; and (vi) Information and co grievances or compla suspected violation of facility regulations, inc resident abuse, negle misappropriation of re facility, non-compliant directives requirement information regarding	he resident may file a ate Survey Agency ected violation of state or regulations, including but abuse, neglect, opriation of resident property inpliance with the advance ts and requests for returning to the community. Ontact information for State rganizations including but e Survey Agency, the State oudsman program inction 712 of the Older 5, as amended 2016 (42 and the protection and designated by the state, and the Developmental e and Bill of Rights Act of 01 et seq.) ding Medicare and Medicaid re; on for the Aging and enter (established under i(iii) of the Older Americans ing Door Program; in for the Medicaid Fraud ontact information for filing ints concerning any f state or federal nursing cluding but not limited to ict, exploitation, esident property in the ce with the advance	F	574					

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		ID HUMAN SERVICES				RINTED: 11/09/20 FORM APPROVE
TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ABNO: 0938-039 3) DATE SURVEY COMPLETED
		495347	B. WING _			03/26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
				23352 COURTHOUSE HI	GHWAY	
CONSULA	TE HEALTH CARE OF V	VINDSOR		WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 574	Based on responses group interview and g facility staff failed to e aware of the contact regulatory and inform email, mailing address in a font large enough The findings included On 3/24/21 at 1:30 p. conducted with 6 resi units. During the gro Council President (Re remaining 5 residents not aware of where the informational agencies posting was located w asked of the group if filing a grievance failed regarding care and se exploitation and or m what other recourse w stated no one had ew information and they information was posted This surveyor was also aforementioned posti	from six residents during a general observations, the ensure the residents were information for all State lational agencies to include uses and telephone numbers in to be read by residents. I: m., a group interview was idents that represented all up interview, Resident CP)-Resident #100 and the sexpressed that they were he State Regulatory and es contact information within the facility. It was in-house procedures for ed to resolve a complaint ervices, abuse, neglect, isappropriation of property, would they have? They all er given them the did not know where the ed. so unable to locate the	F 5	 During the graves in the second state resident #100 and that they were not state Regulatory agencies contact located within the information was a enough to be reaupdated, larger pathe front lobby or with large font. Community Lift will review inform on where the postor located for State informational age Community Lift will provide all reposted information and informational location of inform agencies listed. take place in more meetings and as Any resident commediately and 	encies in the facility. fe Director, or Designee, sidents with education or on for State Regulatory al agencies regarding – nation in the facility and Follow up education will nthly Resident Council	n
	the front lobby to loca RCP-Resident #100 f sheet of paper in a pl receptionist front des names, mailing and e RCP-Resident #100 f contents on the pape	found an 8" by 11" white astic frame sitting at the k with the State Agency		recommendation 5. Date of Compl	s. letion – May 7, 2021	

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		E SURVEY IPLETED	
		495347	B. WING		03	8/26/2021	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CONSULA	TE HEALTH CARE OF W	INDSOR		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 574	was another posting of the front lobby. RCP-I second posting which posted on the wall. Ag able to read its conter RCP-Resident #100 s and the Activities Dire residents would be at document was located lobby was the docume information in order to grievance to resolve a regarding care and se neglect. The font in th wall was also in the si the front lobby. The R the Administrator and was in trouble becaus the posting was located Administrator assured that she was not in ar present the informatio	down the front hallway from Resident #100 went to the was the same size, but gain, Resident #100 was not ints based on the small font. Stated to the Administrator actor that there was no way ble to know that the framed d on the wall or in the front ent with State Agency b independently file a a personal complaint ervices or abuse and le framed document on the ame small font as the one in CP-Resident #100 asked the Activities Director if she se she did not know where ed or its content. The I the RCP-Resident #100 ny trouble and they would on at the next resident e the information more	F 5	74			
F 602 SS=D	debriefing with the Ad Nursing (DON), they s and State regulation r for posting State Ager Free from Misappropr	mately 2:00 p.m., during the ministrator and Director of stated they followed Federal egarding the requirements ney contact information. iation/Exploitation	F 6	02		5/7/21	
	The resident has the neglect, misappropria	right to be free from abuse, tion of resident property, fined in this subpart. This ited to freedom from					

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORI OMB NO	D: 11/09/2021 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	ESURVEY PLETED
		495347	B. WING		03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	TE HEALTH CARE OF W		23	3352 COURTHOUSE HIGHWAY		
			N	VINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 602	any physical or chemi treat the resident's me This REQUIREMENT by: Based on a facility re personal funds review interviews and facility staff failed to prevent resident federal stimu residents in the surve Resident #100. The findings included 1. Resident #14 was 9/12/18 with diagnose to Hypertension, Chro Disease and Congest The most recent MDS Resident #14 was a ARD (Assessment Re Resident #14's BIMS Status) score was a 1 indicating the resident capable of daily decis A Facility Reported In Office of Licensure an 8/13/20 was reviewed as follows: Report Date: 8/13/20 Resident type: Resident	involuntary seclusion and cal restraint not required to edical symptoms. is not met as evidenced ported incident, resident y, resident interviews, staff document review the facility the misappropriation of lus check funds for 2 of 35 y sample, Resident #14 and admitted to the facility on es to include but not limited onic Obstructive Pulmonary ive Heart Failure. (Minimum Data Set) for Quarterly Assessment with a efference Date) of 12/18/20. (Brief Interview for Mental 4 out of a possible 15 t was cognitively intact and ion making. cident (FRI) received at the id Certification (OLC on a and is documented in part, 20 ame (Resident #14) nt property misappropriated.	F 602	 An audit was conducted and it we determined that Resident #14 and Resident #100 had funds withdrawn their stimulus payments and applied their past due liabilities without their authorization. Resident funds have returned to their individual accounts Audit of stimulus funds for all resi completed utilizing report pulled fror report developed by Resident Fund Management System. The Executive Director, Regional Director Business Office Manager, and Corporate Trus Fund Coordinator review the report. Follow up based on findings of audit Business Office team members we educated regarding protection and tracking of Stimulus funds provided recurring basis. Stimulus funds will be monitored monthly utilizing reports pulled from reports developed by the Resident F Management System. The results of Quality Monitoring will be reviewed a monthly QAPI meeting for review, analysis, and further recommendation 5. Date of completion – May 7, 2021 	from to been dents n re t t ill be on a fund f the at	
		luding locations and action nents received in resident's ess Office Manager				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES										
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMF	LETED			
		495347	B. WING _			03/	26/2021			
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.				
CONSULA	TE HEALTH CARE OF W	VINDSOR		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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE COMPLETI THE APPROPRIATE DATE				
F 602	Name (Previous BOM Employee action initia Office Manager suspe- investigation. Facility internal invest conducted/Reported f Department Health)/C Name and Title of Rep Executive Director (Pr The facility's 5 day FF 8/19/20 was reviewed as follows: RE (regarding): Initia Incident: Allegation of resident funds. Investigation: On Aug conducted and it was the Center had funds payments and applied without the resident's Findings: Upon comp misappropriation of re Actions and On-Going 1. On 8/12/2020 Nam suspended pending c 2. On 8/19/2020 Nam terminated, 3. Name (Resident#1 This is the amount tak without authorization.	ad applies to past due volved and their positions: I) Business Office Manager. ated or taken: Business ended pending further igation: Will be forward to VDH(Virginia DLC: 8/19/2020. porting Person: Name, revious Executive Director). RI Investigation dated I and is documented in part, I Report 8/13/2020 f misappropriation of gust 14, 2020 an audit was determined that residents at withdrawn fro their stimulus d to past due liabilities authorization. Deletion of the investigation esident funds did occur. g Interventions: he (Previous BOM) was ompletion of investigation. he (Previous BOM) was 14) was refunded \$831.00. ken from his stimulus check	F	602						
		mately 2:00 P.M. a phone								

