STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 11/08/21 to 11/11/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/08/21 to 11/11/21 Survey Census: 195 Sample Size: 65 Supplemental Residents: 0 A deficiency was cited related to Intake ID VA00050895. No deficiencies were cited related to Intake ID VA00051152. No deficiencies were cited related to Intake ID VA00049979. No deficiencies were cited related to Intake ID VA00049878. No deficiencies were cited related to Intake ID VA00049730.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		12/26/21

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

Electronically Signed | 12/12/2021

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.

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F 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policies, the facility failed to ensure two residents (Resident (R) 194 and R22) were assessed for the self-administration of prescribed medications out of a survey sample of 65. Specifically, the nursing staff left medications at the bedside for R194 and R22. In addition, the facility failed to properly assess each resident and identify the decision-making process to show the capabilities of each resident to self-administer medications. Findings Include: Review of a facility policy and procedure titled "Self-Administration of Medication at Bedside," dated 11/30/14, documented "The resident may request to keep medications at bedside for self-administration. . . Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. Procedure: Verify physician's order in the resident's chart for self-administration of specific medications. . . Complete Self-administration of Medications Evaluation. The interdisciplinary Team will review the evaluation and will document. . . Complete the Care Plan for approved self-administered drugs. . . The MAR [Medication Administration Record] must identify meds [medications] that are self-administered. . . nurse will need to follow-up with resident as to documentation and storage of	F 554	1. R22 / R194 assessed for self -administration of Medication and found unable to self -administer 2. Resident with a 15 BIMS will be reassessed for self- administration of medication. 3. The Staff Development Coordinator (SDC)/ DON and or designee will educate the License Staff the Medication and self-administration of medication policy. 12/19/2021. 4. The Director of Clinical Service (DCS) and or designee will round for observation of medication being left at beside of 10 residents per day X 5 days a week. 3 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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F 554	Continued From page 2	F 554		

medication during each med pass. If kept at bedside, the medication must be kept in a locked drawer."

1. During an observation on 11/08/21 at 1:15 PM, R194 had a white medication administration cup sitting on the bedside table with four pills still in the cup. All four pills were dry and intact in appearance.

During an interview on 11/08/21 at 1:15 PM, R194 stated the pills were left by the bed this morning by the nurse. R194 stated she should have taken them but had not done it yet and she takes responsibility for actions. R194 stated the morning nurse was in a hurry and set them down and left.

Record of R194's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/25/21 the resident had a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15, which indicated the resident was moderately impaired cognitively.

During an interview on 11/08/21 at 1:19 PM, License Practical Nurse (LPN) 9 stated she had worked in facility for one year. LPN9 stated she was trained on medication administration and knew the rights and checked prior to administering medication. LPN9 stated she saw R194 put the medications in her mouth and R194 must have spit them back into the cup when she stepped out. LPN9 acknowledged she did not follow through in ensuring R194 took her medications. LPN9 stated the facility policy was to give the medication and stay and watch the resident swallow the pills to verify they took them. R194 stated she had not been back in to check

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F 554	Continued From page 3	F 554		

on R194 in a few hours and did not realize the medication cup was at the bedside still.

During an interview conducted simultaneously on 11/08/2021 at 1:19 PM, R194 stated the medications were never in her mouth and she did not spit them back into the cup. R194 stated the nurse set them on the table, left, and walked out of the room. R194 stated the pills had been in the cup sitting here and she had no reason to lie about that.

During an interview on 11/10/21 at 1:02 PM, Registered Nurse (RN) 20, the Staff Development nurse, stated she did the education for medication administration, which was done as part of the new employee orientation for nursing staff, and they are educated on the correct medication administration protocol and processes and expectations. RN20 stated staff knew and were aware to stay in room until residents have taken all their medications and they verified the medications were swallowed. RN20 confirmed that in no way is it okay to set a cup of pills down in a resident room and walk off, reiterating that the nurses knew definitively, and her expectation were that the medications were given and verified swallowed with no exceptions. In addition, there were no residents in facility currently who had been approved for self-administration of medication.

2. Review of R22's undated "Admission Record," in the Electronic Medical Record (EMR) located under tab "Profile," indicated the resident was admitted to the facility on 08/03/21, with diagnoses of unspecified intellectual disabilities and glaucoma.

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F 554	Continued From page 4	F 554		

Review of R22's EMR physician orders under tab "Orders," dated 08/04/21 indicated the resident was to be administered dorzolamide Hydrochloride (HCL) timolol one drop in each twice a day to treat glaucoma. The physician orders included Vyzulta Solution 0.024 % and instill one drop in each eye one time day to treat glaucoma. There were no orders for R22 to self-administer his eye drop medications.

Review of R22's admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 08/10/21 indicated R22 could not complete a "Brief Interview for Mental Status (BIMS)." The assessment indicated R22 had short-and long-term memory problems.

Review of R22's EMR failed to have evidence the resident was assessed for the self-administration of prescription eye drops.

Review of R22's EMR care plans under tab "Care Plan" failed to include education and information the resident was capable of the self-administration of his prescribed eye drops.

Review of R22's "Medication Administration Record (MAR)" located under tab "Orders" for the months of 08/04/21 through 11/09/21 failed to indicate the resident was to self-administer dorzolamide HCI timolol and Vyzulta Solution 0.024 %.

During an observation conducted on the initial tour of the facility on 11/08/21 at 10:52 AM, two prescription bottles contained eye drops for dorzolamide HCI timolol and Vyzulta Solution 0.024%, were located to the right of R22's bedside. An interview was attempted with R22,

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F 554	Continued From page 5 but the resident was unable to respond. During an interview on 10/10/21 at 1:20 PM, Licensed Practical Nurse (LPN) 14 stated R22 was not capable to self-administer his eye drops. During an interview on 11/10/21 at 4:31 PM, the Director of Nursing (DON) stated R22 was not able to self-administer his eye drops and the eye drops should have been taken back to the medication cart unless there was a physician orders to leave the eye drops at the bedside of the resident.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		12/26/21

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F 580	Continued From page 6 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to notify the physician of a change in condition for one (Resident (R) 66) of three reviewed for change in condition in a total sample of 65 residents. Findings include: Review of the "Face sheet" under the "Profile" tab in the Electronic Medical Record (EMR) revealed R66 was admitted on 01/05/19 and readmitted 10/04/21 with diagnoses including blindness,	F 580	1. Nurse Practitioners was immediately notified of residents leaving the facility returning Intoxicated several times. Consulting pharmacy asked to review medication for time adjustment so when resident leaves LOA and returns intoxicated. 2. A list will be devised of resident that leave LOA and return under the influence. 3. The Consultant pharmacy, the Practitioners, and the Medical director will be supplied with the list of residents.	

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F 580	Continued From page 7 psychosis (a severe mental disorder in which thoughts and emotions are so impaired that contact is lost with reality), anxiety, and depression. Review of the annual "Minimum Data Set (MDS)", with and an Assessment Reference Date (ARD) of 09/14/21 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. Review of the EMR "Progress Notes" tab, revealed a progress note dated 10/28/21 at 6:18 PM which documented, "Upon return from LOA [leave of absence], resident was observed by this staff member to be intoxicated." The clinical documentation lacked evidence R66's physician was notified of the change in medical status. Review of the EMR "Progress Notes" tab, revealed a progress note dated 11/03/21 at 12:14 AM which documented R66 returned to the facility under the influence of alcohol. The clinical record lacked evidence R66's physician was notified of the change in medical status. Review of the facility policy titled "Notification of Change," with a reviewed date of 12/16/20, directs "The Center is to promptly notify the patient's/resident's attending physician. . ." The policy also directs the change may include "a change in the patient/resident physical. . . status." During an interview on 11/11/21 at 9:20 AM, the Director of Nursing (DON) confirmed knowledge that R66 signed herself out of the facility and went on a "Leave of Absence" on 10/28/21 and 11/3/21. The DON also stated R66 returned to the facility under the influence of alcohol. The DON	F 580	Educate residents on the risk related to drinking with medication. 4. The Staff Development Coordinator (SDC) and or designee will educate the License staff on Protocol for updating practitioner on resident under the influence timely. Unit manager and DON or designee will audit daily in morning meeting. 5X week for 4 weeks. DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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F 580	Continued From page 8 stated that staff were aware of this resident's practice, and it was "not unusual." An interview with the Consulting Pharmacist on 11/11/21 at 9:05 AM revealed, after a review of R66's medication regime, the medications ordered for R66 could be adversely affected by the ingestion of alcohol. During an interview on 11/11/21 at 9:51 AM, the Medical Director confirmed alcohol use would be an acute change in a resident's status. The Medical Director stated that he would expect the resident's physician to be called with any resident's acute change in condition.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		12/26/21

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F 584	Continued From page 9 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: Gosselin, Kimberly Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment. Specifically, the facility failed to provide ensure a homelike environment for three (Resident (R) 75, R188, and R196) residents and failed to provide housekeeping services to ensure shared resident bathrooms were clean and in good repair on two of four units. Findings include: 1. During an interview on 11/08/21 at 11:09 AM, R188 stated there were environmental concerns in his room. Observation at 11:10AM, revealed a missing ceiling tile by the resident's window and	F 584	1. Shared bathrooms on two of the four units have been identified and cleaned and are in the process of repair in shared bathrooms between, 260 & 262, 252 & 254, 251 & 253, 239 & 241, 256 & 258, 240 & 242, 248 & 250, were assessed by housekeeping and deep cleaned. Room 105 floor has been cleaned and scrubbed. Any visible hand towels have been removed and replaced as needed in bathrooms. Maintenance has R188 room has had the ceiling tiles replaced the funnel and hosed removed & window shut on 11/9/21. Mechanical lift was removed from R188 room on 11/8/21. R188 sink in bathroom was checked by maintenance on 11/9/21 and did not have any leaks. Basin under the sink was removed and	

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F 584	Continued From page 10	F 584		

exposed pipes. Hanging under the pipes was a large yellow funnel. The yellow funnel had a hose attached to the bottom of it. The hose's end was hung outside the window in the resident's room. Also observed was a mechanical lift stored next to the window where a second bed should be. At 11:18 AM, R188 stated staff would take the mechanical lift from his room and then return it. At 11:25 PM, R188 directed this surveyor to look in his bathroom. A gray plastic basin was observed under the resident's bathroom sink and was filled with trash and water. R188 stated he believed the sink had a leak.

Review of R188's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/28/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, indicating intact cognition.

During an observation on 11/09/21 at 10:34 AM in R188's room, the Maintenance Director stated the funnel was hung to the ceiling with the exposed pipes since during the summer months. The Maintenance Director stated the pipes collect condensation due to the use of the chillers in the facility, the pipes then drip into the ceiling tiles. During this observation the hose connected to the funnel was now in a bucket. At 10:36 AM, entered R188's bathroom and the grey basin was now empty but still located under the sink. Under the basin was water on the floor.

2. During an observation conducted on 11/08/21 at 1:07 PM, R75's privacy curtain could not pull all the way around and was stuck halfway. The vertical blinds on the sliding door in R75's room were observed to be missing slats. A sheet covered the left corner of the window. R75 stated

disposed of. R75 Blinds have all slats in place on door. The sheet covering the sliding glass has been removed. R75 privacy curtain was repaired to on the track to pull close on 11/12/21 R196 portable floor air condition was removed from room on 11/9/21. 100% sweep of rooms / bathrooms for soiled linen.

2. All Bathrooms and rooms have the potential to be affected.
3. The facility is conducting a facility bathroom audit to identify areas that need maintenance repair work and /or housekeeping. DON and or Designee will educate clinical staff on removing soiled linen from bathrooms on rounds every shift every day. Maintenance and housekeeping will be educated by Regional Maintenance director and /or designee on audit sheets to identify rooms needing repair and/or housekeeping to maintain a clean comfortable, home like environment. Housekeeping will be reeducated on proper housekeeping techniques by Housekeeping supervisor and/or designee. Repairs for resident bathrooms identified will be scheduled weekly as needed.
4. Maintenance director and Housekeeping director conduct observational rounds with audits to see the facility and rooms are properly cleaned and/or repaired. Executive Director and/or designee will complete an audit on the resident rooms and bathrooms observations 2 times a week for four weeks, then weekly for four weeks, then monthly for 4 months to

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11 staff placed the sheet over the window to keep the sun from her eyes. 3. An observation in R196's room on 11/09/21 at 11:05 AM with the Maintenance Director present revealed, a portable floor air conditioner connected to an orange extension cord. The Maintenance Director stated this was used during the summer months and needed to be removed. 4. During an observation on 11/08/21 at 9:01 AM, the bathroom between rooms 260 and 262 had soiled floors, soiled walls, and the caulking around the base of the toilet had black stains. These concerns were unchanged during follow up observations on 11/09/21 at 4:48 PM, 11/10/21 at 3:23 PM, and 11/11/21 at 1:00 PM. During an observation on 11/08/21 at 9:52 AM, the resident bathroom between rooms 252 and 254 had visibly soiled flooring, a white hand towel with visible yellow stains hanging over the visibly soiled metal assist bar, and the base of the toilet was caked with debris. These concerns were unchanged during follow up observations on 11/09/21 at 4:50 PM, 11/10/21 at 3:23 PM, and 11/11/21 at 1:15 PM. During an observation on 11/08/21 at 9:54 AM, the resident bathroom between rooms 251 and 253 had a visible brown stain on toilet seat and visible debris on the floors. A white hand towel with brown stain was hanging over the soiled support bar. This concern was unchanged during follow up observations on 11/09/21 at 4:51 PM, 11/10/21 at 3:24 PM, and 11/11/21 at 1:16 PM. During an observation on 11/08/21 at 9:56 AM the resident bathroom between rooms 239 and 241 was noted to have a visibly soiled metal handrail and floors. This concern was unchanged during follow up observations on 11/09/21 at 4:53PM,	F 584	ensure a clean comfortable homelike environment. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director and/or DCS/designee for further compliance and/or revision of the plan as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 584	Continued From page 12	F 584		

11/10/21 at 3:27 PM, and 11/11/21 at 1:18PM.

