STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated survey was conducted 3/28/22 through 3/31/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints (VA00053147 substantiated with deficiency, VA00052363 substantiated with deficiency, and VA00051625 substantiated with deficiency) were investigated during the survey. The census in this 90 certified bed facility was 85 at the time of survey. The Resident sample consisted of 8 Residents.	F 000	RECEIVED APR 27 2022 VDH/OLC	
F 600 SS=D	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 observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the	F 600	1. The plan of care for resident #4 was updated to reflect current status. Resident #4 BIMS was reassessed and remains a score of 10. Resident #4 placed on 1:1 supervision. Resident #7 is no longer a resident of the center. Resident #2 and #8 have displayed no negative outcomes from the event in 2021. 2. Social Worker/designee will interview residents with BIMS greater than 8 and Responsible Party of residents with BIMS lower than 8 to determine concerns of safety. 3. Social Worker/designee reviewed Resident Rights with residents at resident council to include Abuse, Neglect and Exploitation policy and practice on 4/18/2022. Executive Director/designee will re-educate all staff on abuse policy to include safe-guarding residents,reporting incidents and diversional activities. 4. Clinical records, incidents and grievances will be reviewed in morning meeting to identify abuse occurrences for 6 weeks. The ED will report any identified patterns and trends to the QAPI Committee quarterly. 5. Alleged date of compliance: 4/22/2022	

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

Executive Director 4/15/22

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 600	Continued From page 1 facility staff failed to maintain abuse prevention for three Residents (Residents #2, #7, and Resident #8) in a survey sample of 8 residents. Resident #4 willfully abused Residents #2, #7 and #8. Resident #4 was a demented Resident, however, the act was not accidental. The victims were bed or chair fast on each occasion of occurrence, and Resident #4 ambulated independently to each of their rooms, and assaulted them on 3 separate occasions. The findings included: Resident #2 had diagnoses that included; spinal stenosis, narcolepsy, mild cognitive impairment, hypertension and dementia. The Resident had decreased mobility and stayed in bed most of the time requiring staff assistance for activities of daily living such as transferring, hygiene and dressing, Resident #7 had diagnoses that included; stroke, malnutrition, aphasia, dysphagia, weakness, anxiety, depression, severe cognitive impairment, and dementia.. The Resident was total care and non-ambulatory. Resident #8 had diagnoses that included; atrial fibrillation, cardiac artery disease, hypertension, Alzheimer disease, dementia, severe cognitive impairment, depression, and anxiety. The Resident was total care and non-ambulatory. Resident #4 (the aggressor) had diagnoses including but not limited to; Alcoholic cirrhosis of the liver, and encephalopathy, bipolar disorder with mixed severe psychotic features, Insulin dependant diabetes, and seizure disorder.	F 600	Type text here	

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F 600	Continued From page 2	F 600		

The Full Admission Assessment indicated that Resident #4 was ambulatory and oriented to self with a BIMS (brief interview of mental status) of "10" out of a possible 15, or moderate cognitive impairment. The Resident was able to feed and dress self with supervision.

Review of the nursing progress notes revealed Resident #4 to be documented as physically and verbally abusive toward others upon admission, and continuing up unit the time of survey.

The Residents care plan was reviewed and initiated on 6-25-21, and indicated behaviors including; "yelling, negative statements, hallucinations, hitting at staff, refusing medications, threatening staff and others, yelling at staff for his money, cursing at staff, agitation, wandering around unit, aggressive with staff, attempts to get room mate out of bed, sitting on room mate, packing up belongings, demanding a cab (transportation), yelling at residents, pacing unit, struck resident, pulling down pants peeing on floor and wall, jumping at staff, inappropriate language, paranoid behavior, threatening/attempting to strike other residents and staff, delusions, attempts to climb fence in courtyard, banging chairs against window.

Interventions in the care plan included 1:1 (one staff member with the Resident) or 15 minute safety checks as indicated for behavior monitoring initiated on 9-14-21, after 2 assaults had occurred. The intervention was revised on 3-1-22 to discontinue 1:1.

Progress Notes and Facility Reported Incident (FRI) reports sent to the Virginia Department of

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Health (VDH) Office of Licensure and Certification (OLC) were reviewed for August, September, and October of 2021. These documents revealed the following;

On 8-4-21 Resident #4 wandering into other resident rooms, exiting out of back doors, attempted to get room mate out of bed (Resident #8) and sitting on room mate.
On 8-13-21 Resident #4 makes statements wishing to die.
On 8-19-21 cursing and threatening & aggressive to staff, refusing to allow staff to provide ADL care for room mate.
On 8-23-21 screaming, agitated, cursing at staff, pacing unit, telling room mate to shut up, told staff "you'll see what I do" in personal space of staff, aggressive threatening physical harm to staff, staff afraid of physical harm, other residents agitated due to Resident #4 behaviors, police called twice.
On 8-24-21 wandering into other resident rooms yelling and screaming proceeded toward a resident's room who told him to shut up saying "make me". Sent to ER (emergency room) for evaluation.
On 8-28-21 Resident #4 entered the room of Resident #2 who was in bed and punched him in the chest 3 times.
Went out to the courtyard and tried to get out stating staff won't let him leave.
On 8-25-21 yelling, cursing, screaming at staff.
On 9-4-21 entered an unknown female resident's room pulled down his pants and told her to "kiss his a.." (buttocks). Exit seeking, trying to get other resident to follow him, going into other resident rooms.
On 9-5-21 Resident #4 verbally abusive cursing and threatening to throw Resident #8 out of bed,