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY		
	A. BUILDING	G	COMPLETED		
495347	B. WING		03/26/2021		
3		STREET ADDRESS, CITY, STATE, ZIP CODE	iDE		
OF WINDSOR		23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLE		
nducted with Resident #14 vid Stimulus Check and asked if ny facility documents for the d for any past due balances. ted, "No, I haven't signed e even know I got any money." 13 A.M. a phone interview was ne previous Executive Director. ecutive Director was asked about hisappropriation of funds he on 8/13/2020. The previous or stated, "I was contacted by nan) because Resident #14's him in regards to the account t. Name (previous BOM) was ice Manager at the time and we pending investigation. There is and the stimulus check was mission. Corporate had said we Covid stimulus for past due (previous BOM) had received onal and told not to use the unless it had been authorized by e power of attorney. We also rence calls with corporate and nulus money was to be used for es. When I approached Name she had no answer why she did id do it but didn't know why. BOM) said she remembered ained about what to do and not to lus money. Corporate said I had We terminated her and paid t's money. The Regional ess Office Services did a 100%	F 60				
The set of	Page 19 nducted with Resident #14 vid Stimulus Check and asked if ny facility documents for the d for any past due balances. ated, "No, I haven't signed t even know I got any money." 13 A.M. a phone interview was he previous Executive Director. ecutive Director was asked about nisappropriation of funds he on 8/13/2020. The previous or stated, "I was contacted by man) because Resident #14's him in regards to the account it. Name (previous BOM) was fice Manager at the time and we pending investigation. There he and the stimulus check was mission. Corporate had said we Covid stimulus for past due (previous BOM) had received ional and told not to use the unless it had been authorized by he power of attorney. We also rence calls with corporate and hulus money was to be used for es. When I approached Name she had no answer why she did did do it but didn't know why. BOM) said she remembered ained about what to do and not to alus money. Corporate said I had We terminated her and paid t's money. The Regional less Office Services did a 100% ent's who got stimulus checks sident was found Name to have money taken as well.	R OF WINDSOR PR OF WINDSOR PRY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG page 19 F 60 nducted with Resident #14 wid Stimulus Check and asked if ny facility documents for the d for any past due balances. ated, "No, I haven't signed t even know I got any money." F 60 13 A.M. a phone interview was he previous Executive Director. ecutive Director was asked about nisappropriation of funds he on 8/13/2020. The previous or stated, "I was contacted by man) because Resident #14's him in regards to the account it. Name (previous BOM) was fice Manager at the time and we pending investigation. There he and the stimulus check was mission. Corporate had said we Covid stimulus for past due e (previous BOM) had received ional and told not to use the unless it had been authorized by he power of attorney. We also rence calls with corporate and hulus money was to be used for es. When I approached Name she had no answer why she did did do it but didn't know why. BOM) said she remembered ained about what to do and not to Julus money. Corporate said I had We terminated her and paid t's money. The Regional tess Office Services did a 100% ent's who got stimulus checks sident was found Name to have money taken as well.	R STREET ADDRESS, CITY, STATE, 2IP CODE 0F WINDSOR 23352 COURTHOUSE HIGHWAY WINDSOR, VA 23457 RY STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) ID PREVIEW page 19 F 602 nducted with Resident #14 wid Stimulus Check and asked if ny facility documents for the d for any past due balances. tted, "No, I haven't signed t even know I got any money." F 602 13 A.M. a phone interview was he previous Executive Director. ecutive Director was asked about nisappropriation of funds he on 8/13/2020. The previous or stated, "I was contacted by man) because Resident #14's him in regards to the account. it. Name (previous BOM) was ice Manager at the time and we pending investigation. There te and the stimulus check was mission. Corporate had said we Covid stimulus for past due (previous BOM) had received ional and told not to use the unless it had been authorized by te power of attorney. We also rence calls with corporate and nulus money was to be used for ss. When I approached Name she had no answer why she did lid do it but didn't know why. BOM) said she remembered ained about what to do and not to <i>Jus</i> money. The Regional ess Office Services did a 100% ent's who got stimulus checks sident was found Name		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495347 NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WINDSOR			· ,	NG _ S' 2:	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 2352 COURTHOUSE HIGHWAY WINDSOR, VA 23487	FORM OMB NC (X3) DATE COMP	D: 11/09/2021 MAPPROVED D. 0938-0391 SURVEY PLETED 26/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	What happened cons funds." On 3/25/21 at 9:58 A. conducted with the O Resident #14's stimul Ombudsman stated, ' resident's family (Res facility took money fro check without permiss spoke with the Name Director) who agreed office manager to che On 8/14/20 Name (pri- called and told me an facility by the Adminis was determined that the money from the stimul permission from the re- power of attorney. The on the resident's bill a stimulus check was u amount. Name (previ- agreed to replace the the resident." On 3/25/21 at 10:07 A conducted with the Tr Manager regarding R account. The Travelin resident's stimulus cha account on 4/30/20 in On 6/1/20 \$831.00 wa by Name (previous Bi payment. On 9/8/20 S	M. a phone interview was mbudsman regarding us check. The 'I received a call from the ident #14) alleging that the own the resident's stimulus sion. I called the facility and (previous Executive to get with his business ick on the stimulus check. evious Executive Director) audit was done at the trator and the BOM and it he BOM had in fact taken lus check without getting esident or the resident's here was a past due amount and the money from the sed to pay that past sue tous Executive Director) funds that were taken from A.M. a phone interview was aveling Business Office esident #14's person fund hg BOM stated, "The eck was deposited in the the amount of \$1200.00. as pulled out of the account OM) as a care cost \$831.00 was refunded to the	F	602			

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		IB NO. 0938-0391 DATE SURVEY COMPLETED		
		495347	B. WING				03/26/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
CONSULA	TE HEALTH CARE OF W	INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
F 602	On 3/25/21 at 10:28 <i>A</i> conducted with the Vi Cycle regarding Resident and personal fund active President of Revent have expected Name met with the resident/ signed permission to from the stimulus for the money should not have receiving written permoney should not have receiving written permoney should not the family as funds and sent an author stamped envelop, but returned by the family never been pulled betwas received. A sector was also found on the had been removed with the family of Name (Previous BOM) funds statement data been removed with the family of Name (Resident #14's) according to the family of Name (Resident #14's) according the family of Name (Resident #14's) according the sector of BOM) said the daugh consent, and she had sign and send back. She had contacted the asking why she had metal share the family whe had metal share where the family for the sector of BOM) said the daugh consent, and she had sign and send back.	A.M. a phone interview was ce President of Revenue dent #14's stimulus money count. The renue Cycle stated, "I would (previous BOM) to have POA and to have received use the funds in the account the back balance. The ve been touched without hission. When I asked bout using the stimulus thorization in a returned the authorization was never the authorization was never to The funds should have fore the written authorization and resident (Resident#100) e audit where stimulus funds thout authorization." ated 3/25/21 by the Regional Office Services was mented in part, as follows: garding a complaint filed by tesident #14) regarding his ducted an audit of Name fund and discovered that st of care. I contacted backup funds. Name (previous	F	602	2				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 602	that she should not ha she had the written au this was the process. said, "I'm sorry, I know concluded my audit o account and based on the funds be returned family notified of the o 100% audit of all resid funds." The facility policy title Exploitation and Misa 11/28/17 was reviewe part, as follows: Misappropriation of re deliberate misplacem wrongful, temporary, resident's belongings resident's consent. M is not limited to: -Identity theft -Theft of money from -Unauthorized or coeff resident's funds The facility policy title Tracking Report" date is documented in part Coronavirus stimulus to pay an outstanding	ave moved the funds until uthorization and she knew Name (previous BOM) w I should have waited.". I f Name (Resident#14's) in my findings, instructed that to his account and resident butcome. I then conducted a dents that received stimulus d "Abuse, Neglect, ppropriation" last revised ed and is documented in esident property is the ent, exploitation, or permanent use of a or money without the lisappropriation includes but bank accounts reced purchases on a reced purchases from d "Stimulus Payment ed 9/2020 was reviewed and t, as follows: monies are not to be used pAR (accounts receivable) en permission from the le party. This written	F	602			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495347	B. WING			03/	26/2021		
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.			
CONSULA	TE HEALTH CARE OF W	/INDSOR		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			EACH CORRECTIVE ACTION SHOULD BE CO OSS-REFERENCED TO THE APPROPRIATE			
F 602	Continued From page	23	F	602	2				
	Nursing and the Regi Services the above in to exit no further infor 2. Resident #100 was 11/26/2019 with diagr limited to Diabetes Mo Major Depressive Dis The most recent MDS	Iministrator, the Director of onal Director of Clinical formation was shared. Prior mation was provided. s admitted to the facility on noses to include but not ellitus, Hypertension and							
	a ARD (Assessment F Resident #100's BIMS Status) score was a 1	Reference Date) of 3/8/21. S (Brief Interview for Mental 5 out of a possible 15 t was cognitively intact and							
	The facility's 5 day FF 8/19/20 was reviewed as follows:	RI Investigation dated I and is documented in part,							
	conducted and it was the Center had funds	of misappropriation of gust 14, 2020 an audit was determined that residents at withdrawn fro their stimulus d to past due liabilities							
		oletion of the investigation esident funds did occur. g Interventions:							
	1. On 8/12/2020 Nan	ne (Previous BOM) was completion of investigation.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE	E SURVEY PLETED		
		495347	B. WING			03/26/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CONSULA	ATE HEALTH CARE OF W	/INDSOR			23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION GULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 602	 On 8/19/2020 Nan terminated, Name (Resident#1 This is the amount tal without authorization. On 3/24/21 at approxi- interview was conduc- regarding her Covid S she had signed any fa- money to be used for Resident #100 stated papers. Can you tell received because this about it." On 3/25/21 at 9:13 A. conducted with the pr The previous Executive Resident #100's misa- reported to OLC on 8. Executive Director sta done and the stimulus permission. Corporat the Covid stimulus for Regional Director of E a 100% audit of all re- checks and one other (Resident #100) to ha What happened cons- funds." On 3/25/21 at 10:07 A conducted with the Tr Manager regarding R account. The Travelin resident's stimulus ch account on 4/29/20 in 	ne (Previous BOM) was 100) was refunded \$644.34. ken from her stimulus check imately 10:15 A.M. a phone ted with Resident #100 Stimulus Check and asked if acility documents for the any past due balances. , "I haven't signed any me how much money I s is the first I have heard M. a phone interview was revious Executive Director. ve Director was asked about ppropriation of funds he /19/2020. The previous ated, "there was an audit is check was used without te had said we couldn't use r past due balances. The Business Office Services did sident's who got stimulus r resident was found Name twe money taken as well. titutes misappropriation of	F	602	2			

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING			03/	26/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 602	resident as a reverse 8/13/20 the resident of of \$2624.79." On 3/25/21 at 10:28 A conducted with the Vi Cycle regarding Resid and personal fund active Vice President of Rev have expected Name met with the resident/ signed permission to from the stimulus for the money should not hav receiving written perm have never been pulle authorization was rec The facility policy title Exploitation and Misa 11/28/17 was reviewed part, as follows: Misappropriation of red deliberate misplacem wrongful, temporary, resident's consent. M is not limited to: -Identity theft -Theft of money from -Unauthorized or coeff resident's credit card -Unauthorized or coeff resident's funds	OM) as a care cost \$644.34 was refunded to the care cost credit. On did have a past due balance A.M. a phone interview was ce President of Revenue dent #100's stimulus money count. The venue Cycle stated, "I would (previous BOM) to have 'POA and to have received use the funds in the account the back balance. The ve been touched without hission. The funds should ed before written eived. d "Abuse, Neglect, ppropriation" last revised ad and is documented in esident property is the ent, exploitation, or permanent use of a or money without the lisappropriation includes but bank accounts rced purchases on a	F	602			
	The facility policy title	d "Stimulus Payment					