During an observation on 11/08/21 at 12:05 PM in room 105, the floor was soiled with black residue build up throughout and sticky spots catching on shoes when walking across the floor surface.

During an observation on 11/08/21 at 4:24 PM, the bathroom between rooms 256 and 258 had soiled floors, soiled walls, and the caulking around the base of the toilet had black stains. These concerns were unchanged during follow up observations on 11/09/21 at 4:40 PM, 11/10/21 at 3:20 PM, and 11/11/21 at 1:00 PM.

During an observation on 11/08/21 at 4:38 PM, the resident bathroom between rooms 240 and 242 had visibly soiled walls, a visibly soiled metal handrail, and the toilet was running. These concerns were unchanged during follow up observations on 11/09/21 at 4:49 PM, 11/10/21 at 3:24 PM, and 11/11/21 at 1:115 PM

During an observation on 11/09/21 at 11:43 AM, Housekeeper (HK) 47 entered the bathroom outside of rooms 251 and 253. HK47 removed trash and reentered the bathroom with a broom, and then a mop. After using the broom and mop, he pushed his cart down the hall. This writer then entered the bathroom and noted a white hand towel with brown staining hanging over the soiled metal handrail. Visible large pieces of debris were noted on the floor to the left of toilet, in the corner, and under the sink.

During an observation on 11/10/21 at 6:00 PM, the resident bathroom between rooms 248 and 250 was noted to have visibly soiled walls, flooring, and a metal handrail. This concern was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13	F 584		

unchanged during follow up observations on 11/09/21 at 4:52 PM, 11/10/21 at 3:27 PM, and 11/11/21 at 1:21 PM.

During an interview on 11/09/21 at 11:49 AM, HK47 indicated that it was housekeeping's responsibility to clean the bathrooms. HK47 stated staff swept and mopped the floors daily. HK47 further explained staff cleaned the toilets, the bathtubs, and the handrail daily. HK47 reported that he did not remove the stained hand towel because it was nursing staff's responsibility to remove resident items from the bathrooms.

During an interview on 11/11/21 at approximately 8:28 AM, Licensed Practical Nurse (LPN) 12 confirmed that the bathrooms were shared by multiple residents and that it was housekeeping staff's responsibility to clean the bathrooms. LPN12 confirmed that all the bathrooms can be used by multiple residents, not just the ones that reside in the closest rooms.

During an interview on 11/11/21 at 5:53 PM, the Administrator indicated she was aware "the facility could be a lot cleaner" and that she was aware that the bathrooms, resident rooms, staff areas, and common areas were not cleaned appropriately.

Review of facility Maintenance Policy dated 11/30/2014 revealed "The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair".

The facility failed to provide policies related to housekeeping services and environment upon request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to protect residents from abuse resulting in harm for two residents of five residents (Resident (R) 191, and R89) reviewed for abuse in a total sample of 65 residents. Specifically, physical altercations resulted in R89 requiring an evaluation at the hospital for treatment of open wounds and R191 requiring hospital evaluation and sutures. Findings include: Review of the facility's policy, "Abuse, Neglect, Exploitation, and Misappropriation," dated 11/28/17 documented "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse. . . physical abuse includes. . . hitting. . . biting. . . The center is committed to the prevention of abuse, neglect. . .	F 600	1. Resident R159 and R191 have had no conflict or interaction since incident. R1 no longer resides at our building. R89 is still currently a resident with no conflict since incident. Resident R191 continues to feel safe at the facility. R89 continues to feel safe in the facility. List of all the resident that have had resident □ resident that caused actual injury. Deer Oaks psychological services for Anger management/express feeling. Psychological services to provide support as needed to R89 and R191. 2. Maintain above list. FRI with Resident □ resident injuries assignment have the potential to be affected. 3. During resident council educate re: anger management and physical aggression. Staff education on responding and identifying resident to	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15 Monitoring of resident who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indications of abuse." 1. The facility-provided Facility Reported Incident (FRI) document dated 01/23/21 revealed, "Allegation of Resident to Resident Contact. Residents immediately separated, a head to toe observation was conducted of both residents by a licensed nurse for injuries. Increased supervision implemented for safety. Law enforcement notified. Investigation initiated [sic]." Review of Certified Nursing Assistant (CNA) 8's "Witness Statement" dated 01/27/21, indicated that while charting behind the desk she heard R191 and R159 "fussing," and R159 was "directly up on [R191] like he was ready to hit him [sic]." At this time, she heard License Practical Nurse (LPN)17 tell R159 not to hit R191, and then R159 "rolled down the hall to eat his dinner." CNA8 was unsure as to when R159 returned but heard a commotion and when she looked back R191's face bleeding. Review of LPN17's undated "Witness Statement," revealed while LPN17 was passing medications she saw R159 approached R191 in his wheelchair and stated, "I heard you down the hallway calling out at the staff to suck your dick." At this time LPN17 asked R159 to back away from R191. R159 said "O.K." and left down the hallway. LPN17 continued with her medication pass and was in another resident's room when she heard someone say "OOH." LPN17 came out of the room and saw "[R191] bleeding and [R159]	F 600	resident threatening behavior by staff educator and/or designee. 4. The social worker and/or designee will follow up with R89 and R191 weekly for 1 month to ensure that they feel safe within the facility and then quarterly at careplans for 3 quarters. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Social workers and/ or designee for further compliance and/or revision. The DCS/designee will report event outcomes to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

leaving the unit with a cane."

Review of R159's undated "Witness Statement," revealed R191 was talking "smack" to the nurses and yelling out inappropriately, "suck my dick." R159 told R191 to stop, then went to his room, "and got the cane and hit [R191]. He shouldn't be talking that mess."

Review of R191's undated "Witness Statement" indicated that R159 came up to him and hit him with a cane. R191 denied having an exchange of words.

Review of the facility-provided "Incident Report/five day follow up" dated 01/29/21, revealed that R191 acquired multiple lacerations from the altercation with R159, was evaluated by nursing staff, and was then transferred to the hospital for treatment of his injuries.

The Police Report provided by the facility, dated 01/23/21, documented "Victim and suspect who reside in the same nursing home got into a verbal disagreement. Suspect struck the victim with a cane, causing laceration to his right forehead requiring stitches. Both individuals are mentally incapacitated. . ."

Review of R159's "face sheet" located in the Electronic Medical Record (EMR) in the "Profile" tab revealed that R159 was admitted to the facility on 04/12/12 with diagnoses that included depression, hemiplegia, a seizure disorder, and alcohol abuse.

Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/15/21 revealed R159 had a Brief Interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The assessment indicated that the resident was not ambulatory and only had use of his right arm but is able to self-propel in a wheelchair. The assessment also showed R159 displayed no behaviors during the look back period.

Review of R159's care plan under the "Care Plan" tab revealed the resident had the potential for impaired and inappropriate behaviors due to major depressive disorder and mood disorder. R159 refused medications often.

During an interview on 11/10/21 at 6:33 PM, R159 indicated that he did hit R191 with his cane because he "told me to suck his dick and kiss his ass." R159 further stated that staff had told him to leave R191 alone and to stay away from him but he "had to save face and protect himself."

During an interview on 11/10/21 at 6:25 PM, LPN40 reported R159 spent quite a bit of time in the smoking area, but he also signed himself out and often returned to the facility with obvious signs of drinking alcohol.

Review of R191's "face sheet" found in the EMR under the "Profile" tab revealed that R191 was admitted on 02/19/20 with diagnoses of hemiplegia (inability to move one side), dementia, and alcohol abuse.

Review of R191's quarterly MDS with an ARD of 10/23/21 revealed that R191 had a BIMS of eight out of 15, indicating moderate cognitive impairment. R191 has limited range of motion on one side of this body and rejected care assistance one to three days of the look back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

period.

The care plan located in R191's EMR under the "Care Plan" tab directed staff to: intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; and remove the resident from the situation and take to an alternate location as needed.

The progress note dated 01/23/21 located in the EMR in the "Progress Notes" tab documented R191 returned to the facility with sutures above his right eyebrow.

During an interview on 11/09/21 at 5:46 PM, R191 stated that he "can't quite remember if he was hit or not ...I believe so, but I can't recall it, but if he did, he did." R191 indicated that he felt safe and "did not suffer any harm."

During an interview on 11/10/21 at 1:29 PM, CNA8 indicated she remembered R159 and R191 having words, "but a lot of the residents bicker every now and again." CNA8 stated she heard the nurse ask them to stop and remembered R159 self-propelling down the hall, and then suddenly she heard a yell out and R191's face was bloody. CNA8 indicated that R191 returned with stitches in his forehead.

During an interview on 11/12/21 at approximately 11:50 AM, LPN17 indicated she remembered R191 was being crude and R159 started to approach him, but she intervened, then R159 wheeled himself to his room. LPN17, stated she continued with her medication pass. LPN17 stated while she was in another resident's room, she heard someone yell. When she came out into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

the hallway, R191 was bleeding from his face and R159 was wheeling back to his room with a cane. LPN17 stated she immediately assessed R191 and sent him to the emergency room for evaluation and treatment of his injuries. LPN17 stated R191 returned that night with stitches in his forehead. LPN17 indicated that staff tried to intervene when they saw any resident escalating for any reason and tried to redirect them.

2. Review of the facility's investigation for an incident on 07/02/21 between R1 and R89 revealed, in the five-day report summary, that R1 engaged in a physical altercation with R89 resulting in R89 going to the hospital for the treatment of injuries including bite marks. Staff intervened in the altercation and kept R1 away from other residents until he was sent out of the facility for a psychiatric evaluation.

Review of R89's "Medical Diagnoses" tab in the EMR revealed R89 was admitted to the facility on 05/14/21 with diagnoses including cerebral infarction (also called an ischemic stroke; occurs as a result of disrupted blood flow to the brain) and major depressive disorder.

Review of R89's Quarterly MDS with an ARD of 06/14/21 revealed a BIMS score of four out of 15, indicating severe cognitive impairment. The assessment documented R89 did not display behaviors during the look back period.

Review of R89's "Progress Notes" tab in the EMR revealed in a nursing note dated 07/02/21 at 3:34 PM, "Resident escorted to the floor as he was in an altercation with another resident. [Nurse Practitioner] notified as well as next of kin. . . Resident transported to the [emergency room] for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

scratches to the face, red right eye, several human bites to the right arm and elbow area open area to the mid chest, scrapped right knee. Sent for evaluation and treatment. [sic]"

Review of R1's "Medical Diagnoses" tab in the EMR revealed R1 was admitted to the facility on 05/12/21 with diagnoses including paranoid schizophrenia.

Review of the quarterly "MDS" with an ARD of 07/23/21, located in the EMR under the MDS tab, revealed a BIMS score of seven out of 15, indicating severe cognitive impairment. The assessment documented R1 displayed behaviors of rejection of care one to three days of the look back period.

Review of R1's "Progress Notes" tab in the EMR revealed the following.

a. On 07/02/21 at 3:14 PM, ". . .Mood status is angry. . . Behavioral problems are verbal behaviors (screaming, cursing, etc.) [sic]. Patient was reported having an altercation with another resident. . . Education provided on medication management. . . Patient refused all his scheduled medications on this shift. [Nurse Practitioner, family] and unit manager aware. . ."

b. On 07/02/21 at 3:23 PM, "Social Service Progress Note. . . [R1] was observed in a physical altercation with another resident in the smoking area. Police were called. [Community mental health services] conducted a [video] interview and decided to TDO [temporary detention order (psychiatric hold/evaluation)] resident. SW [Social Worker] faxed face sheet, orders, and progress notes to [Community mental health services].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

Police were called to pick up resident to be taken to the hospital for evaluation and treatment."

c. On 07/02/21 at 8:51 PM, "Resident at this time was escorted out the building with 911 to be transported to [hospital] will notify emergency contact."

During an interview on 11/08/21 at 3:44 PM, R89 stated he had an altercation with a resident that resulted in him (R89) going to the hospital for stitches. R89 stated the other resident (R1) no longer lived in the facility and went to prison. R89 stated that he felt safe in the facility.