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495347	B. WING			03/	/26/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 602 F 622 SS=D	Tracking Report" date is documented in part Coronavirus stimulus to pay an outstanding balance without writter resident or responsibl permission must be k financial file. On 3/25/21 at 3:00 P. debriefing with the Ad Nursing and the Regis Services the above in to exit no further infor Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer at §483.15(c)(1) Facility, (i) The facility must per remain in the facility, a discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the facility (B) The transfer or dis resident's welfare and cannot be met in the facility (C) The safety of indiv endangered due to the status of the resident; (D) The health of indiv otherwise be endanger (E) The resident has fa appropriate notice, to	ed 9/2020 was reviewed and a, as follows: monies are not to be used AR (accounts receivable) on permission from the le party. This written ept in the resident's M. during a pre-exit ministrator, the Director of onal Director of Clinical formation was shared. Prior mation was provided. ge Requirements i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the t the resident's needs facility; scharge is appropriate s health has improved dent no longer needs the the facility; viduals in the facility would		602			5/7/21

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/09/2021 APPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY
		495347	B. WING			03/2	26/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	INDSOR		23352 COURTHOUSE HIG WINDSOR, VA 23487	GHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	submit the necessary payment or after the t Medicare or Medicaid resident refuses to par resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may not resident while the app § 431.230 of this chap exercises his or her ri- discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docume When the facility trans- resident under any of in paragraphs (c)(1)(i) section, the facility mu or discharge is docum- medical record and ap communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the t (i) of this section. (B) In the case of para section, the specific re be met, facility attemp	f the resident does not paperwork for third party hird party, including , denies the claim and the y for his or her stay. For a s eligible for Medicaid after , the facility may charge a e charges under Medicaid; a to operate. to transfer or discharge the beal is pending, pursuant to obter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health nt or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified (A) through (F) of this ust ensure that the transfer pented in the resident's opropriate information is receiving health care	F 62	2			

Facility ID: 0296

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/202 MAPPROVE D. 0938-039
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM		· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER	·	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF V	VINDSOR		-	3352 COURTHOUSE HIGHWAY		
				W	/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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From page	e 28	F	622			
	facility to meet the ne						
		on required by paragraph (c)					
	(2)(i) of this section m						
	· · /	ysician when transfer or					
	-	ry under paragraph (c) (1)					
	(A) or (B) of this section						
	· / · ·	i transfer or discharge is agraph (c)(1)(i)(C) or (D) of					
	this section.						
	(iii) Information provided to the receiving provider						
	must include a minim						
	(A) Contact information	on of the practitioner					
	responsible for the ca						
	• •	ntative information including					
	contact information	- information					
	(C) Advance Directive	tions or precautions for					
	ongoing care, as app	•					
	(E) Comprehensive c	•					
	(F) All other necessa	ary information, including a					
		s discharge summary,					
		21(c)(2) as applicable, and					
	•	ition, as applicable, to ensure					
	a safe and effective to	ransition of care.					
	by:	is not met as evidenced					
	•	views, clinical record review			1. The facility failed to send a copy o	f	
		tation review the facility staff			Care Plans for two residents that wer		
	failed to send a copy	of the Resident's Care Plan			discharged/transferred to the hospital	l:	
	•	after being transferred and			Resident #94 discharged to the hospi	ital	
	admitted to the hospi				on 1/25/21	4 - 1	
	(Resident #91 and #91 residents.	94) in survey sample of 35			Resident #91 discharged to the hospi on 8/9/2020	ital	
	The findings included	l:			 Director of Nursing or Designee will conduct a Quality Review of resident documentation that 		
		iled to send a copy of of Care summary to include			transferred/discharged to the hospital the last 30 days. Follow up based on	over	

Event ID: GNW911

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			BE	(X5) COMPLETION DATE
F 622	plan care goals was s to the hospital on 01/2 Resident #94 was re- 02/02/21. Diagnosis f but were not limited to Type 2, Bipolar Disord The current Minimum assessment with an A (ARD) of 12/02/20 co out of a possible scor Interview for Mental S A nursing note dated #94 was discharged f transferred to the hos During an interview o the administrator she	eent upon transfer/discharge 25/21. admitted to the facility or Resident #91 included o Hypertension, Diabetes - der and Heart Failure. Data Set (MDS), a quarterly assessment Reference Date ded the resident with a 15 e of 15 on the Brief Status (BIMS). 1/25/21 indicated: "Resident from the facility and pital." n 3/25/21 at 11:13 A.M. with stated, " A care plan was al upon discharge from the	F	622	 findings. 3. Director of Nursing or Designee to educate licensed nurses on providing required documentation to include car- plan goals, bed hold policy, and physic documentation. The Director of Nursin Designee will review information provi- during resident transfers to receiving facility/hospital for 6 weeks and as nee- to ensure the required documentation provided. 4. The results of the Quality Monitoring be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, a further recommendations. 5. Date of Completion – May 7, 2021 	cian g or ded eded is g to	
	#91's Plan of Care Su	iled to ensure that Resident ummary to include care plan transfer/discharge to the					
	on 09/29/17. Diagnos	ed to Chronic Obstructive					
	The current Minimum	Data Set (MDS), a quarterly					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CONSULA	ATE HEALTH CARE OF W	/INDSOR			2352 COURTHOUSE HIGHWAY NINDSOR, 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	assessment with an A (ARD) of 03/01/21 co- out of a possible scor Interview for Mental S severe cognitive impart The Discharge MDS a 08/09/20 - discharged On 08/09/20, accordin documentation read in observed ambulating nurse's station and with noted facial drooping from the mouth and m call physician made a send Resident #91 ou hospital. VS: (BP) 120 with oxygen saturation A phone interview wa Administrator on 03/2 p.m., who stated, "Th been sent with Reside to the hospital. The Administrator and was informed of the fi 03/25/21 at approxim- did not present any fut findings. The facility's policy titl Notification and Right date of 03/26/18. Policy: Transfer and initiated by the center	Assessment Reference Date ded the resident with a 06 e of 15 on the Brief Status (BIMS) indicating airment. assessments was dated for d with return anticipated. In part, "Resident #91, was out of her room towards as met by staff member, to left side of face, drooling humbling her words. The on tware with new orders to ut via 911 to the local D/78, (P) 72, (R) 18, (T) 97.5 in at 100%. s conducted with the 6/21 at approximately 2:03 e Care Plan should have ent #91 when discharged out d Director of Nursing (DON) nding during a briefing on ately 2:55 p.m. The facility inther information about the led: Transfer/Discharge to Appeal with a revision discharges of residents, f (facility initiated) will be to Federal and/or State	F	622			

Facility ID: 0296

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		DNSTRUCTION		<u>NO. 0938-039</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>			COMPLETED		
		495347	B. WING			o	3/26/2021	
NAME OF P	ROVIDER OR SUPPLIER	·		STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
	TE HEALTH CARE OF V	VINDSOR		2335	2 COURTHOUSE HIGHWAY			
CONSOLA		INDSOR		WIN	IDSOR, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 622	Continued From page	e 31	F	622				
		to the receiving provider						
	must include but is no Comprehensive care	plan goals.						
F 623 SS=D	· ·	Before Transfer/Discharge -(6)(8)	F	623			5/7/21	
	the reasons for the m	fers or discharges a nust- and the resident's he transfer or discharge and love in writing and in a r they understand. The						
	representative of the Long-Term Care Oml (ii) Record the reason discharge in the resid	Office of the State oudsman.						
	(iii) Include in the not paragraph (c)(5) of th	ice the items described in is section.						
	(c)(8) of this section,	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be						
	made by the facility a resident is transferred (ii) Notice must be ma	t least 30 days before the d or discharged. ade as soon as practicable						
		charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of						
	(B) The health of indi	viduals in the facility would er paragraph (c)(1)(i)(D) of						

Facility ID: 0296

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í		E CONSTRUCTION	(X3) DATE	
		495347	495347 B. WING 03/				26/2021
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follor (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental dia disabilities, the mailin telephone number of the protection and add developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility	alth improves sufficiently to ate transfer or discharge, I)(i)(B) of this section; hafer or discharge is ent's urgent medical needs, I)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nafer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,	F	623			

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		ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		NTE SURVEY
		495347	B. WING		03/26/2021		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	TE HEALTH CARE OF V	VINDSOR		:	23352 COURTHOUSE HIGHWAY		
CONCOL				· ·	WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 623	Continued From page	- 33	Í F	623			
. 020		lephone number of the	1	020			
	agency responsible f	•					
		als with a mental disorder					
		Protection and Advocacy					
	for Mentally III Individ	•					
	§483.15(c)(6) Chang						
		ne notice changes prior to or discharge, the facility					
		pients of the notice as soon					
		he updated information					
	becomes available.						
		in advance of facility closure					
	-	closure, the individual who is he facility must provide					
		ior to the impending closure					
	-	gency, the Office of the					
		e Ombudsman, residents of					
	the facility, and the re	esident representatives, as					
		e transfer and adequate					
		lents, as required at §					
	483.70(I).	is not mat as suideneed					
	by:	is not met as evidenced					
	•	ecord review, staff interviews			1. The Ombudsman was not notifie	d of	
		reviews, the facility staff			Resident #43 (6/11/20) and Resider		
	failed to notify the Of	fice of the State Long-Term			transfer from the facility to the hospi	tal on	
		writing of discharges for two			1/25/2021. Ombudsman to be notified		
		43 and #94) in the sample			transfer for Resident #94 and Resid	ent 43	
	of 35 residents.				as of 4/12/2021.		
	The findings included	ŀ			2. An audit of residents discharged	from	
		•			the facility in the past 30 days will be		
	1. The facility staff fa	iled to notify the Office of			completed to ensure Ombudsman		
	-	n Care Ombudsman in			notification. Follow up based on find	ings.	
	-	nt #94 was transferred to the					
	hospital on 1/25/21.				3. The Director of Social Services w		
					educated on the notification process	s for	