During an interview on 11/09/21 at 5:24 PM, SW4 stated on 07/02/21 she saw the Registered Nurse (RN) 20 and another staff member running past her door. SW4 stated she followed them to the smoking area where she saw R89 on top of R1 in his wheelchair. SW4 stated after staff separated the residents, R89 stated he had asked R1 to move, and R1 reacted physically. SW4 stated R89 reported he jumped on R1 to stop him, because R1 was biting him (R89). SW4 stated the facility called the police, the police came out but did not do anything since they had not witnessed it. SW4 stated R89 was sent to the emergency room for an evaluation of bite marks and injuries. SW4 stated the staff secured the smoking area and kept R1 supervised there as he continued to have behaviors. SW4 stated the facility called the local mental health service via video so they could witness R1's behaviors, who agreed with sending R1 to the emergency room for a psychiatric evaluation as he was a danger to himself and others. SW4 stated R1 was often confused; in his own world; heard voices; was often agitated; was argumentative with staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

residents; and he would yell at staff, residents, or internal stimuli. SW4 stated that prior to this incident, R1's behaviors were verbal, and he would deescalate on his own after his outbursts. SW4 stated that R1 had been refusing his psychiatric medications as well as refusing cares and services from staff. SW4 stated R89 was calm, childlike, got along with others, made friends, and was not believed to have done anything to provoke R1. R89 had not had other resident to resident altercations. SW4 stated that there was always a staff member present in the smoking area, but she did not recall who was on duty the day of the altercation between R89 and R1.

During interview on 11/10/21 at 10:15 AM, the Director of Nursing (DON) stated that on 07/02/21 she and several other staff (RN20 and a former social worker) ran to the smoking area when they heard what sounded like an altercation occurring. The DON could not recall exactly what was happening when staff arrived but stated R1 was talking to himself and other residents in the area stated R1 attacked R89. The DON stated R89 had asked R1 to move so others could get by when he was attacked by R1. The DON recalled taking R89 to evaluate his injuries, he had several lacerations and cuts, so he was sent out to the emergency room. The DON stated staff cleared the smoking area and stayed with R1 in the smoking area until he was able to be evaluated and sent out for a psychiatric hold. The DON recalled that R1 would talk to himself and curse; but did not recall other altercations with residents. The DON stated the facility assigned a staff member to the smoking area for all shifts; however, there was no one scheduled during the shift of the incident. She reported that many of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 600	Continued From page 23 the staff's office windows overlooked the smoking area and pointed across the hall where the windows looked out into the smoking area. The DON stated that if no one was assigned to the smoking area, staff were informed so they could do regular rounds of the smoking area. The DON could not recall what staff were in the smoking area when the incident occurred.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to complete a thorough investigation for one of three resident-to-resident altercations reviewed. Specifically, Resident (R)1 and R89 were involved in a physical altercation and the investigation lacked witness interviews and times.	F 610	1. A review of the facility reported incident by the executive director for R1 and R89 was reviewed and additional staff were asked if present during incident on 7/2/21. Documentation of approximate time was amended into facility FRI report. 2. Residents that are involve resident □	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 610	Continued From page 24 Findings include: Review of the facility's policy, "Abuse, Neglect, Exploitation, and Misappropriation," dated 11/28/17 under "Investigation" documented "The Abuse Coordinator and /or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse." Review of the five-day report summary portion of the facility's investigation for an incident on 07/02/21 revealed R1 engaged in a physical altercation with R89, resulting in R89 going to the hospital for the treatment of injuries, including bite marks. Staff intervened in the altercation and kept R1 away from other residents until he was sent out of the facility for a psychiatric evaluation. The facility's investigation included witness statements from R1, R89, and R78 but did not indicate how many witnesses were present for the incident. There were no additional resident or staff witness statements in the investigation. The investigation did not document the time or approximate time the incident occurred or was identified by staff. During an interview on 11/09/21 at 5:24 PM, Social Worker (SW) 4 stated on 07/02/21 she saw Registered Nurse (RN)20 and another staff member running past her door. SW4 stated she followed them to the smoking area where they observed R89 on top of R1, who was in a wheelchair. SW4 stated after staff separated the residents, R89 stated he had asked R1 to move and R1 reacted defensively. SW4 stated the staff	F 610	resident FRI have the potential to be affected 3. Executive Director was educated by Regional vice president of operations on witness statements and proper documentation of time of incident added to incident reports on 11/10/21. Facility Reported incidents will be reviewed as reported by the facility by regional nurse and/or designee to ensure proper documentation and statements are included at time of incident witness statements. 4. Executive Director or Director of Clinical Service (DCS) and or designee Review every FRI for witness statements weekly for 4 weeks, every other week for 2 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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F 610	Continued From page 25	F 610		

secured the smoking area and kept R1 supervised there as he continued to have behaviors. SW4 stated that there was always a staff member present in the smoking area, but she did not recall who was on duty that day. During interview on 11/10/21 at 10:15 AM, the Director of Nursing (DON) stated many of the staff's office windows overlook the smoking area and pointed across the hall where the windows looked out into the smoking area. The DON stated that she and several other staff (RN20 and a former social worker) ran to the smoking area when they heard what sounded like an altercation occurring. The DON could not recall exactly what was happening when she arrived but stated R1 was talking to himself and other residents in the area stated R1 attacked R89. The DON stated staff cleared the smoking area and stayed with R1 in the smoking area until he was able to be evaluated and sent out for a psychiatric hold. The DON stated the facility assigned a staff member to the smoking area for all shifts; however, there was no one scheduled during the shift of the incident. The DON stated that if no one was assigned to the smoking area staff were informed so they could do regular rounds on the smoking area. The DON could not recall who all was present during the incident but confirmed, additional residents and staff other than R1, R89, and R78, were present during the incident.

During an interview on 11/20/21 at approximately 6:30 PM, the Administrator who was the facility's Abuse Coordinator, stated she had overheard the incident on 07/021/21 occurring from her window. The Administrator's window behind her desk was observed to view the smoking area. The Administrator said she ran out to the smoking area with the other staff when she heard the

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F 610	Continued From page 26 commotion. The Administrator recalled the staff cleared the area of all residents, besides R1 who was having behaviors. The Administrator reported R89 was assessed by staff and then sent out to the hospital. The Administrator stated staff were focused on the residents at the time of the incident and she did not get witness statements from the staff later as part of her investigation. The Administrator stated there were other residents present at the time of the incident, however many of the residents stated they did not see anything. The Administrator acknowledge she did not document who was present and whose interviews were attempted within the investigation. The Administrator knew the DON, SW4, and several other staff ran to the smoking area when the incident occurred. The Administrator was uncertain if any staff were present in the smoking area prior to the incident. The Administrator stated from her review of the resident's nursing notes, the incident likely occurred between lunch and about 3:00 PM and took all day to settle.	F 610		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 645		12/26/21

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F 645	Continued From page 27 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified,	F 645		

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F 645	Continued From page 28 before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure a "Preadmission Screening and Resident Review" (PASRR) level II was completed for one resident of eight residents (Resident (R)196) reviewed for PASRR II in a total sample of 65 residents. Findings include: Review of facility policy "Preadmission Screening and Resident Review" (PASRR) dated 11/08/21 revealed, "The center will assure that all Serious Mentally Ill (SMI) ...The purpose is to ensure that the residents with SMI ...receive the care and services they need in the most appropriate setting. If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and/or inform the appropriate agency to conduct the screening and obtain the results.	F 645	1. R196 PASARR level II was requested and a Level II from 2014 was received. Facility has received the information to request a new Level II for R196. 100% audit on current residents for Level I PASARR that trigger a level II will be conducted by 12/22/21 2. All residents who have been identified as needing a Level II has the potential to be affected. 3. Education has been conducted with admissions and Social services on PASRR screenings needing level II documentation prior to admission to the building on 11/12/21 by Executive Director. 4. Admission coordinator and/ or designee will review PASARR□s on all potential admissions prior to entrance to the facility to ensure that if the screening triggers a Level II, it is completed prior to admission. Admission will be on hold until Level II is obtained.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 645	Continued From page 29 Results of the screening evaluation will be placed in the appropriate section of the individual's medical records and any recommendations for services will be followed. Recommendations will be incorporated in the individual resident's plan of care and approaches/interventions developed to meet the identified needs of the individual." Review of R196's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab, revealed that R196 was admitted to the facility on 06/10/21 with diagnoses of psychosis, schizophrenia, and major depressive disorder. Review of R196's quarterly "Minimum Data Set (MDS)" with Assessment Reference Date (ARD) date of 10/27/21 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that she was cognitively intact. Review of the facility provided "Screening for Mental Illness, Mental Retardation/Intellectual disability, or Related Conditions" dated 05/27/21 indicated that R196 had a serious mental illness that resulted in functional limitations in major life activities. During an interview on 11/10/21 at 10:00 AM, the Administrator indicated that R196's PASRR Level I did trigger for a level II to be completed and the facility did not request it. During an interview on 11/11/21 at 9:14 AM, the Social Services Assistant (SSA) indicated that a PASRR II should have been requested upon	F 645	4. Executive director and/ or Designee will audit new admissions PASARR screening 1 time a week for 4 weeks and 1 time a month for 3 months for appropriate documentation. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director for further compliance and/or revision.	

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F 645	Continued From page 30 R196's admission. At the time of interview, SSA confirmed that the facility had not requested a PASRR II for R196.	F 645		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		12/26/21

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F 655	Continued From page 31 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, and facility policy review, the facility failed to ensure four residents out of 65 sampled residents (Resident (R) 147, R188, R254, and R253) had baseline care plans developed. This had the potential for staff not to be aware of the associated care needs of the residents who were newly admitted. Findings include: 1. Review of R147's undated "Admission Record," in the Electronic Medical Record (EMR) located under tab "Profile," indicated R147 was admitted to the facility on 10/11/21 with diagnoses including dementia with behaviors, essential hypertension, and adult failure to thrive. Review of R147's clinical EMR failed to indicate a baseline care plan was completed. Review of an undated document provided by the facility titled "Base Line Care Plan and Summary," was blank. 2. Review of R188's undated "Admission Record, in the EMR located under tab "Profile," indicated R188 was admitted to the facility on 10/21/21 with	F 655	1. R147, R188, R254, R253 base line care plan completed immediately by the MDS team. . 2. 100% audit of current residents baseline care plan. 3. The DON and or designee will educate the license staff, the MDS staff along with IDT team on initiating and completing the Interim Care-plan. MDS Nurse will ensure all area of Baseline care-plan completed prior to the 72 hour journey home meeting. 4. The DON will audit 5 X a week for 4 weeks then weekly X 2 weeks The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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F 655	Continued From page 32	F 655		

diagnoses including vascular dementia, type two diabetes mellitus, and end stage renal disease.

Review of R188's clinical EMR failed to indicate a baseline care plan was completed.

Review of an undated document provided by the facility titled "Base Line Care Plan and Summary," was blank.

3. Review of R254's undated "Admission Record," in the EMR located under tab "Profile," indicated R254 was admitted to the facility on 11/05/21 with diagnoses including sepsis, cerebral infarction (stroke), and dysphasia.

Review of R254's clinical EMR failed to indicate a baseline care plan was completed.

Review of an undated document provided by the facility titled "Base Line Care Plan and Summary," was blank.

4. Review of R253's undated "Admission Record," in the EMR located under tab "Profile," indicated R253 was admitted to the facility on 11/05/21 with diagnoses including chronic obstructive pulmonary disease, bi-polar disorder, and schizophrenia.

Review of R253's clinical EMR failed to indicate a baseline care plan was completed.

Review of an undated document provided by the facility titled "Base Line Care Plan and Summary," was blank.

During an interview on 11/10/21 at 9:15 AM, the Director of Nursing (DON) stated any staff

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F 655	Continued From page 33 member could complete the baseline care plan. A subsequent interview was conducted on 11/10/21 at 4:26 PM, the DON stated her expectations were for nursing to develop the baseline care plan and confirmed the base line care plans were not developed for the four residents. Review of policies and procedures provided by the facility titled "Plans of Care," dated 11/30/14 indicated ". . .Develop and implement an individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy orders, social services . . . and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed. . ."	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		12/26/21

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F 656	Continued From page 34 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to revise the comprehensive care plan related to restorative services for one resident of three (Resident (R)13) reviewed for rehabilitation and restorative services; and related to falls/safety for two residents of five (R34 and R197) reviewed for accidents/falls in a total sample of 65 residents. Finding include:	F 656	1. Residents on restorative and have had falls care plans reviewed and updated. .R13 Restorative was on care-plan but had been d/c. Care plans updated. R34 FRI done on site immediately. R197 fall care plan updated 2. All residents with a change of condition have the potential to be affected. All residents with restorative care 3. The Staff Development Coordinator	

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 656	Continued From page 35 1. Review of the "Profile" tab in the Electronic Medical Record (EMR) revealed R34 was admitted on 02/05/12 with diagnoses including cervical spinal cord injury, early onset dementia, and schizoaffective disorder. The quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/14/21 revealed R34 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The assessment documented R34 required supervision to one assist with bed mobility, transfers, mobility on and off the unit. Review of a nursing note dated 08/19/2021 at 3:24 PM, located in R34's EMR under the "Progress Notes" tab, revealed the resident was transferred to the hospital following a heat exposure-related event. A progress note dated 08/19/21 at 8:21 PM, indicated the resident was admitted to the hospital. Review of the "MDS" tab of the EMR revealed an Entry-Tracking assessment with an ARD of 08/20/21 showing R34 was re-admitted to the facility from an acute care hospital. Review of the EMR care plan tab lacked evidence the facility revised R34's care plan following the heat exposure-related event which resulted in hospitalization. The care plan did not include interventions for the prevention of additional outdoor temperature related medical issues that R34 may experience. Interview with the Director of Nursing (DON) on 11/11/21 at 9:20 AM confirmed the facility failed to	F 656	(SDC) and or designee will educate the License nurses, MDS nurse and unit managers on updating care plans. 4. The Director of Clinical Service (DCS) and IDT Team or designee will review residents transitioning to restorative, change of condition and events to verify care plans have been updated 5 x week for 4 weeks, 2 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 656	Continued From page 36	F 656		

update R34's care plan after the resident's weather-related health issue and the resident's inability to recognize weather-related symptoms.

2. Review of R13's "Face Sheet," located in the EMR under the "Profile" tab, revealed that R13 was admitted to the facility on 12/16/20 with diagnoses including morbid obesity, hemiplegia (paralysis of one side), cerebral infarction (stroke), and congestive heart failure.

Review of R13's Quarterly MDS with ARD of 08/06/21 revealed a BIMS score of 15 of 15, indicating that R13 was cognitively intact. The assessment documented R13 required moderate assistance from staff for transfers.

Review of R13's care plan, located in the EMR under the "Care Plan" tab, revealed that R13 received range of motion exercises daily with AM and PM care.

During an interview on 11/11/21 at 1:34 PM, Physical Therapy Aide (PTA) indicated that R13 received therapy in April 2021, part of May 2021, and then was transitioned to restorative care on 05/13/21. She further indicated that R13 was non ambulatory, was admitted with a severely contracted right foot, and that she had reached her rehabilitation potential at that time. She further indicated that R13 was not safe to walk.

During an interview on 11/11/21 at 2:22 PM, the Assistant Director of Nursing (ADON) indicated that R13 had received therapy services, was not improving, and was moved to restorative services for a period of time in May 2021. The ADON reported that since then restorative services had been discontinued. The ADON confirmed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 656	Continued From page 37	F 656		

care plan was not revised for R13 regarding daily range of motion exercises.

3. The facility policy titled "Fall Management," dated 07/29/19, states, " ... Purpose: Is to identify residents at risk for falls and establish/modify interventions to decrease the risk of future fall(s) ... Post Fall Strategies: update care plan with new interventions..."

Review of R197's "Face Sheet," located in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on 06/17/21 with diagnoses of dementia, cerebral infarction (stroke), and anxiety.

Review of R197's "MDS" with ARD of 10/27/21 revealed a BIMS score of 11 of 15, indicating moderately impaired cognition.

Review of the facility provided "Incident Log" with start date of 02/19/19 through 11/10/21 revealed that R197 fell on 08/09/21, 08/19/21, and 09/18/21.

Review of the "Care Plan" with a revision date of 11/05/21, found in the EMR under the "Care Plan" tab, revealed R197's falls on 08/09/21, 08/19/21, and 09/18/21 were not addressed.

During an interview on 11/10/21 at 6:37 PM, Charge Nurse indicated that the care plan should be updated with a new intervention after every fall.

During an interview on 11/11/21 at 4:25 PM, Licensed Practical Nurse (LPN) 40 indicated that care plans should be updated with a new intervention after every fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 38 During an interview on 11/11/21 at approximately 5:54 PM, the Administrator confirmed R197's care plan was not updated after falls on 08/09/21, 08/19/21, and 09/18/21.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide Activities of Daily Living (ADLs) related to nail care for one resident of four (Resident (R)15) reviewed for ADLs in a total sample of 65 Residents. Findings include: Review of R15's "Face Sheet," located in the Electronic Medical Record (EMR) under the "Face Sheet" tab, revealed that R15 was admitted to the facility on 03/22/18 with diagnoses including manic-depressive disorder (mood disorder that causes feelings of sadness and loss of interest that can interfere in daily living), hemiplegia, and history of cerebrovascular accident (stroke). Review of R15's quarterly "Minimum Data Set (MDS)" with Assessment Reference Date (ARD) of 11/04/21 revealed that R15 was totally dependent on staff to meet her daily needs and had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating that she is cognitively	F 677	1. R15 Nails clipped and cleaned immediately. 100 % audit completed. 2. All residents have the potential to be affected. 3. The Staff Development Coordinator (SDC) and or designee will educate the direct care staff on ADL care including nail care. 4. The Unit manager and or designee will do nail audit 100% weekly X 5 weeks. Random audits weekly for 2 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 677	Continued From page 39	F 677		

intact.

Review of R15's care plan located in the EMR under the "Care Plan" tab, revealed staff were directed to checked for nail length, and to trim and cleaned her nails, as necessary.

During observation on 11/09/21 at 2:42 PM, R15 had visibly soiled, long fingernails. Her left thumbnail and middle finger were chipped with sharp edges. Her right pinkie finger and pointer finger were also chipped with sharp edges.

During an observation on 11/10/21 at 10:27 AM, R15 had visibly soiled, long fingernails. Her left thumbnail and middle finger were chipped with sharp edges. Her right pinkie finger and pointer finger were also chipped with sharp edges.

During an observation on 11/11/21 at 10:52 AM, R15 had visibly soiled, long fingernails. Her left thumbnail and middle finger were chipped with sharp edges. Her right pinkie finger and pointer finger were also chipped with sharp edges.

During an interview on 11/09/21 at 2:42 PM, R15 indicated that it had been approximately two weeks since staff had cut her fingernails. R15 further reported that it bothered her when her nails were dirty and/or overgrown.

During an interview on 11/11/21 at 6:35 PM, Restorative Aide (RA)41 indicated that residents' nails should be cleaned daily, trimmed as needed, and it was everyone's responsibility to ensure it was done.

During an interview on 11/11/21 at 09:50 AM, Licensed Practical Nurse (LPN)1 indicated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 677	Continued From page 40 both nurses and certified nursing assistants (CNAs) had the ability and responsibility to trim and clean fingernails regularly. During an interview on 11/10/21 at approximately 4:12 PM, the Assistant Director of Nursing indicated that the expectation was staff assisted residents with their ADLs and followed per their care plan.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two residents of three residents (Resident (R) 109 and R81) reviewed for limited range of motion (ROM), received appropriate treatment and services to increase range of motion and/or to prevent further	F 688	1. R109, R81 and R85 therapy referral immediately for PT/OT and referral to restorative during survey. Audit of resident last 3 months of therapy case load for restorative referral. 2. Residents that transition from therapy	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 688	Continued From page 41	F 688		

decrease in range of motion; and that one resident of three residents (R85) reviewed for rehabilitation restorative care received services to maintain or improve mobility.

The findings include:

Review of the facility policy for "Contracture Prevention, Document Name: N-904," Effective date: 11/30/2014, Revision Date: 08/22/201 revealed the policy was to prevent contracture of extremities for those residents who no longer have full use of their extremities. Each resident must be evaluated for need of contracture prevention procedures on admission, readmission, and as needed.

1. During an observation on 11/08/21 at 10:15 AM, R109 was resident in bed with noted bilateral lower extremity contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Interview was attempted with R109, R109 was not interviewable.

Review of the "Profile" tab in the Electronic Medical Record (EMR) for R109 revealed he was admitted by the facility on 03/19/21 with diagnosis to include Alzheimer's Disease with early onset, Multiple Sclerosis, and Dementia.

Review of R109's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/26/21 revealed, R109 was rarely/never understood by staff and a Brief Interview for Mental Status (BIMS) was not attempted; R109 had a functional limitation in range of motion on both sides in the lower extremities and had not received restorative or

have the potential to be affected.
3. The DON and or Designee will educate the unit managers/ therapy department that residents will be reviewed for restorative as appropriate.
4. The Assistant Director of Clinical Service (DCS) and or designee will residents transitioning from therapy receive restorative nursing as recommended. 5 x week for 3 weeks, 2 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 42	F 688		

range of motion services in the last seven days.

Review of the R109's care plan located under the "Care Plan" tab in the EMR, was absent to a care plan for his contractures.

Review of R109 initial physical and occupational therapy evaluations, treatment plans, and discharge plans provided by the facility revealed, R109 was initially evaluated by physical therapy on 03/19/21 and received services from 03/19/21 through 04/05/21. The recommended services upon discharge from physical therapy was referral to the restorative nursing maintenance program. R109 was initially evaluated by occupational therapy on 03/19/21 and received services from 03/19/21 until 04/07/21, discharged to follow up with the restorative nursing maintenance program on 04/07/21.

Interview with the Assistant Director of Nursing (ADON), on 11/10/21 at 4:00 PM who supervised the restorative nursing maintenance program, stated R109 had never been on restorative services at the facility. The ADON stated that when a resident admitted by the facility was seen by therapy, they would make a referral to restorative services if needed. The ADON stated the therapy department would drop off a paper referral to her office and she would add the resident to the restorative programming. The ADON related she did not know why R109 was not picked up by the restorative service program. The ADON stated she would investigate the situation and send a referral for R109 to therapy.

Interview with the Director of Rehabilitation (DOR), on 11/11/21 at 9:00 AM revealed all three disciplines had evaluated and treated R109 since

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 688	Continued From page 43	F 688		

admission. The DOR related the resident presented like a quadriplegic and was placed on protocol for contractures and referred to restorative when he was discharged from physical and occupational therapy in April. The DOR confirmed a referral was send to the restorative department and the DOR does not keep copies of the referral made to restorative.

During an interview and observation on 11/11/21 at 2:50 PM of R109 with Licensed Practical Nurse (LPN) 31, R109 was lying in bed on his back with his knees bent. LPN31 asked R109 to straighten his legs, R109 was not able to straighten his legs. LPN31 attempted to straighten R109's legs and stated that R109 was contracted bilaterally at the knees.

2. During an interview on 11/09/21 at 9:37 AM, R85 stated that she had gone to the hospital in June 2021 and since she readmitted to the facility on 06/24/21 she had not received any restorative services or therapy services to help her to get back to walking.

Review of R85's quarterly MDS with an ARD of 09/19/21 revealed, R85 had a BIMS score of 15 out of 15, which indicated she was cognitively intact; R85 had not received therapy or restorative services during the look back period; and required extensive assistance with bed mobility and did not transfer or walk in room or walk in corridor during the look back period.

Review of R85's "Census" tab in the EMR revealed, R85 was initially admitted to the facility on 05/11/21 and discharged on 06/08/21. R85 readmitted to the facility on 06/24/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 44	F 688		

Review of R85's "Medical Diagnoses" tab in the EMR revealed, R85 was admitted with diagnoses including pleural effusion and morbid obesity.

Review of R85's "Initial Evaluation," provided by the facility for the dates of service 05/12/21 through 06/08/21 revealed R85 received Occupational therapy from 05/12/21 through 06/08/21 to improve her average daily living skills, hygiene, grooming, dressing and toileting. R85 received physical therapy services from 05/12/21 through 06/08/21 to improve muscle strength and mobility skills.

Review of R85's "Discharge Summary," provided by the facility, from physical therapy documented a discharge recommendation on 06/08/21 of Restorative Nursing Maintenance Program to maintain her highest level of function.

During an interview on 11/10/21 at 4:00 PM, the ADON stated R85 had not received restorative services while at the facility.

During an interview on 11/11/21 at 9:00 AM, the DOR stated R85 received occupational and physical therapy from 05/12/21 through 06/08/21. The DOR confirmed a referral was send to the restorative department and the DOR did not keep copies of the referral made to restorative. The DOR stated all residents were screened by therapy services on admission or readmission to the facility however there was no documentation of the screening process and if R85 did not have a change in status on return from the hospital she would not have been picked up by therapy again.

3. During interview and observation on 11/09/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 45	F 688		

at 11:06 AM, R81's left hand appeared contracted, four fingers were observed to be clenched into the shape of a fist. R81 was unable to answer specific questions about her care.

Review of R81's "Census" tab in the EMR revealed, R81 was initially admitted to the facility on 10/18/04 and discharged on 01/09/21. R81 readmitted to the facility on 01/19/21.

Review of R81's "Medical Diagnoses" tab in the EMR revealed R81's diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (hemiplegia) following unspecified cerebrovascular (related to brain and its blood vessels) disease affecting unspecified side.

Review of R81's quarterly MDS with an ARD of 09/21/21 revealed R81 had a BIMS of eight out of 15, indicating moderate cognitive impairment; R81 had limited range of motion in the upper extremity on one side; R81 had not received restorative services during the look back period.

Review of R81's "Progress Notes" tab in the EMR, revealed a restorative nursing progress note dated 01/08/21 at 4:34 PM which documented "patient tolerate passive range of motion to left hand patient tolerate gentles [sic] stretch patient tolerate left palm guard patient skin intact with no break down." There were no additional restorative nursing progress notes after 01/08/21.

Review of R81's care plan located in the "Care Plan" tab in the EMR, revealed a focus for alteration in pain or comfort related to contractures. The interventions included to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 46	F 688		

provide medication for pain relief, observe and report changes in range of motion, and to reposition for comfort. The care plan did not have current interventions to address maintaining the current range of motion.

Review of the "Tasks" tab in R81's EMR, revealed the following restorative tasks that were no longer active, undated: palm guard application during the day, passive range of motion through bilaterally lower extremities, and passive range of motion to left hand for contracture management.