Event ID: GNW911

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2021 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	TE HEALTH CARE OF W			23	3352 COURTHOUSE HIGHWAY		
CONCOL		MADOOR		W	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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
TAG F 623	Continued From page Resident #94 was re- 02/02/21. Diagnosis for but were not limited to Type 2, Bipolar Disord The current Minimum assessment with an A (ARD) of 12/02/20 coo- out of a possible scor Interview for Mental S A nursing note dated #94 was discharged f transferred to the hos A phone interview wa Worker (SW) on 03/2 a.m. The SW stated, transmittal slip to valid made aware of Resid local hospital on 01/2 The Administrator and was informed of the fi 03/25/21 at approxima- did not present any fu findings. 2. The facility staff fa the State Long-Term Resident #43's transfe 06/11/20. Resident # the facility on 07/13/1	e 34 admitted to the facility or Resident #91 included o Hypertension, Diabetes - der and Heart Failure. Data Set (MDS), a quarterly assessment Reference Date ded the resident with a 15 e of 15 on the Brief Status (BIMS). 1/25/21 indicated: "Resident rom the facility and pital." s conducted with the Social 5/21 at approximately 9:02 "I am not able to locate the date the Ombudsman was ent #94's discharge to the 5/21." d Director of Nursing (DON) nding during a briefing on ately 2:55 p.m. The facility inther information about the		623		ive ill of	DATE
		Data Set (MDS), a quarterly Assessment Reference Date					

Facility ID: 0296

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2021 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		495347	B. WING		_	03/:	26/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-		
CONSUL	ATE HEALTH CARE OF W	/INDSOR		3352 COURTHOUSE HIG VINDSOR, VA 23487	HWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	 (ARD) of 01/21/21 colout of a possible scor Interview for Mental S severe cognitive impart The Discharge MDS a 06/11/20 - discharged anticipated. On 6/11/2020, accord documentation, "Resi nurse having an unstel leaning toward her rig trying to walk numero unsteady gait. The Nu notified with a new or out via 911 to the hos A phone interview wa Worker (SW) on 03/2 a.m. The SW stated, transmittal slip to valid made aware of Resid local hospital on 06/1 The Administrator and was informed of the fi 03/25/21 at approxim- did not present any fu findings. The facility's policy titl Notification and Right date of 03/26/18. Policy: Transfer and initiated by the center 	ded the resident with a 03 e of 15 on the Brief status (BIMS) indicating no airment. assessments was dated for assessment - return not ing to the facility's dent was noticed by this eady gait and resident was that side. Resident almost fell us times due to her urse Practitioner (NP) was der to send Resident #43 pital for possible stroke. s conducted with the Social 5/21 at approximately 9:02 "I am not able to locate the date the Ombudsman was ent #43's discharge to the 1/20." d Director of Nursing (DON) nding during a briefing on ately 2:55 p.m. The facility in ther information about the led: Transfer/Discharge to Appeal with a revision discharges of residents, (facility initiated) will be to Federal and/or State	F 623					

Facility ID: 0296

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03		
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	(X3) DATE SURVEY COMPLETED			
		495347	B. WING		03/26/2021		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	·		
CONSUL	TE HEALTH CARE OF W	VINDSOR		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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC		
F 623 F 625 SS=D	Notice must be made before transfer or disk Note: Notices to the situations can be sen a list of residents on a Notice of Bed Hold P CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing faciliti bed-hold periods, wh paragraph (e)(1) of the resident to return; and (iv) The information s of this section. §483.15(d)(2) Bed-hold the time of transfer of hospitalization or their facility must provide to resident representative specifies the duration described in paragrap	as soon as practicable charge. ombudsman in these t when practicable, such as a monthly basis. olicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to nt representative that e state bed-hold policy, if e resident is permitted to sidence in the nursing wayment policy in the state of this chapter, if any; cy's policies regarding ich must be consistent with his section, permitting a d pecified in paragraph (e)(1)	F 623		5/7/21		

Facility ID: 0296

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/09/2021 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTIV	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495347	B. WING			03	/26/2021
NAME OF PROVIDER OF	RSUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULATE HEALT				2	23352 COURTHOUSE HIGHWAY		
CONCOLATE MEAL				V	WINDSOR, VA 23487		
	ACH 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
 2. The f #91 was bed-hold transfer/ Residen on 09/25 included Pulmona The curr assessm (ARD) o out of a Interview severe of The Disc 08/09/20 On 08/09 document observed nurse's s noted fa from the call physis send Re hospital, with oxy On 03/25 interview who statt been set the hospital, was info 	provided a v d and reserved discharge to t #91 was ori 0/17. Diagno but not limite ary Disease (rent Minimum hent with an A f 03/01/21 co possible scor v for Mental S cognitive impa charge MDS 0 - discharged 0/20, accordi ntation read i d ambulating station and w cial drooping mouth and r sician made a sident #91 or VS: (BP) 12 gen saturatio 5/21 at appro- v was conduc- red, "The bed nt with the re pital."	alied to ensure that Resident written copy of the facility's e bed payment policy upon the hospital on 08/09/20. ginally admitted to the facility sis for Resident #91 ed to Chronic Obstructive COPD.) a Data Set (MDS), a quarterly Assessment Reference Date ded the resident with a 06 re of 15 on the Brief Status (BIMS) indicating airment. assessments was dated for d with return anticipated. Ing to the facility's n part, "Resident #91, was out of her room towards as met by staff member, to left side of face, drooling numbling her words. The on aware with new orders to ut via 911 to the local 0/78, (P) 72, (R) 18, (T) 97.5	F	625	 Resident #91 was transferred to the hospital on 8/9/2020 Resident #94 was transferred to the hospital on 1/25/2021 and readmitted the facility on 2/2/2021. Bed hold polic provided to both residents as of 4/9/20 The Director of Nursing, or Designe will conduct a Quality Review of resid- discharged over the last 30 days to determine if a bed hold policy was ser with the resident upon transfer to the hospital Follow up based on findings. Director of Nursing, or Designee, w educate licensed nurses on required documentation with hospital transfers include bed hold policy and care plan goals. The DON, or Designee, will re- information provided during resident transfers, to include appropriate documentation, for 6 weeks, and as needed. The results of the Quality Monitorin be reviewed at the monthly QAPI meetings for review, analysis, and fur recommendations. Date of Completion – May 7, 2021 	to cy 021. ee, ents nt fill to view	

Facility ID: 0296

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		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMP	LETED
		495347	B. WING			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 625	did not present any fu findings. Based on resident rec and facility document	cord review, staff interviews review, the facility staff esidents (Resident #91 and	F	625			
	transferred to a hospi 35 residents.	tal, in the survey sample of					

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING		03/26/2021	
	ROVIDER OR SUPPLIER TE HEALTH CARE OF W	/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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 475	
F 625	Continued From page	9 39	F 62	25		
	The findings included	:				
	2/2/21 with diagnoses hypertension, type two and heart failure. The a copy of the facility's	re-admitted to the facility which included o diabetes, Bipolar disorder facility staff failed to provide Bed Hold Policy prior to he hospital on 1/25/21.				
	assessment with an A					
	A nursing note dated #94 was discharged f transferred to the hos					
		•				
F 641 SS=D	facility's Bed Hold Pol being transferred to th Accuracy of Assessm		F 64	11	5/7/21	
	resident's status. This REQUIREMENT by:	of Assessments. t accurately reflect the is not met as evidenced n, resident interview, staff		1. Resident #70 MDS modified on		
		record review, the facility's		3/25/21 to accurately reflect the reside	nt's	

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Facility ID: 0296

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/09/2021 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		495347	B. WING			03/26/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CONSUL	TE HEALTH CARE OF V	VINDSOR		2	3352 COURTHOUSE HIGHWAY			
CONCOL		INDOOR		V	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	Continued From page	e 40	F	641				
		sment at sections "H0100"			use of an indwelling catheter.			
		ppliances and "H0300"			2. Quality monitor review will be			
	#70), in the survey sa	or 1 of 35 residents (Resident			conducted by MDS Coordinator of assessments completed within the part	st		
		imple.			30 days to ensure accuracy of "H0100			
	The findings included	i:			and "H0300". Follow up will be based findings.			
		iginally admitted to the facility						
		er been discharged from the			3. MDS Coordinator will be educated	on		
		iagnoses included; stroke, rgement of the prostate			MDS accuracy according to the RAI manual, to include completion of "H01	00"		
	gland, and a neuroge	-			and "H0300" by the Regional MDS Coordinator. Prior to submission of M			
	The quarterly Minimu	ım Data Set (MDS)			Assessments, the IDT will review the			
		assessment reference date			assessment date to verify accuracy of			
	(ARD) of 2/18/21 cod				these sections. The Executive Directo			
		Interview for Mental Status 3 out of a possible 15. This			or Designee, will complete quality mor review weekly for 6 weeks to validate	nitor		
		70's cognitive abilities for			MDS assessment accuracy.			
	daily decision making							
					4. Findings will be reported to the QAR	기		
		cal functioning) the resident			Committee monthly for review, analys	is,		
	with toileting. In secti	ng total care of one person on "H" the resident was			and further recommendations.			
		ces such as an indwelling ent catheter, and at the best			5. Date of Completion – May 7, 2021			
		continence the resident was						
	Resident #70 had a p 10/1/20, for an indwe							
	secondary to neuroge							
	from 2/12/21 through	nent Administration Record 2/18/21, revealed Resident						
l	#70 did have an indw catheter care was pro	velling catheter in place and ovided.						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		495347	B. WING			03	/26/2021	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	The current care plan (name of the resident related to a neurogen (name of the resident catheter-related traum (name of the resident urinary tract infection The interventions incl shift and as needed. as ordered. Monitor/o pain/discomfort due to bag and tubing below away from entrance r allowing drainage bag During an interview w at approximately 1:50 bag was observed att The resident was una utilizing an indwelling catheter The Resident Assess manual stated at "HO appliance that was us days. Select none of appliances A-D were read indwelling catheter catheter and nephros MDS 3.0 chapter 3 pa The (RAI) manual stat not rated: if during the resident had an indwe condom catheter, oste is on chronic dialysis	had a problem which read;) has Indwelling catheter ic bladder. The goal read;) will be/remain free from ha through review date.) will be free of symptoms of (UTI) through review date. uded; Catheter care every Change catheter and bag document for the level of the bladder and com door. Refrain from g to rest on floor. With Resident #70 on 3/23/21 1 p.m., a bedside drainage ached to the bed frame. ble to state if he was catheter or a condom ment Instrument (RAI) 100" to check next to each the above if none of the used in the past 7 days. A. ter (including suprapubic tomy tube). (RAI manual, age H-2). ted at at "H0300" to code 9,	F	641				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER						
CONSULA	TE HEALTH CARE OF W	INDSOR			3352 COURTHOUSE HIGHWAY /INDSOR, VA 23487		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 641 F 689 SS=D	An interview was come Coordinator on 3/25/2 a.m. The MDS Coordinator on 3/25/2 a.m. The MDS Coordinator presented a modification of the M made. At approximat Coordinator presented assessment. The mo the resident utilized a "H0100" and his urinative was not rated. On 3/25/21, at approximation information was shared Director, the Director Corporate Consultant offered to the facility's information but no add provided. Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on clinical rec and facility document to provide supervision interventions to reduct	ducted with the MDS 1 at approximately 11:27 linator stated the MDS was "H0100" and "H0300" and MDS assessment would be ely 12:40 p.m., the MDS d a copy of the modified dified assessment stated n indwelling catheter at ry continence at "H0300" imately 2:00 p.m. the above ed with the Executive of Nursing and the . An opportunity was a staff to present additional ditional information was ards/Supervision/Devices 2)		641	Past noncompliance: no plan of correction required.		4/12/21