Review of R81's "Initial Evaluation," provided by the facility revealed R81 received physical therapy services from 07/11/18 through 08/09/18 to improve muscle strength and functional mobility.

Review of R81's "Discharge Summary," dated 08/09/18, provided by the facility, from physical therapy documented a recommendation of referral to Restorative Nursing Program to achieve Full Maximum Potential.

During an interview on 11/11/21 at 11:32 am, Restorative Aide (RA) 30 stated R81 had previously been on restorative services and used a palm guard. RA30 stated R81 was not currently on services, and she did not recall how long R81 had been off services or why she was removed.

During an interview on 11/11/21 at 11:45 AM, RA18 stated R81 had previously been on the restorative program and palm guard. RA18 stated R81 did not currently have the palm guard and was not on services at this time. RA18 stated R81 had discharged to the hospital, and she did not recall R81 returning to restorative services, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 47 did not know why the R81 had not been picked up again. During an interview and observation on 11/11/21 at 2:50 PM of R81 with Licensed Practical Nurse (LPN) 31, LPN31 asked R81 if she could open her hand and attempted to assist R81 to open her hand. R81 stated that it hurt, and she did not want LPN31 touch her hand. During an interview on 11/10/21 at 4:00 PM, the ADON stated R81 had previously received restorative services several times at the facility. The ADON confirmed that R81 was not currently receiving restorative services or contracture management. The ADON did not know why R81 was not currently receiving services. During an interview on 11/11/21 at 9:00 AM, the DOR stated R81 had been on a restorative plan for contracture management and was not sure why she was not picked up after hospitalization.	F 688		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to	F 695	1. R189- tubing was dated and label. R13 □ tubing on O2, nebulizer and BIPAP	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 695	Continued From page 48 ensure staff maintained appropriate infection control measures for the safe handling, cleaning, and storage of respiratory equipment for four residents of five residents (Resident (R)13, R44, R90 and R189) reviewed for respiratory care in a total sample of 65 residents. Findings include: Review of the facility policy, "Oxygen Therapy," dated 08/28/17 stated, " ...label tubing and humidifier with date and time..." 1. Review of R189's "Treatment Administration Record (TAR)" and "Medication Administration Record (MAR)" for November 2021, located in electronic medical record (EMR) under the orders tab, revealed an oxygen tubing change order active to be changed every Wednesday. During an observation on 11/08/21 at 12:18 PM, R189's oxygen tubing was not dated or labeled to indicate the last change of tubing. 2. Review of R13's "Admission Record," located in the EMR under the "Profile" tab, revealed the facility admitted R13 on 12/16/20 with diagnoses that included chronic respiratory failure, diastolic (congestive) heart failure and atrial flutter (abnormal heart rhythm). Review of R13's EMR physician orders located under tab titled "Orders," dated 12/12/20 indicated the resident had an order for, "oxygen-continuous 2L/min [liters per minute] via NC [nasal cannula]." Review of R13's EMR physician orders located under tab titled "Orders," dated 12/23/20,	F 695	changed dated and labeled. R44 □tubing changed, dated O2 and nebulizer. R90 □ air compressor, suction machine tubing changed and dated. 100% audit of current residents with respiratory equipment tubing□s changed and dated. 2. Residents with respiratory equipment have the potential to be affected. 3. The Staff Development Coordinator (SDC) and or designee will educate the license staff on policy for changing and labeling all respiratory tubing□s. 4. The Director of Clinical Service (DCS) and or designee will conduct weekly audits on Thursday and Mondays for 5 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 695	Continued From page 49	F 695		

indicated the resident had an order for staff to "change oxygen tubing and or [sic] nasal cannula and/or mask weekly. May change sooner as needed every night shift every Wed [Wednesday]."

Review of R13's EMR, TAR, located under tab titled, "Orders," for the months of October 2021 and November 2021 documented that R13's tubing was last changed on 10/03/21.

During an observation of R13 in bed on 11/09/21 at 9:24 AM, it was noted that an oxygen (O2) concentrator was running at two liters per minute. In addition, there was a nebulizer and a continuous positive airway pressure (CPAP) machine at R13's bedside. Each device had tubing attached which was not labeled with a date and time to indicate when it was last changed.

During an observation of R13 in bed on 11/10/21 at 8:23 AM, O2 was running at two liters per minute. In addition, there was a nebulizer and a CPAP machine at R13's bedside. Each device had tubing attached which was not labeled with a date and time to indicate when it was last changed.

During an interview on 11/10/21 at 8:23 AM, R13 indicated that a lot of staff did not normally label the oxygen tubing and she could not remember the last time it was changed. She indicated that she used the nebulizer, CPAP, and O2 daily.

During an interview on 11/10/21 at 6:55PM, Licensed Practical Nurse (LPN) 40 indicated oxygen tubing should be changed every Wednesday by the evening shift nurses. LPN40 reported tubing should be labeled. At the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 50	F 695		

interview, LPN40 confirmed that R13's respiratory tubing was not dated or labeled.

During an interview on 11/11/21 at 11:05 AM, the Infection Preventionist (IP) indicated that all respiratory tubing was supposed to be dated and labeled by the evening nurse on Wednesdays.

During an interview on 11/11/21 at approximately 4:04 PM, the Director of Nursing (DON) indicated it was her expectation that residents' respiratory tubing was changed, and labeled with the date it was changed, at least once a week, unless otherwise indicated.

3. Review of the "Profile" tab in the EMR for R44 revealed an admission date of 02/11/21 with diagnoses including chronic obstructive pulmonary disease (COPD; progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and dementia.

The quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact.

Review of the physician's orders located in the "Physician's Orders" tab in the EMR revealed an order dated 02/11/21 for supplemental oxygen at 3 liter/minute per nasal cannula.

Observation of R44's supplemental oxygen concentrator on 11/08/21 at 9:30 AM revealed undated oxygen tubing. The humidifier bottle, which adds humidification to the supplemental oxygen, was attached to the concentrator and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 695	Continued From page 51	F 695		

was dry, not providing humidification.

Observation and interview with the Assistant Director of Nursing (ADON) on 11/11/21 at 9:30 AM revealed R44's oxygen concentrator tubing was not changed weekly as per policy and confirmed the humidifier bottle was dry with white scale/deposits in the bottle of the bottle.

4. Review of R90's undated "Admission Record," located in the EMR, revealed the facility admitted R90 on 03/19/21 with diagnoses that included acute respiratory failure and a tracheotomy ((trach) an opening in a patient's windpipe to clear an obstruction and assist them in breathing).

Review of R90's EMR physician orders located under tab titled "Orders," dated 03/19/21, indicated the resident had an order to suction his trach as needed.

Review of R90's EMR physician orders located under tab titled "Orders," dated 03/23/21, indicated the resident had an order for the use of oxygen at five liters to run continuously at five liters via trach.

Review of R90's quarterly MDS with an ARD of 09/14/21 indicated R90 had a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident was ambulatory, required suctioning and trach care.

Review of R90's EMR care plan under tab "Care Plan," revealed the resident was to be suctioned as needed.

Review of R90's EMR TAR, located under a tab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 695	Continued From page 52	F 695		

titled "Orders," for the months of September 2021, October 2021, and November 2021 (through 11/09/21) revealed there were no treatment orders to change R90's oxygen tubing, air compressor tubing, or suctioning machine tubing.

During an observation of R90's room on 11/09/21 at 3:45 PM, to the left side of R90's bed, the top of the bed side table had a suctioning machine, air compressor, and a suctioning machine. Each device had tubing from it and the tubing was unlabeled with time and date.

During an interview on 11/10/21 at 8:53 AM, Licensed Practical Nurse (LPN) 14 stated the labeling of respiratory tubing was completed by the night shift staff. LPN 14 stated not changing the respiratory tubing on a regular basis could be a potential infection control issue.

During an observation of R90's room on 11/10/21 at 9:07 AM, to the left side of R90's bed, the top of the bed side table had a suctioning machine, air compressor, and a suctioning machine. Each device had tubing from it and the tubing was unlabeled with time and date.

During an interview on 11/10/21 at 4:40 PM, the Corporate Nurse and the DON were present. The DON stated it was her expectation residents' respiratory tubing was changed and labeled with time and date once a week, unless otherwise indicated.

During an interview on 11/11/21 at 10:09 AM, R90 was only able to respond to yes/no questions. R90 confirmed, by nodding his head "yes" nursing staff change his respiratory tubing monthly.

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F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident out of 65 (Resident (R)187) sampled residents was seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Findings include: Review of the "Medical Diagnoses" tab in the electronic medical record (EMR) revealed R187 was admitted by the facility on 07/16/21 with diagnoses including generalized weakness, major depressive disorder, and chronic diastolic congestive heart failure.	F 712	1. R187 had visit on 11/12 2. Long term care new admissions have the potential to be affected. 3. The DON and or designee will educate the physician teams and NPP on the regulations for Medicaid Admission visits. 4. The Director of Clinical Service (DCS) and or Medical records Coordinator will audit the visitation regulation requirements on the admissions 5 x week for 4 weeks, 2 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 712	Continued From page 54 Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/22/21 revealed R187 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. During an interview on 11/08/21 at 2:21 PM, R187 reported he was upset regarding not seeing the doctor or nurse practitioner since admission to the facility. Review of physician visits provided by the facility, revealed the R187 was seen by the attending physician on 07/19/21, three days after admission and by the Nurse Practitioner (NP) on 10/31/21, 102 days after initial exam of attending physician. The documentation lacked evidence R187 was seen by the physician or NP other than 07/19/21 and 10/31/21. During an interview on 11/11/21 at 2:03 PM, the Director of Nursing (DON) reported it was not her responsibility to monitor the physician visits because they were contracted personnel. She further explained that the physicians scheduled their own visits with the residents because they were private contractors. The DON was uncertain if someone at the facility followed up to monitor the frequency of physicians' visits.	F 712		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 730		12/26/21

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 730	Continued From page 55 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on facility document review, staff interviews, and policy review, the facility failed to ensure three Certified Nursing Assistants (CNAs) of five CNAs (CNA23, CNA8, and CNA16) reviewed were provided annual performance reviews. Additionally, the facility failed to ensure CNA 23 completed 12 hours of annual education which included dementia training, and other areas in which CNA 23 showed an area of weakness. The deficiency could result in a decreased quality of life or quality of care for the residents. Findings include: Review of CNA23's employee record indicated the staff member was hired on 05/23/17. Review of a document provided by the facility titled "Performance Evaluation," undated and unsigned was in CNA23's employee file. There was no evidence CNA23 had an annual performance review since his date of hire per review of the employee's file. In addition, review of a document provided by the facility titled "Training Hours," dated 11/11/21, indicated CNA23 completed three hours of annual training for the date range of 05/23/18 to 05/23/19 and completed two hours of annual training for the date range of 05/23/20 to 05/23/21. There was no evidence the staff member was provided annual training for dementia care and other training based on the outcome of his annual reviews. Review of CNA8's employee record indicated the staff member was hired on 07/13/11. Review of a document provided by the facility titled	F 730	1. Performance review completed for staff (23, 8,16). CNA 23 off schedule until he completed all of mandatory educations. 2. All staff have the potential to be affected. Audited all staff education and 100% clinical PMP conducted 3. The Staff Development Coordinator (SDC) and or designee will educate the staff on completing mandatory education. The Director of Clinical services will educate the managers and HR on the Performance reviews. 4. The Director of Clinical Service (DCS) and or designee review the performance evaluation and the education weekly on Monday and Friday X 5 weeks, Thursday X 2 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 730	Continued From page 56	F 730		

"Performance Evaluation," signed as dated 03/28/18 by CNA8. There was no evidence CNA8 had an annual performance review since 03/28/18 per review of the employee's file.

Review of CNA16's employee record indicated the staff member was hired on 08/21/11. Review of a document provided by the facility titled "Performance Evaluation," signed as dated 08/26/18 by CNA16. There was no evidence CNA16 had an annual performance review since 08/26/18.

During an interview on 11/11/18 at 1:59 PM, Registered Nurse (RN) 20 who was also the facility's Staff Development Director, confirmed CNA 23 lacked the 12 hours of training.

During an interview on 11/11/21 at 2:16 PM, the Director of Nursing (DON) confirmed CNA 23 did not complete his required 12 hours of training and the facility needed to do better with tracking training for CNAs. The DON stated annual performance reviews were provided to nursing managers to complete with CNAs on an annual basis.

During an interview on 11/11/21 at 2:49 PM, the Human Resource Director confirmed there were no annual performance reviews for CNA 23 since his anniversary date of 05/23/17 forward. Human Resource Director confirmed there were no annual performance reviews for CNA 8 since 03/28/18 forward, and CNA 16 since 08/26/18 forward.

During an interview on 11/11/21 at 3:05 PM, the Administrator stated the Human Resource Director was recently hired and completing audits

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 730	Continued From page 57 on all the employee files. The Administrator stated she became aware of the incomplete annual performance reviews for CNA 23, CNA 8, and CNA 16 recently. The Administrator stated Human Resources was to distribute the performance reviews to the CNAs' managers. The CNAs' managers were then to complete the staff members' performance reviews and upon completion the managers were to return the performance reviews back to Human Resources. The Administrator stated her expectation were for CNAs to complete the required 12 hours of annual training. Review of a facility policy and procedure titled "Employee j=Job Performance Evaluation," dated 11/30/14 indicated ". . .It is the policy of The Company to evaluate each employee's job performance prior to the completion of their Introductory Period and annually thereafter. . . Performance evaluations should contain goals and objectives, which provide employees with guidelines and time frames within which to attain such goals and/or to improve their performance. . ."	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 732	Continued From page 58 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure daily staffing was posted in which the posting contained the daily census of the facility. This had the potential to not provide residents and family members information regarding staffing and current census. Findings include: During an observation on 11/10/21 at 4:25 PM, the staff posting was located at the main entrance	F 732	1. Daily staffing is currently being posted daily to include on the daily Census and was not completed on day of the survey. 2. No residents have the potential to be affected. 3. The Executive director educated the Director of Clinical services on fully completing the Daily staffing including census. 4. The Executive Director or designee will Audit daily staffing posting 5 x week for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 732	Continued From page 59 of the facility. This area was currently closed due to management of screening of staff, vendors, and residents. Review of documents provided by the facility titled "Daily Nursing Staffing Form," for the dates of 11/08/21 and 11/09/21 failed to have the census identified on each form. There was no staffing information posted for 11/10/21. During an interview on 11/11/21 at 2:26 PM, the Administrator stated the Director of Nursing (DON) completed the staff posting. The Administrator stated it was her expectation that the staff posting was filled out completely.	F 732	weeks, 2 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 756	Continued From page 60 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure pharmacy services thoroughly reviewed the resident medication regimens to identify irregularities related to the use of an anti-psychotropic (Seroquel) medication for one of five residents (Residents (R) R 147) reviewed for unnecessary psychotropic medication use. Findings include: Review of a hospital document provided by the facility titled "Discharge Summary," indicated R147 was treated for a urinary tract infection. The discharge summary indicated the resident had a diagnosis of dementia with behaviors and was started on Seroquel 25 milligrams (mg). Review of R147's undated "Admission Record," in the Electronic Medical Record (EMR) located	F 756	1. R147 Drug review was completed. No initial change in medication because of review. . 2. New admissions on antipsychotics have the potential to be affected. 3. Permanent consulting pharmacist has been assigned to facility. Education with pharmacist will be completed on drug regimen review by consulting pharmacy management and /or designee. 4. The Director of Clinical Service (DCS) and or designee audit admission 5 x week for 2 weeks, 2 x week for 4 weeks, then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 756	Continued From page 61	F 756		

under tab "Profile," indicated the resident was admitted to the facility on 10/11/21, with a diagnosis of dementia with behaviors.

Review of R147's EMR physician orders, located under tab "Orders," dated 10/11/21 indicated staff were to administer Seroquel 25 mg at bedtime.

Review of a document provided by the facility titled "Admission Medication Regimen Review Report," dated with the review period of 10/04/21 through 11/09/21, indicated the Consultant Pharmacist reviewed an order for a lidocaine patch for R147. There was no evidence the Consultant Pharmacist identified Seroquel as a medication that was started during the resident's previous hospital stay.

During an interview on 11/09/21 at 5:19 PM, R147's family member confirmed the resident was started on Seroquel while she was in the hospital.

During an interview on 11/11/21 at 8:52 AM, the Consultant Pharmacist stated he was temporarily assisting the facility with medication reviews for new admissions. The Consultant Pharmacist stated the facility had a recent resignation of the assigned Consultant Pharmacist. The Consultant Pharmacist confirmed he missed R147 being placed on Seroquel while in the hospital and should have picked this issue up during his review. The Consultant Pharmacist stated Seroquel 25 mg was a low dose and should have recommended Seroquel 12.5 mg to begin a gradual dose reduction. The Consultant Pharmacist stated since R147 was currently on a low dose it would be easy to get her off Seroquel 25 mg.

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 756	Continued From page 62 Review of a policy and procedure provided by the facility titled, "Monthly Drug Review," dated 04/21/17 indicated, ". . .During the drug regimen review the consultant pharmacist to identify drug irregularities . . . Drug regimen irregularities to be communicated to the attending physician. . ."	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility	F 761	1. TB (2A) discarded and reordered,	12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 63 policy review, the facility failed to properly label and initial three multi-vial medications from two of the four medication storage rooms located on the first and second floor. Additionally, the facility failed to monitor refrigerator temperatures daily for two of the facility's five medication refrigerators on the first and second floor. This had the potential to affect any resident who may receive medication which has been stored in these medication refrigerators. Findings include: Review of the facility policy for "Administering Medications, Med-Pass, Inc." with a revision date of April 2019, documented " ...The expiration/beyond use date on the medication label is checked prior to administering ...When opening a multi-dose container, the date opened is recorded on the container ..." 1. Observation on 11/11/21 at 8:00 AM of the medication room and medication refrigerator on the 2A nursing unit, revealed one open multi-dose vial of tubersol mantoux (serum used to test for the presence of Tuberculosis) with a lot number of 28764, and expiration date of 10/22. The vial was not labeled and dated as to when the vial had been opened. During an interview immediately following the observation of the 2A medication room, License Practical Nurse (LPN) 33, reported the staff should date and initial the tubersol mantoux vial when it is opened. LPN33 continued to relate it was her understanding that the tubersol mantoux vial was good until the expiration date of 10/22, and she was not sure what the facility's practice was for checking the medication room.	F 761	Lorazepam- (1B) discarded and reordered. (1B) Lantus discarded and reordered. Temperature are being taken daily and vaccine refrigerator twice a day. Refrigerator not done on weekends. 2. Residents and staff have the potential to be affected. 3. The Staff Development Coordinator (SDC) and or designee will educate the license staff on monitoring refrigerators on unit. And All License staff will be educated on storage and dating medication. The Immunization refrigerator, 2A unit fridges. The storage of medication will be audited by The Director of Clinical Service (DCS) and or designee review the will audit logs 5 X week for 4 weeks, 2 x week for 2 weeks and then monthly X 2. 4. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 761	Continued From page 64	F 761		

2. Observation on 11/11/21 at 8:45 AM of the medication room and medication refrigerator on the 1B nursing unit revealed one bottle of Lorazepam (an anti-anxiety medication) concentrate two milligrams per milliliter (mg/ml), with a lot number of C8D3, and expiration date of "28Feb2023." The bottle was opened and not dated or initialed. Observation of the 1B medication room also revealed one Lantus insulin pen. The lid to the pen was dated 08/29/21 with a label directing staff to discard after 28 days. and the pen itself was marked with a date of 10/11/21 an incorrect top on insulin pen which was opened an 08/29/21 and labeled to discard after 28 days, the body of the pen was dated as being opened on 10/11/21.

During an interview immediately following the observation of the 1B medication room, Unit Manager, Licensed Practical Nurse (LPN) 32 reported all medication vials should be dated and initialed when opened and discarded after 30 days. LPN 32 continued to reveal that she completed a walk through on the medication room twice a week to check on the refrigerator to ensure the safety and potency of the refrigerated medication for the residents of the facility.

Continued observation revealed, the medication room refrigerator temperature logs for the 2A unit revealed inconsistent documentation of temperature monitoring. The temperature log posted on the outside refrigerator door lacked any documentation of temperatures for the for the month of November 2021; lacked documentation of temperatures for 30 of 31 days for the month of October 2021; lacked documentation of temperatures for 21 of 30 days for the month of

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 761	Continued From page 65 September 2021; and lacked documentation of temperatures for 20 of 31 days for the month of August 2021. During an interview immediately following the observation, Unit Manager, LPN reported the night shift nursing staff was responsible for documenting the temperature of the medication fridge. LPN32 further stated she last checked the log when she placed a new one on the refrigerator for November 2021. LPN32 stated she did not know what happened to the November 2021 log. Observation on 11/11/21 at 9:00 AM of the medication refrigerator temperature log in the conference room, which stored influenza vaccine, revealed for the month of October 2021, the temperature was not recorded on the days of October 6th and 7th, Saturday and Sunday. Interview with the Director of Nursing (DON) on 11/11/21 at 2:00 PM revealed it was her expectation that all the staff nurses should date and initial multi-dose medication vials when opened and discard the vial after 30 days. The DON reported the night shift nurse was responsible for recording daily medication refrigerator temperatures for the medication refrigerators located on their respective nursing units. The DON further explained that the temperature of the medication refrigerator in the conference room was not checked on the weekend, because no one else had the keys to the conference room except for the DON.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 66 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 67 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policies and review of Center for Disease Control (CDC) guidance, the facility failed to: ensure all staff don (put on) proper personal protective equipment (PPE) prior to providing care and encountering R253 who potentially was exposed to COVID-19 while in the hospital; store and label resident personal items in shared restrooms in a manner to prevent cross-contamination; maintain infection control practices in the laundry area of the facility; and failed ensure staff members wore face masks appropriately to prevent the spread of	F 880	1. Staff are wearing proper PPE when entering room to provide care for R253. Storing items in shared BR to are be labeled appropriately in a manner that prevents contamination. Staff wearing mask to prevent COVID spread. Catheter removed from the floor. Shower rooms cleaned, item personal removed and labelled, chair cleaned, Personal items removed and or labelled in Bathrooms. R135 and R253 were separated into private rooms on 11/11/21 and remained	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 68 COVID-19. Findings include: 1. Review of a document provided by the facility titled "MODERNA-SARS-CoV-2- M RNA," dated 09/02/21, indicated R253 received her first COVID-19 vaccine. Review of a document provided by the facility, titled "H&P (History and Physical)," dated 11/03/21, indicated R253 presented to the hospital on 11/02/21 with a head injury and change in her condition. Review of a document provided by the facility, dated 11/03/21, indicated R253 had a negative rapid antigen COVID test. Review of R253's undated "Admission Record," in the Electronic Medical Record (EMR) located under tab "Profile," indicated the resident was admitted to the facility on 11/05/21. Review of R253's EMR document titled "COVID-19 Symptom Monitor," dated 11/07/21 indicated the resident was provided a full assessment for COVID-19 symptoms. There was no additional evidence R253 was being monitored every 12 hours for symptoms of COVID-19. During an observation conducted on 11/08/21 at 2:35 PM, Patient Care Assistant 22 ((PCA) training position to become a Certified Nursing Assistant (CNA)), donned a gown and then a pair of disposable gloves. Observed PCA 22 with a disposable surgical mask on and then entered R253's room. PCA 22 failed to don eye protection and a N95 mask prior to entering into R253's	F 880	on quarantine. Admission coordinator was educated on entering a resident□s room on quarantine and donning and doffing appropriate PPE prior to entering room on 11/11/21. 2B shower room, duct tape was removed from the striker hole on 11/11/21. Resident tub between 160 & 170 was cleaned and items removed from tub. Floors in laundry room on clean and soil side have been cleaned. Washing machine #1 debris on rubber on the door has been removed and clean. Washing machine #2 base does have rust, when examined, it does not affect the cleaning effect of the washing machine. The Vertical plastic dividers panels in laundry have been removed and cleaned. Replacement panels have been ordered for all. Dryer #1 brown debris inside drum has been removed and clean. Dryer #3 visible rust does not affect the function or the quality of the linen or clothes used in the machine according to vendor. Vendor for the dryer and washer will be providing a quote for replacements. 2. All staff and residents have the potential to be affected. 3. The Staff Development Coordinator (SDC) and or designee will educate the staff on Transmission based precautions, cleaning and labeling residents items to include cleaning patient care areas after use equipment and proper placement of catheter bag. Education for laundry staff on infection control will be performed and education on cleaning schedule for washers and dryers. Weekly cleaning schedule checklist for maintaining laundry has been implemented.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69 room. Observed R135, who shared the room with R253, was in the bed closest to the door. Observed a posted sign on the door of the residents' room titled "Contact Precautions" published by the CDC. The posted sign directed staff to perform hand hygiene, to don a gown, and to use dedicated or disposable equipment. The privacy curtain, located in the residents' room, was not pulled to separate both residents. Observed PCA 22 go to the bedside of R253. Observed R253 in bed and her bed was located by the window. Observed PCA22 take R253's remote control and raise the head of the bed for R253. At 2:38 PM, observed PCA 22 to doff (take off) the gown and gloves and perform hand hygiene. During an interview at 2:39 PM, PCA22 stated R253 wanted the rest of her cookie to eat, and she provided the resident some liquids to drink. PCA22 confirmed R253 was under quarantine. PCA22 stated if a resident was positive with COVID-19, she would don a gown, N95, gloves and eye protection. During an observation on 11/08/21 at 3:32 PM, the Admission Coordinator stood next to R253's bed and had the resident, while in bed, sign documents. Observed the Admission Coordinator without a gown, gloves, N95 mask or eye protection. Observed the Admission Coordinator with a disposable face mask during her encounter with R253. Observed the privacy curtain and it was not pulled to separate both residents. During an interview on 11/11/21 at 10:26 AM, Assistant Director of Nursing (ADON), who was the facility's Infection Control Preventionist (ICP) stated it was her understanding when an unvaccinated new admission resident was placed under quarantine, staff were to don eye	F 880	4. The Director of Clinical Service (DCS) and or designee audit shower room, catheter bag placement patient Bathrooms, 5 X weeks for 4 weeks, 2 X week for 32 weeks , then monthly for two months. The DCS/designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. Housekeeper supervisor and/or designee will audit laundry area 2 times a week for 4 weeks and weekly for 4 weeks for infection control. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the housekeeping supervisor and/ or Executive Director for further compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 70	F 880		

protection, gown, gloves, and a surgical mask. Also present during this interview was the Administrator. The ADON stated R253 should not have been placed in the same room as R135 since R135 was not considered a new admission. The ADON stated R135 was unvaccinated. When the ADON was asked what type of precautions should R253 be under, the ADON stated "droplet." The ADON stated newly quarantined residents were monitored every 12 hours for 14 days. The Administrator stated the facility was waiting for an authorization on the day R253 was admitted. The Administrator stated the hospital transferred R253 to the facility without an authorization and the Administrator stated the facility did not send residents back to the hospital, so the staff admitted the resident. The Administrator stated the 12 hours of monitoring for signs and symptoms were not completed for R253. The ADON stated R135 would need to be placed under transmission-based precautions for potential exposure to COVID-19.