Event ID: GNW911

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	43	F	689	9		
	The findings included	:					
	staff interviews and P of Corrections the fac supervision and imple	hazards for one resident					
	The findings included	:					
		l to provide supervision and ns to reduce environmental ent (Resident #4).					
	The facility presented Past-Non-Compliance elopement of Resider	e in response to an					
	Psoriasis, Disorder of and Anxiety. Resider completed on 7/28/20 Resident #4 was able	es that included the Disease, Peripheral foliative dermatitis, Pruritus, urea cycle, Xerosis cutis, tt BIMS score is 3					
	Initial Report 7/26/20						
	assessed by a license	esident elopement. Resident ed nurse, no injuries ent. Responsible Party and					

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495347	B. WING			03	/26/2021	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	reported that the resid ambulating in the hall Statement collected fi unit stated that she w station going over her and she noticed that if the unit door at the er standing there." She if prompted her to look immediately went to t escorted the resident incident. When asked the resident stated, "I could kill the bugs that heat will kill them." Up was discovered that t contributed to the inci Resident has Wander however, the door she door secured for the N Root Cause of the inci the door was disarmen nurses' station due to to the parking lot. Door pushed open if set ap The alarm panel is not disarm. Findings: Upon comp the resident did eloper not leave the property injuries while she was Actions and On-Going 1. Staff education on Procedures initiated.	nvestigation of the incident, dent had been up way with her walker. rom one of the CNA's on the as sitting at the nurses r assignment for charting the resident was outside of ad of the hallway 'Just heard the door click which up from her charting. She he door to open it and back in without further what she was trying to do, wanted to be in the sun so I at are crawling on me. The bon further investigation, it he following actions dent: Guard device in place, e exited out of was not a Wander guards. cident was that the alarm for d from the panel at the staff exiting out of the door or generally alarms when propriately. It secured, allowing staff to letion of the investigation and did not sustain any s outside of the facility. g Interventions:	F	68	9			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/09/2021 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	E SURVEY PLETED
		495347	B. WING			03	/26/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W				23352 COURTHOUSE HIGHWAY		
CONSOLA		MADSOR			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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	 Head to toe assess licensed nurse to assess skin also checked to e present on her skin or present. Care Plan updated scratching. Care plan updated to include ex triggers and pharmace non-pharmacological NP assessed the re- interventions in place a. Aquaphor Ointmen psoriasis Tea Tree Oil topica dermatitis Permethrin Cream 12 hours after applyin exposure Bendaryl 25 mg. ev itching Cetaphil cream-app f. Ketoconazole Sharr eery 4 days for 4 wee completed on 8/24 g. Prednisone 10 mg. Gabepentin 100 mg pruritus for 14 days - i. Buspar 5 mg. v by n Generalized anxiety- All alarms on the pa ensure proper functio Maintenance Direct alarm panels at each 	sment completed by a ess for injuries. Resident's ensure no bugs were r in/on her clothing. None , to include interventions for and behavior monitoring it seeking along with ological and interventions. esident. Current for the resident include: t three times a day for Ily daily for Exfoliative every 7 days - Wash off for of for suspected scabies very 8 hours as needed for obly to skin daily spoo- apply to scalp topically ks for psoriasis - to be by mouth daily for psoriasis g by mouth at bedtime for To be completed 8/6 nouth daily for 14 days for	F	689	9		

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	-					FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
		495347	B. WING			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CONSULA	TE HEALTH CARE OF W	INDSOR		2	23352 COURTHOUSE HIGHWAY		
				١	WINDSOR, VA 23487		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 689	Continued From page	246	F	689			
	medication carts.						
		nsure box is secured every with securing the box, these					
		Maintenance Director					
	immediately.						
	8 The facility will con	tinue to conduct ongoing					
		t. All additional incidents of					
	elopement will be rep	orted as required.					
		ported to QAPI committee mpliance and or revision."					
		Inpliance and or revision.					
		Iopement Risk Evaluation					
	dated 7/16/19 that inc						
	1. Resident is cognitiv	very imparieu					
	2. Resident is indepen	ndently mobile					
	3. Resident have poo	r decision-making skills					
	4. Resident has not d behaviors	emonstrated exit seeking					
	5. Resident is not obli	ivious to safety needs					
	6. Does the resident h	nave a history of elopement,					
	7. Does the resident h facility, yes	nave the ability to exit the					
		risk factors above, resident t risk for elopement, NO					
	Resident #4 had an E dated 7/26/19 that inc	Elopement Risk Evaluation dicated:					
	1. Resident is cognitiv	vely impaired					

Event ID: GNW911

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
		495347	B. WING _			03/	26/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
CONSULA	ATE HEALTH CARE OF W	VINDSOR			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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 47	F6	689				
	2. Resident is indepe	ndently mobile						
	3. Resident have poo	r decision-making skills						
	4. Resident has demo behaviors	onstrated exit seeking						
	5. Resident is not obl	ivious to safety needs						
	6. Does the resident I yes - If yes how many	nave a history of elopement, / times (2)						
	7. Does the resident I facility, yes	nave the ability to exit the						
	-	risk factors above, resident t risk for elopement, YES						
	Resident #4 is an elo safety awareness, co resident's safety will t review date. The resident unattended through the	be maintained through the dent will not leave facility ne review date. Intervention- device, monitor for function						
	indicated: "Chief com attempted elopement outside exit door, She and Resident #4 state sunlight for her pruriti	lote dated 7/23/20 at (12:29) plaint: Agitation, Pruritis and - Resident #4 walked e was brought back in by NP ed she wanted some s, stating "it will help kill lo visible bugs noted on						
		te dated 7/26/20 at (10:45 sident seen standing outside						

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495347	B. WING			03/	/26/2021
NAME OF P	ROVIDER OR SUPPLIER		I	:	STREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
CONSULA	TE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	exited. The exit was r the door did not go of wander guard on. Wh outside she was prom When asked why she sun will get these bug on skin." Nursing Progress Not P.M.) indicated: "Elop skin assessment com are delusions when th he discomfort, Reside some sun to kill all the During an interview of the Maintenance Dire him aware that the do properly. The Mainter check the doors once Director stated, he plat the door to ensure the disarmed. During an interview w 3/25/21 at 10:30 A.M. using the door to go in the staff parking lot. Observations made d staff parking lot was in door. A facility Delayed Egr indicated: "Visually in signage is in place to	eet from the door where she not witnessed. The alarm on f, and resident does have a en resident was seen nptly brought back inside. was outside she stated "the as or evidence of bug bites the dated 7/26/20 at (14:02 mement assessment, and pleted. Behavioral problems he resident was asked about ent claimed, I wanted to get bugs that are on me." In 3/25/21 at 10:13 A.M. with ctor he stated, no one made hor was not functioning hance Director stated he a week. The Maintenance aced a locked key system on a alarm could not be with the Administrator on she stated, staff had been in and out of the building to uring the survey indicated a in close proximity to the exit	F	689	ο		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495347	B. WING _			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CONSULA	TE HEALTH CARE OF W	/INDSOR			3352 COURTHOUSE HIGHWAY IINDSOR, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690			F 6				5/7/04
F 690 SS=D			F 6	90			5/7/21
	admission receives se maintain continence u	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is					
	ensure that- (i) A resident who entrindwelling catheter is resident's clinical com- catheterization was me (ii) A resident who entrindwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the extern	on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.					
	ensure that a resident receives appropriate t restore as much norm possible.	on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to					

Facility ID: 0296

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			OMB NO	1 APPROVEI 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE COMP	
		495347	B. WING _		03/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
CONSUL	TE HEALTH CARE OF V	VINDSOP		23352 COURTHOUSE HIGHWAY		
CONCOL		Meddek		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 C ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 690	Based on observation record review, the fact appropriate care and prevent/reduce traum bladder, and other con- indwelling catheter for #70), in the survey sat The findings included Resident #70 was orf 8/29/20 and had never facility. The current d hemiparesis, an enla- gland, and a neuroge The quarterly Minimu assessment with an a (ARD) of 2/18/21 cod	on, staff interview, and clinical cility's staff failed to ensure services were provided to na to the urethra and omplications while utilizing an or 1 of 35 residents (Resident ample. d: iginally admitted to the facility er been discharged from the iagnoses included; stroke, rgement of the prostate enic bladder. Im Data Set (MDS) assessment reference date	F6	 1. The facility failed to er #70, had a securement d while having an indwelling place. Securement device immediately upon identifie deficient practice. 2. Quality monitor review physicians' orders for ind will be reviewed by the D to ensure securement de place. Follow up based of 3. Licensed nursing staff, by DON or Designee on f physicians' orders and pr in accordance with profess of practice for indwelling DON or Designee will con observations, to ensure s 	evice in place g catheter in ce placed cation of of residents with welling catheters, ON or Designee, vices are in on findings. , will be educated following roviding services ssional standard catheters. The mplete random	
	(BIMS) and scoring 1 indicated Resident #1 daily decision making In section "G" (Physic was coded as requiri with toileting. In secti coded for no appliand catheter, an intermitted description of urinary coded as always inco Resident #70 had a p 10/1/20, for an indwe secondary to neuroge The current care plan (name of the resident	3 out of a possible 15. This 70's cognitive abilities for g were intact. cal functioning) the resident ng total care of one person on "H" the resident was ces such as an indwelling ent catheter, and at the best continence the resident was ontinent.		 devices are in place on the with indwelling catheters weeks, will complete randobservations. 4. The results of the qual will be reported to the qual committee team monthly analysis. 5. Date of Compliance: Note that the provide the provide the provided to the qual committee team monthly analysis. 	weekly x 6 dom ity monitoring, ality assurance for review	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	(name of the resident catheter-related traum (name of the resident urinary tract infection The interventions incl shift and as needed. as ordered. Monitor/o pain/discomfort due to bag and tubing below away from entrance re allowing drainage bag On 3/23/21 at approxi- drainage bag was obs frame. The resident was utilizing an indwe catheter. Again on 3/ 10:50 a.m. a bedside attached to the bed fr was observed with lig 3/25/21 at approximation observation was mad with Licensed Practice resident had an indwe drainage bag. The in secured and/or stabilic catheter should have but; apparently when was changed a few d amount of sediment in to attach the stabilized resident and explaine secure the catheter to The facility's policy titl Female Urinary with a read under Male Cath) will be/remain free from na through review date.) will be free of symptoms of (UTI) through review date. uded; Catheter care every Change catheter and bag document for o catheter. Position catheter the level of the bladder and oom door. Refrain from g to rest on floor. imately 1:50 p.m., a bedside served attached to the bed was unable to state if he elling catheter or a condom 24/21 at approximately drainage bag was observed ame and the catheter tubing ht yellow urine in it. On tely 10:55 a.m., an e of the residents catheter al Nurse (LPN) #1. The elling catheter to a bedside dwelling catheter wasn't zed. LPN #1 stated the been secured at the thigh the catheter drainage tubing ays ago because of a large in the tubing the staff forgot r. LPN #1 covered the d she would be back to o his thigh.	F	690			

Facility ID: 0296

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	-	D HUMAN SERVICES				FORM	MAPPROVED
	FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF (CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		COMF	PLETED
		495347	B. WING			03/	26/2021
NAME OF PRO	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULAT	E HEALTH CARE OF W	INDSOR			23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 758 SS=D	stabilization. The drain catheter is taped to th abdomen. The area o for taping with women catheter use the site o abdomen. (http://www On 3/25/21, at approx information was share Director, the Director of Corporate Consultant stated the resident's in have been secured ai removal and/or trauma Free from Unnec Psyc CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behavio but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe- resident, the facility m §483.45(e)(1) Resider psychotropic drugs ar unless the medication	a frequent method used for nage tube attached to the e person's thigh or f the thigh is the best site a. Men to secure the of the thigh or lower a public.asu.edu/) imately 2:00 p.m. the above ed with the Executive of Nursing and the . The Director of Nursing indwelling catheter should d in preventing accidental a. chotropic Meds/PRN Use e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following		758			5/7/21

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/0 FORM APPF OMB NO. 0938	ROVE
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	Υ
		495347	B. WING		03/26/202	21
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	TE HEALTH CARE OF V	VINDSOR		23352 COURTHOUSE HIGHWAY		
CONCOLF		Indector		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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMP	X5) PLETION ATE
F 758		e 53 ents who use psychotropic	F 75	58		
	drugs receive gradua behavioral interventio	I dose reductions, and				
	unless that medication	ursuant to a PRN order on is necessary to treat a ondition that is documented				
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the Pl beyond 14 days, he o	RN order to be extended or she should document their ent's medical record and				
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. Γ is not met as evidenced				
	interviews and facility staff failed to ensure Trazadone was follow	ecord record review, staff / document review the facility a gradual dose reduction for ved through for 1 of 35 /ey sample, Resident #88.		1. The facility failed to ensure a dose reduction for Trazadone wa completed for Resident #88. MI on 3/25/2021 for resident assess needed for GDR.	as D notified	
	7/18/19 with diagnose	l: Imitted to the facility on es to include but not limited sorder, Bipolar Disorder and		2. Resident currently residing in that, are prescribed psychotropic medication have the potential to affected. A quality monitor review conducted by the DON/Designe	c be w will be	

Event ID: GNW911

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495347	B. WING			03	/26/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 758	Major Depressive Dis The most recent MDS Resident #88 was a C ARD (Assessment Re Resident #88's BIMS Status) score was a 1 indicating the residen capable of daily decis NO410 Medications F received Days: Antid Resident #88's Pharm 10/1/20 through 10/30 documented in part, a Recommendation dat Comment: Name (Re mg(milligrams) QHS (Recommendation: PI dose reduction (GRD discontinuation, while reemergence of targe symptoms. Rationale for Recomm be attempted in 2 sep 1 month between atter which an individual is medication or after the medication, and then contraindicated.	order. 6 (Minimum Data Set) for Quarterly Assessment with a eference Date) of 3/2/21. (Brief Interview for Mental 5 out of a possible 15 t was cognitively intact and ion making. Under Section Received, C. Medication epressant-7. macy Consultation Report for 0/20 was reviewed and is as follows: a 10/10/20. esident #88) Trazadone 50 (every day at bedtime). lease attempt a gradual), with the end goal of concurrently monitoring for at and/or withdrawal mendation: A GDR should parate quarters, with at least empts, within the first year in admitted on a psychotropic e facility has initiated such annually unless clinically e: I accept the ve WITH THE FOLLOWING	F	758	 ensure residents with orders to GDR a completed. 3. Licensed nursing staff will be educated by the DON/Designee on the policy for GDR and following through with the physician's order. Random observation will be conducted by the DON/Designee weekly x 6 weeks, to ensure that GDR are completed timely and as ordered. 4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review and analysis. 5. Date of Compliance: May 7, 2021. 	nted r ns ee X's J, ce	

If continuation sheet Page 55 of 71

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/09/2021 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING _			03/	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET 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 758	Continued From page	9 55	F7	758			
	Physician Signature: Date: 10/29/20.	Name (Medical Doctor)					
		ation Administration ed 10/1/2020-3/25/2020 re documented in part, as					
	10/1/2020: Trazodon 0.5 tablet by mouth at BIPOLAR Disorder\$						
	0.5 tablet by mouth at	e HCL tablet 100 mg Give t bedtime related to Start Date-09/15/2020					
	0.5 tablet by mouth at	e HCL tablet 100 mg Give t bedtime related to Start Date-09/15/2020					
		HCL tablet 100 mg Give 0.5 dtime related to BIPOLAR 09/15/2020					
		HCL tablet 100 mg Give 0.5 dtime related to BIPOLAR 09/15/2020					
		HCL tablet 100 mg Give 0.5 dtime related to BIPOLAR 09/15/2020					
		nt Physician Orders were rumented in part, as follows:					
	-	zadone HCL Tablet 100 MG uth at bedtime related to R.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495347	B. WING			03/	/26/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
CONSULA	ATE HEALTH CARE OF W	VINDSOR			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 758	Order Status: Active Order Date: 9/15/202 Start Date: 9/15/202 Resident #88's Comp reviewed and is docu Focus: Name (Resident #88) related to bi-polar dis disorder. Date Initiated: 11/01/ Interventions: -Administer Antipsych by physician. Monitor side effects. Date Ini -Dose reduction atten clinically indicated. I Resident #88's Progra and are documented 3/25/2021 16:01 P.M. Note: Note Text: This writer Practitioner), concern Trazadone from 10/2 She stated she would before agreeing to thi the provider at the tim The plan is to continue On 3/25/21 at 1:02 P. conducted with the R Services regarding R GDR order from 10/2 of Clinical Services st	20 Drehensive Care Plan was mented in part, as follows: 1 is on antipsychotic therapy order, schizoaffective 2019. 1 otic medications as ordered behavioral symptoms and tiated: 11/01/2019. npts per evaluation if Date Initiated: 11/01/2019. ess Notes were reviewed in part, as follows: . (4:01) Nursing Progress notified NP (Nurse ing GDR of residents D/20 that was not completed. I need to assess the resident s GDR due to her not being he this GDR was written. le the current treatment. M. a phone interview was egional Director of Clinical esident #88's Trazadone 9/20. The Regional Director tated, "Last night when we	F	758			
	Start Date: 9/15/2020 Resident #88's Comp reviewed and is docu Focus: Name (Resident #88) related to bi-polar dis disorder. Date Initiated: 11/01/ Interventions: -Administer Antipsych by physician. Monitor side effects. Date Ini -Dose reduction atten clinically indicated. If Resident #88's Progrand are documented 3/25/2021 16:01 P.M. Note: Note Text: This writer Practitioner), concern Trazadone from 10/20 She stated she would before agreeing to thi the provider at the tim The plan is to continue On 3/25/21 at 1:02 P. conducted with the R Services regarding R GDR order from 10/20 of Clinical Services st	 brehensive Care Plan was mented in part, as follows: a is on antipsychotic therapy order, schizoaffective 2019. behavioral symptoms and tiated: 11/01/2019. apts per evaluation if Date Initiated: 11/01/2019. ess Notes were reviewed in part, as follows: a (4:01) Nursing Progress notified NP (Nurse ing GDR of residents 9/20 that was not completed. I need to assess the resident s GDR due to her not being the this GDR was written. the current treatment. M. a phone interview was egional Director of Clinical esident #88's Trazadone 9/20. The Regional Director 					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		495347	B. WING		03	/26/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	/INDSOR		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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	10/29/20 was not fold GDR did not happen. Doctor about it and w come in to assess the changes could be ma attending when the G 10/29/20." The facility policy title Management-Psycho revised on 3/23/2018 documented in part, a POLICY: The center implement unless clinically contra- needed) order for psy limited. Procedure: 10. Gradual dose rec attempted per accept unless clinically contra- by the prescriber inclu- benefit. On 3/25/21 a pre-exit Administrator, the Dir Regional Director of C	or the Trazadone dated owed through with. The We called the new Medical ere told she would have to a resident first before de because she was not the DR was ordered on d "Medication tropic Medications" last was reviewed and is as follows: ts gradual dose reduction aindicated and a PRN (as rehotropic medication is duction (GDR) to be ed standards of practice aindicated. Documentation udes specific risk versus debriefing was held with the ector of Nursing and the Clinical Services were the s shared. Prior to exit no as provided. d Biologicals	F 7	758		5/7/21
00-0	§483.45(g) Labeling o Drugs and biologicals	of Drugs and Biologicals used in the facility must be with currently accepted				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	/26/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF W	INDSOR			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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 761	§483.45(h)(1) In acco Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 an abuse, except when the package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on the observand 2 medication root dispose of expired med The facility staff failed medications on the Pe 300 Unit. The findings included On 03/23/21 at appro- inspection of the Med Unit was made with L Nurse) #3. Upon visue	s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. Fility must provide separately affixed compartments for drugs listed in Schedule II of brug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the simal and a missing dose can f is not met as evidenced ation of 3 medication carts ms; the facility staff failed to edications for two units. I to dispose of expired each Unit and The Green carticly 2:25 PM an ication Cart on the Peach PN (Licensed Practical	F	761	 The facility failed to dispose of expi glucagon injectable on the Peach and Green unit medication carts. Expired Glucagon immediately discarded on 3/23/2021. A quality monitoring review will be conducted, by the DON/Designee of th medication of the medication carts and medication rooms. Follow up based of findings. Licensed nursing staff will be educar by DON or Designee regarding the pol for the storage and disposal of expired 	ie n ted	