During an interview on 11/11/21 at 3:12 PM, the Admission Coordinator confirmed she entered the room to R253 without eye protection, gown, gloves, and a N95 mask on and was aware she was to don these items prior to entering a quarantined resident room.

Review of a document provided by the facility titled "COVID-19-Pandemic Plan," dated 10/04/21 indicated ". . . COVID-19 is a respiratory illness thought to be spread mainly from person to person, between people who come in close contact to one another (about 6 feet). Symptoms may include fever, cough, shortness of breath, sore throat, vomiting, diarrhea, muscle pain, headache, new loss of taste or smell, chills, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 71	F 880		

repeated shaking with chills . . . New admissions/readmissions . . . Unvaccinated residents (even those with a negative test upon admission) will be quarantined for 14 days. . . Place the resident in a private room - if a private room is not available, resident placed in a room with another new admission. . . Initiate transmission based precautions based on CDC guidance (Standard, Contact, and Droplet) Including PPE - Respirator, face shield or eye protection, gown, and gloves. . . increase monitoring from daily to every shift. . ."

Review of the CDC (Centers for Disease Control) guidelines dated 09/10/21, revealed ". . .In general, healthcare facilities should continue to follow the IPC (Infection Control Prevention) recommendations for unvaccinated individuals (e.g., use of Transmission-Based Precautions for those that have had close contact to someone with SARS-CoV-2 infection). . . However, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility. . . Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation . . . Implement Universal Use of Personal Protective Equipment for HCP . . . Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. . . Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters . . ."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 880	Continued From page 72	F 880		

retrieved on 11/11/21 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.

2. During an observation on 11/08/21 at 11:33 AM outside of room 214, Restorative Aide (RA) 18's face mask was under her chin fully exposing the nose and mouth. RA18 was immediately interviewed. RA18 stated it was policy in the building to wear masks over the nose and mouth and to keep the mask on when going into and out of resident rooms.

During an observation on 11/09/21 at 8:18 AM, Certified Nursing Assistant (CNA) 27's mask was placed under her chin fully exposing nose and mouth while coming out of a resident room and carrying a meal tray.

During an interview on 11/09/21 at 8:18 AM, CNA27 stated she was part time and knew the mask policy but was just hot in the room. CNA27 Acknowledged wearing the mask under the chin was not the right way to properly wear it and confirmed being properly trained on donning and doffing of PPE.

3. During an observation on 11/10/21 at 8:28 AM, R78's catheter bag was lying flat on the floor under the resident's bedside table.

During an interview on 11/10/21 at 8:48 AM, the Assistant Director of Nursing (ADON), entered the resident's room and acknowledged the catheter bag lying on the floor; donned gloves and then proceeded to pick up the catheter bag and hang on the bed. The ADON then performed hand hygiene and stated the catheter policy definitely did not allow for the catheter bag to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 73	F 880		

on the floor and she would expect it to be hanging on the bed correctly, checked by staff and covered with a privacy bag.

4. During an observation on 11/08/21 at 12:57 PM in the shared 2B shower room, fecal matter was smeared on the resident shower chair, open personal items were sitting on the counter area with no label or date, and duct tape was stuck on the striker hole of the door.

Observation and interview conducted simultaneously on 11/10/21 at 8:55 AM in the 2B shower room, ADON/Infection Control Preventionist (ICP) stated she saw the duct tape on the striker and did not know why it was there but should not be. The ADON acknowledged the personal items were not labeled and left on the shelf and the fecal matter on the shower chair, stating the CNAs were supposed to clean the shower chairs after each shower between residents stating this was not acceptable.

An observation on 11/08/21 at 9:45 AM of the Unit 2A back shower room revealed two unlabeled bottles of body wash and two unlabeled bottles of skin and hair cleanser sitting on the sink. These concerns were unchanged during follow up observations on 11/09/21 at 4:47 PM, 11/10/21 at 3:21 PM, and 11/11/21 at 1:13 PM.
An observation on 11/08/21 at 9:49 AM of the resident bathroom between rooms 160 and 170 revealed the tub was visibly soiled and an unlabeled bath basin containing an unlabeled bottle of body soap and roll of toilet paper were in the room. These concerns were unchanged during follow up observations on 11/09/21 at 4:48PM, 11/10/21 at 3:23 PM, and 11/11/21 at 1:00 PM.

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 74	F 880		

During an observation on 11/08/21 at 9:52 AM, the resident bathroom between rooms 252 and 254 had an unlabeled bottle of skin and hair cleanser on the sink. This concern was unchanged during follow up observations on 11/09/21 at 4:50 PM, 11/10/21 at 3:23 PM, and 11/11/21 at 1:15 PM.

During an observation on 11/08/21 at 9:56 AM of the resident bathroom between rooms 239 and 241, revealed an unlabeled bottle of skin and hair cleanser. This concern was unchanged during follow up observations on 11/09/21 at 4:53PM, 11/10/21 at 3:27 PM, and 11/11/21 at 1:18PM.

During an observation on 11/08/21 at 4:38 PM, the resident bathroom between rooms 240 and 242 contained an unlabeled bath basin, an unlabeled bottle body bath oil, and an unlabeled bottle of skin and hair cleanser on the sink, as well as an opened bag of large adult briefs on the floor under the sink. These concerns were unchanged during follow up observations on 11/09/21 at 4:49 PM, 11/10/21 at 3:24 PM, and 11/11/21 at 1:115 PM

During an observation on 11/10/21 at 6:00 PM the resident bathroom between rooms 248 and 250 contained a white sweatshirt draped over commode in corner. This concern was unchanged during follow up observations on 11/09/21 at 4:52 PM, 11/10/21 at 3:27 PM, and 11/11/21 at 1:21 PM.

During an interview on 11/09/21 at 11:49 AM, Housekeeper (HK)47 indicated it was the nursing staff's responsibility to take the residents' items out of the bathrooms.

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 75	F 880		

During an interview on 11/10/21 at approximately 1:53 PM, Certified Nursing Assistant (CNA) 46 indicated nursing staff should label resident personal supplies and personal supplies should be returned to the resident's room after use. CNA46 reported there should be no supplies on bathroom sinks, floors, or in the tubs.

During an interview on 11/11/21 at approximately 8:28 AM Licensed Practical Nurse (LPN)12 confirmed that the bathrooms were shared by multiple residents, staff should label all residents' personal items, and all personal items should be taken back to the resident's room after use.

5. During an observation of the laundry department on 11/11/21 at 08:14 AM, with Laundry Aide (LA)37 revealed the following:
Floors in the clean and dirty sides were visible soiled with debris;
Washing machine number one had debris in the rubber of the door;
The bottom of washing machine number two was rusty;
The vertical plastic divider panels between the clean and dirty areas were visibly soiled with dust and debris;
Three plastic divider panels that separated the clean and dirty areas were missing;
Dryer number one had solid caked-on brown debris of unknown origin on the inside of the drum; and
Dryer number three had visible rust on the inside of the drum.

During an observation on 11/11/21 at 8:15 AM, Laundry Aide 37 used her right arm to push the vertical plastic panels to the right side of the door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 880	Continued From page 76 frame resulting in dust and debris visibly floating in the air on the clean and dirty side of the laundry room. During an interview on 11/11/21 at 8:14 AM, Laundry Aide 37 reported the vertical plastic divider panels between the clean and dirty areas had been missing for a long time, and they did not seem dirty to her. Laundry Aide 37 confirmed the sink, dryers, and the floors of the clean and dirty laundry areas were visibly soiled. At the time of interview, Laundry Aide 37 indicated that eight of the total 195 residents had their laundry done outside the facility. During an interview on 11/11/21 at 5:50 PM the Administrator confirmed that the vertical plastic divider panels which separated the clean and dirty laundry areas were missing and soiled, the eye was station was not clean, dryer number one had caked on brown debris in the drum, dryer number three had rust in the drum, washing machine number one had visible debris on the door, and the filters on washers one and two were visibly soiled.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure equipment located in the laundry services areas were in safe operating condition, specifically washing machine filters were not cleaned daily as indicated on the manufacturer's	F 908	1. Washing Machine filters were cleaned and laundry staff was educated on proper cleaning of filters. Dryer Number 2 continues to be out of service and not in use. Vendor has been notified for	12/26/21

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 908	Continued From page 77 instruction label, dryer number two was not in working order, and the laundry room sink was not in working order. This failure has the potential to affect 187 of 195 residents in the facility whose laundry was cleansed onsite. Findings include: During an observation of the laundry department on 11/11/21 at 8:14 AM, with Laundry Aide 37 revealed the following: The sink next to the eye wash station was soiled with a missing faucet handle, and was not in working condition; The filter on left side of washing machine number two was visibly caked with dust and debris, with a label that read, "clean filter daily"; Washing machine number three's filter on the left side was visibly caked with dust and debris, with a label that read, "clean filter daily"; and Dryer number two's inside drum was visibly rusty and not in working order. During an interview on 11/11/21 at 08:14 AM, Laundry Aide 37 indicated that dryer number two had been broken down "for a long time." She said she could not remember how long it had been since the sink next to the eye wash station worked. Laundry Aide 37 reported that maintenance was aware of all the equipment problems in the laundry room. She reported she had not been cleaning the filters on the washing machines daily. At the time of interview, Laundry Aide 37 indicated that eight of the total 195 residents had their laundry done outside the facility. During an interview on 11/11/21 at 5:50 PM the Administrator indicated she was aware dryer	F 908	replacement quote. Dryer 1 and 3 remain operational and sufficient for workload. Laundry room sink faucet was replaced and sink cleaned on 12/8/21. 2. All Residents that have the potential to be affected. 3. Daily filter checklist for washing machine will be posted and signed off for filter cleaning. Laundry staff educated on the proper use of the filter checklist. Vendor for washing machine and dryer will provide a quote for replacement and/ recommendation for repairs. 4. Environmental Services Director and/or designee will audit washing machine filter cleaning checklist weekly for accuracy for 4 weeks. Then every other week for 4 weeks. Maintenance will audit laundry sink functioning properly weekly for 4 weeks. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the environmental services director and/ or designee for further compliance and/or revision.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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

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F 908	Continued From page 78 number two and the laundry room sink were not in working order.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the facility failed to adequately provide call light assistance for two) of 65 sampled residents (Residents (R)110 and R159). Findings Include: During an interview on 11/09/21 at 8:58 AM, R159 stated the ring bell was on table before but has no idea where it is now. R159 then pushed the call light attached to the wall and no light came on to alert staff. R159 stated the call light did not work and has not worked for a while and maintenance was aware. R159 confirmed the use of a wheelchair for mobility and pointed to the wheelchair next to bed. Record review R159 minimum data set (MDS) with an Assessment Reference Date of 10/15/21 found in the electronic healthcare Record (EHR) revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, which indicated the resident was cognitively	F 919	1. R 159 and R110 call bell was replaced and in operating condition on 11/9/21. 2. All resident rooms with call bells have the potential to be affected. 3. Call bells maintenance request will be placed in maintenance log for service when call bells are not functioning properly. Call bell vendor was at the facility 11/10/21 approximately around 5 pm to ensure 1B call bells were functioning and unit 1B was in working order. If call bells are not working properly the facility has hand bells available for residents to alert the staff. Audit sheets have been implemented for all call lights in the building to ensure working properly. Staff will be re-educated on logging items in maintenance log. Maintenance staff has been reeducated on responding to maintenance requests log book. 4. Maintenance and/or Designee with audit call bell functions in 10 resident	12/26/21

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 919	Continued From page 79 intact. During an interview on 11/09/21 at 8:58 AM, R110 stated he had a ring bell but it was on the floor by the dresser because it gets knocked off the table sometimes. R110 stated he would just yell "nurse, nurse" if he needed something. R110 pushed the button on call light attached to wall and no light came on to alert staff. R110 stated he used a wheelchair to get around and reaching for the call bell on the floor can be challenging. Record review of R110 minimum data set (MDS) with an Assessment Reference Date of 10/1/21 found in the electronic healthcare Record (EHR) revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. Observation on 11/09/21 at 8:58 AM of R110 and R159's call bells initiated confirmed no light illuminate to alert staff to come in room for assistance. During an interview on 11/09/21 at 9:23 AM, Licensed Practical Nurse (LPN) 10 stated maintenance needs to explain what is going on with the call system and their ring bell issue, the residents are supposed to have bells if there is a call system issue and the residents do have ring bells because the call light is not working in R110 and R159's room. LPN10 stated she would get get R159 a new ring bell since his was missing. During an interview on 11/09/21 at 3:26 PM, the Maintenance Director stated he was not aware the call light was out in R110 and R159's room. The Maintenance Director stated he relied on the	F 919	rooms per unit 2 times a week for 4 weeks and 5 resident rooms per unit weekly for 4 weeks. Executive director will audit maintenance logs to ensure that maintenance requests are being addressed 2 times a week for 1 month and weekly for 2 months. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Maintenance director and/ or designee for further compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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CONSULATE HEALTH CARE OF NORFOLK	3900 LLEWELLYN AVE NORFOLK, VA 23504