Facility ID: 0296

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	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		495347	B. WING		03/26/2021	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CONSUL	ATE HEALTH CARE OF W	/INDSOR		2352 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 761	called the pharmacy to On 03/24/21 at appro- inspection of the Med Unit 300 was conduct Practical Nurse) #4. U medication cart one G an expiration date of G "That's way past due. Policy: Facility's Phar Procedures Manual. If Expiration dating of M Syringes and Needles Last revision date: 10 Facility should ensure biologicals that: (1) ha label are stored sepai until destroyed or retu- supplier. On 3/24/21 at approxi- debriefing was condu Administrator, The Re- Services and with the concerning the above voiced. Lab Srvcs Physician G CFR(s): 483.50(a)(2) §483.50(a)(2) The fac (i) Provide or obtain la ordered by a physicial practitioner or clinical	e of 12/2020. LPN #3 e looked in the stat box and to re-order." ximately 10:13 AM an ication Cart on the Green ted with LPN (Licensed Upon visual inspection of the Blucagon Kit was found with 06/2020. LPN #4 stated, We need to get a new one." macy Services and Policy Title: Storage and ledications, Biologicals, s. Effective date: 12/01/07. /28/19. Paige 2 reads: that medications and ave an expiration date on the rate from other medications urned to the pharmacy or imately, 3:00 PM a cted with the Facility egional Director of Clinical DON (Director of Nursing) issue. No comments were Order/Notify of Results (i)(ii) cility must- aboratory services only when n; physician assistant; nurse	F 761	 medications/biologicals from the medication carts and medication root. Weekly observations will be conduct the DON/Designee weekly x 6 week ensure that there are no expired medications present in the medicatic carts and medication rooms. 4. The results of the Quality Monitor be reviewed at monthly QAPI meeting review, analysis, and further recommendations. 5. Date of Compliance: May 7, 2021 	ted by (s, to on ring to ngs for	

Facility ID: 0296

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		ATE SURVEY
		495347	B. WING				03/26/2021
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	3352 COURTHOUSE HIGHWAY		
CONSULA	TE HEALTH CARE OF V	VINDSOR		v	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 APPROPRI, DEFICIENCY)		(X5) COMPLETIO DATE
F 773	Continued From page	- 60		770			
1 115			F	773			
	(ii) Promptly notify the						
		urse practitioner, or clinical					
	-	poratory results that fall					
		erence ranges in accordance					
	with facility policies a	-					
		itioner or per the ordering					
	physician's orders.	- is not mot as suideneed					
		is not met as evidenced					
	by: Based on clinical rec	and review and staff			1. The facility staff failed to provide		
					1. The facility staff failed to provide prompt notification to the physician of		
		's staff failed to promptly f laboratory results which fell			laboratory results for Resident #36. MI	۲	
		range for administration of			notified of lab results on 3/25/2021.	J	
		35 residents (Resident #36),			Resident not affected.		
	in the survey sample.	· · · ·			Resident not anected.		
	in the survey sample.				2. DON/Designee will conduct a quality		
	The findings included	ŀ			review of resident labs from the last 30		
	The mange molded				days to determine if the Physician notif		
	Resident #36 was ori	ginally admitted to the facility			in a timely manner of all lab results.	neu	
		ver been discharged from					
		nt diagnoses included; mild			3. Licensed nursing staff will be educated	ted	
	intellectual disabilities				by the DON/Designee on promptly	lou	
					notifying the physician of lab results. T	he	
	The quarterly Minimu	m Data Set (MDS)			DON/Designee will conduct random		
		assessment reference date			observations of labs to ensure labs are	9	
	(ARD) of 1/16/21 cod				being reported, and addressed weekly		
	· · ·	nterview for Mental Status			6 weeks.		
		out of a possible 15. This					
		36's cognitive abilities for			4. The results of the quality monitoring	,	
		were severely impaired.			will be reported to the quality assurance		
					committee team monthly for review and	d	
		cal functioning) the resident			analysis.		
	•	ed supervision of one person					
		ependent after set-up with			5. Date of Compliance: May 7, 2021		
	-	eting, personal hygiene and					
		dent with bed mobility,					
	walking with a walker	and locomotion in room.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/09/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		ECONSTRUCTION		(X3) DATE	
		495347	B. WING			_	03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	INDSOR			23352 COURTHOUSE HIG WINDSOR, VA 23487	HWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	at 5:30 a.m. the follow by certified nursing as hit his room mate with was asked about incid he did not want him in the residents until a re Observed with scant a bedside and on outer and covered with scant a bedside and on outer and covered with dres or discomfort from eith Further review of the following Physician Ph at 12:17 p.m., "(name per nursing regarding roommate. Per nursin hallway and informed struck him with a walk immediately separate resident) is seen toda to be at baseline. No incident that occurred resident unable to rec recalls striking roomm stated, "No, my cane The physician's assess follows; 1. Physical al agitation this a.m., wit resident with cane, se Urinalysis (UA) Cultur Labs on Monday. A urinalysis report wa record as obtained 1/3 The urinalysis was sig 2/1/21 and an order w Monohyd Macro Caps	ving nurse's note "Informed asistant (CNA) that resident the a cane. When resident dent resident responded that the room. Writer separated esolution could be made. amount of blood on floor at left forearm. Area cleansed asing. No complaint of pain ther resident at this time". clinical record revealed the rogress Note dated 1/29/21 of resident) is seen today physical altercation with ng, roommate entered into staff that (name of resident) king cane. Residents d for safety. (name of y sitting up in chair, seems distress. Inquired about earlier this a.m. and hall events. Inquired if he hate with his cane and he is gone". assment and plan was as tercation, acute th other resident. Struck	F	773				

Facility ID: 0296

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2021 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495347	B. WING		_	03/2	26/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, S			
CONSULA	TE HEALTH CARE OF W	VINDSOR		3352 COURTHOUSE HIG VINDSOR, VA 23487	HWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	(UTI). Start Date - 02/ Further review of the didn't reveal the C&S Nurse #1 was asked of clinical record for the stated the report was would retrieve it from wasn't obtained throu routinely processes the facility's staff has imm On 3/25/21 at approxi- provided the final C&S reveal 15,000 colonie bacteria, isolated. LP laboratory report was the practitioner's sign the practitioner had re- further stated resident with an antibiotic whe a UTI (urgency, increa- pain) and less than 10 growing. LPN #1 furth the time of the lab rep Nursing and the Assis were responsible to for results and use of the On 3/25/21, at approxi- information was share	a urinary tract infection 02/2021 0900. clinical record on 3/24/21, report. Licensed Practical on 3/25/21 to review the C&S report as well. LPN #1 n't on the record but she the local laboratory for it gh the laboratory which heir labs and for which the neediate access. mately 12:10 p.m., LPN #1 S of the urine report which is of mixed urogenital flora in #1 stated because the n't on the clinical record with ature on it she couldn't say eviewed the report. LPN #1 I's are not normally treated in there there are no signs of ased frequency, burning or 00,000 colonies of bacteria her stated she was out at bort therefore; the Director of stant Director of Nursing blow-up on the laboratory antibiotic to treat. stimately 2:00 p.m. the above ed with the Executive	F 773				
	stated practitioners do colonies of bacteria in	. The Director of Nursing on't routinely treat 15,000 of the urine with an antibiotic ractitioners wasn't aware of					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		E SURVEY PLETED
		495347	B. WING			03	/26/2021
NAME OF PI	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF V	VINDSOR					
				N N	/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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 775	Continued From page	e 63	F	775			
F 775 SS=D	Lab Reports in Reco	rd - Lab Name/Address		775			5/7/21
	§483.50(a)(2) The fa (iv) File in the resider	cility must- nt's clinical record laboratory					
-	address of the testing	d and contain the name and g laboratory. Γ is not met as evidenced					
	by:	is not met as evidenced					
Bas inter labo	Based on clinical rec	cord review and staff			1. The facility failed to have to have fin	al	
	interviews, the facility	's staff failed to have			lab results obtained for the clinical reco		
	laboratory results obt	ained 1/30/21, on the clinical			for Resident #36. Lab results obtained	on	
	record for 1 of 35 res	idents (Resident #36), in the			3/25/2021. Resident not affected.		
	survey sample.						
					2. DON/Designee will conduct a quality		
	The findings included	1:			review of residents' clinical record in the	e	
					last 30 days to determine if lab results		
	Resident #36 was ori	ginally admitted to the facility			have been filed in the clinical record aft	er	
	12/27/18 and had ne	ver been discharged from			they have been addressed by the		
	the facility. The curre	nt diagnoses included; mild			physician.		
	intellectual disabilities	s and dementia.					
					3. Medical Records Staff and Licensed		
	The quarterly Minimu	ım Data Set (MDS)			Nursing Staff will be educated by the		
		assessment reference date			DON/Designee on promptly filing lab		
	(ARD) of 1/16/21 cod				results into the residents' clinical record		
		nterview for Mental Status			The DON/Designee will conduct randor		
	, ,	out of a possible 15. This			observations of clinical records to ensur	re	
		36's cognitive abilities for			labs are being promptly filed and		
		y were severely impaired. al functioning) the resident			addressed in the clinical record weekly 6 weeks.	for	
		ed supervision of one person			4. The results of the quality monitoring,		
		lependent after set-up with			will be reported to the quality assurance	2	
		eting, personal hygiene and			committee		
		dent with bed mobility,			team monthly for review and analysis.		
		and locomotion in room.			team monthly for review and analysis.		
					5. Date of Compliance: May 7, 2021		
	Review of the clinical	record revealed on 1/29/21					
		wing nurse's note "Informed					

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 11/09/2021 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE	
		495347	B. WING			_	03/2	26/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF W	INDSOR			3352 COURTHOUSE HIGH /INDSOR, VA 23487	łWAY		
(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	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 775	by certified nursing as hit his room mate with was asked about incid he did not want him in the residents until a re Observed with scant a bedside and on outer and covered with dres or discomfort from eitt Further review of the following Physician Pi at 12:17 p.m., "(name per nursing regarding roommate. Per nursin hallway and informed struck him with a walk immediately separate resident) is seen toda to be at baseline. No incident that occurred resident unable to rec recalls striking roomm stated, "No, my cane The physician's Asses follows 1. Physical alt Agitation this a.m. wit resident with cane-se Urinalysis (UA) Cultur Labs on Monday. A urinalysis report wa record as obtained 1/ The urinalysis was sig 2/1/21 and an order w Monohyd Macro Caps Give 1 capsule by mo	sistant (CNA) that resident a cane. When resident dent resident responded that the room. Writer separated esolution could be made. amount of blood on floor at left forearm. Area cleansed using. No complaint of pain her resident at this time". clinical record revealed the rogress Note dated 1/29/21 of resident) is seen today physical altercation with ng, roommate entered into staff that (name of resident) ting cane. Residents d for safety. (name of y sitting up in chair, seems distress. Inquired about earlier this a.m. and all events. Inquired if he nate with his cane and he is gone". ssment and plan was as ercation, acute h other resident. Struck	F 7	75				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2021 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	
		495347	B. WING			03/:	26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	INDSOR		23352 COURTHOUSE HIGHN WINDSOR, VA 23487	WAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 775	didn't reveal the C&S Nurse #1 was asked of clinical record for the stated the report was would retrieve it from wasn't obtained throu routinely processes the facility's staff has imm On 3/25/21 at approxi- provided the final C&S reveal 15,000 colonie isolated. LPN #1 stat report wasn't on the of practitioner had review further stated resident with an antibiotic whe a UTI (urgency, increa- pain) and less than 10 LPN #1 further stated the lab report therefor and the Assistant Dire- responsible to follow-fa- and use of the antibio On 3/25/21, at approx- information was share Director, the Director Corporate Consultant stated routine lab repor- dashboard but immed process by another en-	02/2021 0900. clinical record on 3/24/21, report. Licensed Practical on 3/25/21 to review the C&S report as well. LPN #1 n't on the record but she the local laboratory for it gh the laboratory which heir labs and for which the hediate access. mately 12:10 p.m., LPN #1 S of the urine report which is of mixed urogenital flora ed because the laboratory linical record with the e on it she couldn't say the wed the report. LPN #1 t's are not normally treated in there there are no signs of ased frequency, burning or 00,000 colonies growing. she was out at the time of e; the Director of Nursing ector of Nursing were up on the laboratory results tic to treat. timately 2:00 p.m. the above ed with the Executive of Nursing and the . The Director of Nursing borts are available on the liate requested labs are netity and the report is faxed e laboratory report is crucial	F 775				
	to the facility and if the						

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		495347	B. WING _			03/26/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
CONSULA	TE HEALTH CARE OF W	VINDSOR		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 881	Continued From page	e 66	F 8	81		
F 881 SS=D	Antibiotic Stewardshi	p Program	F 8			5/7/21
	program. The facility must esta and control program (a minimum, the follow	-				
	that includes antibioti system to monitor and This REQUIREMENT by:	is not met as evidenced				
	unnecessary adminis seven days (use of a	's staff failed to ensure tration of an antibiotic for n antibiotic when an infection ^r 1 of 35 residents (Resident		1. The facility failed to ensu unnecessary administration antibiotic for seven days for Resident not affected. Antib discontinued on 2/8/2021.	of an Resident #36.	
	The findings included			2. DON/Designee will condu review of residents that rece	ived	
	12/27/18 and had nev	ginally admitted to the facility ver been discharged from nt diagnoses included; mild s and dementia.		antibiotics in the last 30 days if lab results were in clinical warrant antibiotic use. Follo on findings.	range to	
	The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were severely impaired.			3. Licensed nursing staff will by the DON/Designee on pro- notifying the physician of lab immediately in order for resu- reviewed to determine if anti warranted. The DON/Desig conduct random observation ensure labs are being report addressed weekly x 6 weeks	omptly o results ults to be ibiotic gnee will ns of labs to red, and	
	was coded as require	cal functioning) the resident ed supervision of one person ependent after set-up with		4. The results of the quality i will be reported to the quality		

Facility ID: 0296

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	MPLETED
		495347	B. WING		0	3/26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
CONSULA	TE HEALTH CARE OF W	VINDSOR		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 881	Continued From page	e 67	F 88 ⁻	1		
	bathing and independ	ting, personal hygiene and lent with bed mobility,		committee team monthly fo analysis.	or review and	
	walking with a walker	and locomotion in room.		5. Date of Compliance: Ma	av 7. 2021	
	at 5:30 a.m. the follow by certified nursing as hit his room mate with was asked about incid he did not want him in the residents until a ro Observed with scant a bedside and on outer and covered with dres or discomfort from eit	record revealed on 1/29/21 ving nurse's note "Informed ssistant (CNA) that resident in a cane. When resident dent resident responded that in the room. Writer separated esolution could be made. amount of blood on floor at left forearm. Area cleansed ssing. No complaint of pain her resident at this time".				
	at 12:17 p.m., "(name per nursing regarding roommate. Per nursi	rogress Note dated 1/29/21 of resident) is seen today physical altercation with ng, roommate entered into staff that (name of resident)				
	struck him with a walk immediately separate resident) is seen toda to be at baseline. No incident that occurred resident unable to rec	king cane. Residents ed for safety. (name of ny sitting up in chair, seems distress. Inquired about				
	stated, "No, my cane The physician's asses	is gone". ssment and plan was as				
	resident with cane, se	th other resident. Struck				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CONSULA	ATE HEALTH CARE OF W	/INDSOR			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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 881	The urinalysis was sig 2/1/21 and an order w Monohyd Macro Caps Give 1 capsule by mo seven days related to (UTI). Start Date - 02. Further review of the didn't reveal the C&S Nurse #1 was asked clinical record for the stated the report was would retrieve it from wasn't obtained throu routinely processes th facility's staff has imm On 3/25/21 at approx provided the final C&S reveal 15,000 colonie bacteria, isolated. LF laboratory report was the practitioner's sign the practitioner had re further stated residen with an antibiotic whe a UTI (urgency, increa- pain) and less than 10 growing. LPN #1 furt the time of the lab rep Nursing and the Assis were responsible to for results and use of the Review of the medica revealed Resident #3 Monohyd Macro Caps	30/21 and reported 1/31/21. gned by a practitioner on vas given for Nitrofurantoin sule 100 MG (an antibiotic). both two times a day for a urinary tract infection /02/2021 0900. clinical record on 3/24/21, report. Licensed Practical on 3/25/21 to review the C&S report as well. LPN #1 n't on the record but she the local laboratory for it gh the laboratory which heir labs and for which the nediate access. imately 12:10 p.m., LPN #1 S of the urine report which s of mixed urogenital flora PN #1 stated because the n't on the clinical record with ature on it she couldn't say eviewed the report. LPN #1 t's are not normally treated n there there are no signs of ased frequency, burning or 00,000 colonies of bacteria her stated she was out at port therefore; the Director of stant Director of Nursing pollow-up on the laboratory	F	881			

Facility ID: 0296

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495347	B. WING			03/	26/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CONSUL	TE HEALTH CARE OF W	/INDSOR			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 881	seven days, as evided signatures. On 3/25/21, at approvation was Director, the Director Corporate Consultant stated practitioners do colonies of bacteria in and it appeared the p the laboratory results ordered antibiotic. Health care profession of your urine to diagn rare cases, a health corder another test to b Lab tests Urinalysis. You will conspecial container at a health care profession bacteria and white bloc produces to fight infect found in the urine of h infection is diagnosed symptoms and lab test Urine culture. In some professional may cult what type of bacteria Urine culture is not re- important in certain ci- having repeated UTIs conditions. The result about 2 days to return care professional deta for you.	A control of the second of the the the the second of the	F	881			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/09/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		495347	B. WING		_	03/2	26/2021
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CONSULA	TE HEALTH CARE OF W	VINDSOR		23352 COURTHOUSE HIG	HWAY		
				WINDSOR, VA 23487			0.1-1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 881	Continued From page	e 70	F 88	1			
		r-infection-uti-in-adults/diagn					
	should be collected b antibiotics. While the are pending, the initia delayed until the resu available, if possible. directed at the specifi antibiotics are started agent should be reeva are available.	results of the urine culture tion of antibiotics should be lts of the culture are This way, therapy can be c pathogen(s).2,11 When empirically, the choice of aluated once culture results					
		.nih.gov/pmc/articles/PMC5					

Event ID: GNW911

Facility ID: 0296

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