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F 919	Continued From page 80 staff to tell him of any issues. the Maintenance Director stated he would fix the issue in the room now. The Maintenance Director stated the ring bells were their emergency use bells and he thinks that is why staff gave them out to R110 and R159. During an interview on 11/09/21 at 3:40 PM, LPN10 stated maintenance knew the call light has not been working in R110 and R159's room for a while and it has been since the middle of the year. LPN10 confirmed the ring bells were used for the residents when the call lights do not work. During an interview on 11/11/21 at 8:33 AM, LPN35 stated the hand ring bells have been out for a while and was surprised to see that the call light went off in the residents' room this morning. LPN35 stated the call system had been out for a while and the hand bells have been in resident rooms for months. Review of facility "Maintenance Policy" dated 11/30/2014 revealed "The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair."	F 919		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of policies, the facility failed to provide a safe,	F 921	1. 2A nursing station ceiling tiles, ceiling tiles hallway between 157 &158, room	12/26/21

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F 921	Continued From page 81 functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the facility failed to ensure community spaces, shared shower rooms, and sinks were in good repair. These failures had the potential to affect all 195 residents residing in the facility. Findings include: During an observation of the 2A nursing station on 11/08/21 at 9:42 AM, four ceiling tiles above the residents' charts were stained. These concerns were unchanged during follow up observations conducted on 11/09/21 at 4:49 PM, 11/10/21 at 3:30 PM, and 11/11/21 at 1:21 PM. During an observation on 11/08/21 at 9:45 AM of the Unit 2A back shower room revealed a missing drain cover, missing tiles on floor, visibly soiled grout, and visibly soiled floors and walls. Multiple ceiling tiles along the back of the wall were stained. These concerns were unchanged during follow up observations conducted on 11/09/21 at 4:47 PM, 11/10/21 at 3:21 PM, and 11/11/21 at 1:13 PM. During an observation on 11/08/21 at 9:47 AM of the 2A hall between rooms 157 and 158 ceiling tiles next to exit sign had black stains. These concerns were unchanged during follow up observations conducted on 11/09/21 at 4:48 PM, 11/10/21 at 3:23 PM, and 11/11/21 at 1:10 PM. During an observation on 11/08/21 at 10:30 AM, the 1A unit had a strong odor of urine in the hallway. During an observation in room 107 on 11/08/21 at 10:32 AM, a resident washed their hands in the	F 921	157, 140, 141, 143, 150, 158, 164, 168, 170, 172, 173, and 174 ceiling tiles have all been changed and completed 12/10/21. Drain cover in 2A bathroom replaced on 11/11/21. 2A bathroom has been cleaned. Urine smells on 1A and 1B by rooms 226 to 234 is resolved and cleaned. 107 sink drain has been cleared. 1A nurses station bathroom sink and cabinet has been replaced and all trash has been disposed of. Sink in conference room has no apparent repairs needed. Sink is draining appropriately. Faucet in room 104 has been replaced. Sink in room 219 was repaired. 2A nurses bathroom is in the process of being renovated sink and cabinet has been replaced. 2. All rooms and bathrooms have the potential to be affected. 3. Room audit sheets has been implemented to identify rooms needing ceiling tile repair, sink or faucet repair, and paint repair. The facility has assigned room rounds to report repairs in rooms and bathrooms and rooms in need of housekeeping. Maintenance has been educated on audit sheets by Executive Director. Maintenance has been reeducated on room round observation by Executive Director. All Staff will be educated by staff educator and/or designee on logging maintenance requests and repairs. 4. The Executive director and/or designee will complete an audit on the facility rooms 2 times a week for 4 weeks, then weekly for four weeks then monthly for 4 months to ensure a clean	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 82 sink, shut off the faucet, and the sink did not drain. During an observation on 11/08/21 at 12:47 PM, the staff bathroom located behind the 1A nursing station had water running and the handles to the faucet could not turn off. The sink had a door partially hinged to the cabinet below the sink and upon opening the cabinet there was a damp roll of toilet paper and a rag covered with a dark substance covering a spray bottle. There was a strong damp odor present. There was a black substance around the base of the cabinet sink floor. During an observation on 11/08/21 at 12:48 PM on Unit 1B, heavy urine odors were noted throughout the hallway area from rooms 226 through room 234. During an observation on 11/08/21 at 4:27 PM in room 157, revealed water stains on two ceiling tiles above the television. During an observation on 11/09/21 at 9:30 AM, the sink located in the conference room of the facility was audibly gurgling. A foamy white substance was observed to fill the base of the sink. During an observation with the Maintenance Director on 11/09/21 at 10:25 AM, in room 104 the sink's left handle to the faucet could not completely shut the water off. The Maintenance Director stated staff must have pushed the handle to the off position too hard and now the handle did not work. The Maintenance Director stated he could not repair areas in the facility if he was not alerted to these concerns.	F 921	comfortable homelike environment. The results will be reported to the Quality Assurance Performance Committee by the Executive Director monthly for further compliance and/or revision.	

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	495273	A. BUILDING _____ B. WING _____	C 11/11/2021

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F 921	Continued From page 83	F 921		

During an observation conducted on 11/09/21 at 10:41 AM, the Maintenance Director entered the staff bathroom, located behind the 1A nursing station. At the time of observation, water was running from the sink. The Maintenance Director confirmed he was not notified of the broken handles to the faucet. The Maintenance Director opened the partially hinged cabinet door, and a damp roll of toilet paper was present, and a rag stained with a dark substance draped over a spray bottle. There was a strong damp musty smell emitting from the cabinet.

During an observation with the Maintenance Director on 11/09/21 at 3:48 PM in room 219, the sink continuously leaked. The Maintenance Director confirmed the sink was leaking and reported he had not been aware of the issue previously. The observation continued with the Maintenance Director as he entered room 105 and revealed the water to the sink in room 105 was turned on. The Maintenance Director reported it was just turned back on after being off for an extended amount of time follwoing repairs.

During an observation conducted on 11/10/21 at 9:08 AM, the bathroom behind the 1A nursing station still had running water on. A random staff member entered the bathroom to wash her hands and then left the area and the water remained on.

During an observation conducted on 11/11/21 at 2:37 PM, the bathroom located behind the 2A nursing station had an area on the wall above the sink that was patched but had not been sanded down. The wall patch was peeling. The walls in the bathroom were stained. There were water stains located under the paper towel dispenser.

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F 921	Continued From page 84	F 921		

Across from the toilet there were drilled holes that were open and not patched.

During an observation on the 2B unit on 11/10/21 at 6:40 PM, multiple stained ceiling tiles were observed in rooms 140, 141 143, 150, 158, 164, 168, 170, 172, 173, and 174.

During an interview on 11/09/21 at 10:20 AM, the Maintenance Director stated the process for alerting him to needed repairs was the two additional maintenance staff did general rounds, identified areas in need of repairs, and then to proceeded with the repairs.

During an interview on 11/09/21 at 3:38 PM, Licensed Practical Nurse (LPN)10 stated she usually picked up the phone and called the Maintenance Assistant to come do something when she was aware of an issue. LPN10 stated maintenance was informed of the water issues in the resident rooms, but they had not been fixed yet. LPN10 stated this had been an issue for a while.

During a confidential staff interview on 11/10/21 at 6:50 PM, the staff member indicated that "maintenance replaces the ceiling tiles all the time, but they never address the problem causing the stains."

During an interview on 11/11/21 at 5:21 PM, the Administrator stated the facility had a two-pipe system and when the air conditioning was on the pipes sweat and then leaked into the ceiling tiles. The Administrator stated she developed maintenance plans and sometimes the plans got approved and there were times the maintenance plans were not approved by the corporate office.

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F 921	Continued From page 85 The Administrator stated she must develop a plan of correction and all major repairs go through the corporate office. The Administrator stated if repairs did not get approved then the facility's maintenance department attempted to complete the project. During an interview on 11/11/21 at 5:53 PM the Administrator stated she was aware "the facility could be a lot cleaner" and she was aware that the bathrooms, resident rooms, staff areas, and common areas were not in good repair. The Administrator indicated that she was aware the facility had a lot of environmental concerns, but they did not have money for repairs. Review of a policy and procedure document provided by the facility titled "Maintenance," dated 11/30/14, indicated ". . .The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair. . ." The facility failed to provide policies related to housekeeping services and environment upon request.	F 921		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and facility policy review, the facility failed to maintain an effective pest control program to ensure the building remained free of pests,	F 925	1. Pest Control Company was called and treated rooms #216, 149, 102, 219. 2. All residents have the potential to be affected.	12/26/21

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F 925	Continued From page 86 specifically the facility failed to follow recommendations from the pest control company. This failure had the potential to affect all 195 residents living in the facility. Findings include: Review of facility pest control policy dated 11/30/14, revealed the facility will maintain a pest control program, which includes inspection, reporting, and prevention and treatment will be rendered as required to control insects and vermin. Review of the pest control summary sheets dated 07/29/21, 08/17/21, 08/19/21, 8/24/21, 09/02/21, 09/16/21, 09/23/21, 09/30/21, 10/05/21, 10/14/21, 10/22/21, 10/26/21, and 11/09/21 indicated additional steps the facility could take to assist in reducing pests, such as removing organic matter found in resident rooms and picking up resident belongings off the floors in resident rooms. The pest control summary sheets also revealed recommendations that the facility needed treatment for cockroaches, German roaches, in all the interior of facility. During an observation in R103's room on 11/08/21 at 10:41 AM, revealed a product titled "Fly Ribbon" by Raid, was hanging next to the mounted television. There was one dead fly on the ribbon and several gnats. During an observation on 11/08/21 at 10:42 AM, R36 rested quietly in bed with his eyes closed. A water bottle with a straw and pre-packaged snacks were noted on the bedside table. Over one dozen gnats were swarming the lid and the water bottle at the time of observation.	F 925	3. Maintenance staff and/or designee will meet with pest control specialist document and communicate recommendations with department managers at weekly morning meeting for recommendations for pest mitigation. Pest Control Company and Executive Director schedule a meeting reviewing alternate professional treatment and control for building, review of recommendations. The Pest control company has schedule 2 times week visit to maintain a pest control and as needed. Staff to be re-educated on logging items in pest control book, and on strategies of reducing the presence of pest in facilities. Maintenance will ask resident council president if he can speak at next council meeting to share strategies of reducing pests. 4. Pest Book will be reviewed by Maintenance or Executive Director weekly for concerns times 4 weeks. Maintenance staff and/or designee will meet with pest control specialist 1 time a week for recommendations for pest mitigation. The maintenance director and/or executive director will conduct a walking audit of rooms and facility grounds weekly for 4 weeks then monthly for 6 months which includes the monitoring of traps and pest control devices and observation of pest control specialist recommendations are being followed. Variances will be addressed promptly. The QAPI committee will determine the frequency of continued ongoing monitoring thereafter. The results will be reported to the Quality Assurance Performance Improvement	

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F 925	Continued From page 87 During an interview on 11/08/21 at 10:46 AM, R141 stated he had seen a couple of cock roaches in his room. During an observation on 11/08/21 at 12:16 PM, R36 rested quietly in bed with his eyes closed. A water bottle with a straw and R36's covered lunch tray were on the bedside table. Approximately six gnats were observed flying around the food and drink. During an interview on 11/09/21 at 8:30 AM with R110 and R159, R110 stated he had been in the facility since March of this year and there was a roach issue in the facility. R110 then pointed to a dead roach on the floor next to his dresser. R110 stated they had seen roaches on the floor before and reported roaches get in residents' personal belongings like clothes in the dresser. R159 confirmed there were roaches in their dressers and crawling on the floor in their room. The room was observed to be cluttered. During an interview on 11/09/21 at 8:43 AM, Licensed Practical Nurse (LPN)17 and LPN10 both stated there were roaches in the facility. LPN17 and LPN10 said they had seen roaches in resident rooms, both on the floor and in their dressers. Both LPNs reported they had seen pest control in the facility but there were still roaches seen in the facility frequently. A group interview with member of the Resident Council was conducted on 11/09/21 at 2:00 PM with R21, R49, R92, R137, and R192 in attendance. All five residents reported they had concerns with insects in the building, specifically roaches. The residents stated the roaches were	F 925	Committee (QAPI) by the Maintenance director and/ or designee for further compliance and/or revision.	

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F 925	Continued From page 88 in their clothing and other personal items. The residents also reported they were bothered by gnats. An interview was attempted on 11/11/21 at 2:07 PM, the pest control company could not be reached.	F 925		