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F 600	Continued From page 4	F 600		

then attempted to hit another unknown resident, then entered an unknown female resident's room pulled down his pants and told her to "kiss his a.." (buttocks).
On 9-7-21 Yelling at room mate that rent is due, going into other resident rooms, fussing at residents and staff, stating "I don't belong here and I'm going to be mean to everyone until I get out of here."
On 9-9-21 same behaviors.
On 9-11-21, going into other resident rooms and peeing on the walls.
On 9-20-21 telling staff he is going to shoot them, told another resident he was going to shoot them
On 9-29-21 jumping at staff, cursing at staff, going into other resident rooms
On 9-30-21 Verbally and physically abusive to residents and staff, going into resident rooms making them feel uncomfortable and afraid, wandering out into the common area with no pants on.
On 10-3-21 Resident #4 walked over to a wheel chair bound female Resident #7, and told staff if they approached him he would hit the Resident. The staff stepped toward him and he punched Resident #7 in the face, then tried to hit the staff member.

This behavior was documented over 16 times in 3 months, and included 3 known assaults. Supervision interventions for this Resident were not described as to how and when to perform them in the care plan.

The incidents of the three known assaults were not reported to the state agency timely. A synopsis of each occurrence and report date to the state agency follows;

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F 600	Continued From page 5 Wednesday Resident #8 incident 8-4-21 never reported Saturday Resident #2 incident 8-28-21 reported Monday 8-30-21 Sunday Resident #7 incident 10-3-21 reported Wednesday 10-6-21 The notes indicated continued willful acts on the part of Resident #4, and the fact that the facility failed to protect Residents #2, #7, and #8 from their attacker is well documented. The incidents of Resident #4 entering other resident rooms, while the residents were in their rooms and cursing at them (verbal abuse), disrobing in front of them, and urinating on the walls of their rooms, is also abuse, and was not reported to the state agency. Nursing Progress Notes describe that during staff attempts at redirection for these behaviors, the Resident becomes agitated and strikes out verbally and physically at staff. Notes describe staff inability to redirect successfully, and also describe 15 minute checks and 1:1 used interchangeably and randomly at staff discretion. The care plan does not direct under what circumstances it is appropriate to apply continuous 1:1 monitoring, versus just 15 minute checks. On 3-28-21 Staff members, and the Activity Director on the Dementia care locked unit, were interviewed and stated that redirecting Resident #4 was very difficult and didn't work most of the time. They further stated that he would escalate and turn his aggression on the staff when they attempted to get him out of other resident's rooms, or keep him from yelling and cursing. The staff stated they were at times fearful of the	F 600		

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Resident because " he can walk as well as we can and he is a strong man, you never know when he is going to lash out, he will hit us and other residents." They stated 1:1 and 15 minute checks were still used as needed, and they could not describe what situation would warrant 1:1 as opposed to 15 minute safety checks.

The Resident was being followed by Psychiatric medical practioner, which included evaluations and medication management.

At the time of survey, the Resident was in semi private room with no room mate.

The facility Abuse policy was reviewed and revealed under Item #3 "Prevention - the following systems have been implemented - under bullet #3 - Sufficient numbers of staff to meet the resident needs. Under item #6 Protection - under bullet #3 - increased supervision of the alleged victim and residents, bullet #4 - room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Under Item #7 Reporting/Response - report...not later than 24 hours ...to other officials in accordance with state law."

The Psychiatric services were not attempted to be arranged for 3 months after admission, during which time the Resident was abusive to Residents and staff. On 9-15-21 weeks after the Resident had physically assaulted a resident, a revision to the care plan was documented, and stated "Psyche PRN (as needed)." Psychiatric notes were found in the clinical record, dating as early as 8-19-21. These were conducted under the Covid-19 waiver and conducted via telemedicine and Resident #4 was not seen in

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F 600	Continued From page 7 person. The Resident continued to be abusive and aggressive for 3 months before this intervention was implemented. No Direction was given as to when Psychiatric services should be requested, only "as needed", however, no description of triggers for a needed consult were documented to direct care in the care plan for nursing staff to follow. No specific supervision direction was specified in the care plan for any of these behaviors. Who will supervise, when to supervise, and how to supervise this Resident have not been included, and are not person centered or measurable indicating staff is unaware of Resident need and how to meet it. In conclusion, the facility failed to maintain adequate supervision of Resident #4, and provide a safe environment for Residents #2, #7, and #8, and other potential victims. On 3-30-22, and 3-31-22 at the end of day meetings, the facility failure was reviewed with the Administrator, and Director Of Nursing. No further information was provided. Complaint deficiency.	F 600		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care	F 608	1. Executive Director of record at the time of these incidents is no longer employed at the center. The RVPO educated the current Executive Director of record the policy to report Abuse, Neglect and Exploitation and specificlly reporting the suspicion of a crime to the state agency and law enforcement within the required timelines. Resident #4 was placed on 1:1 supervision. Resident #7 is no longer a resident of the center. Resident #2 and #8 have displayed no negative psych/social outcomes from the event in 2021.	

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F 608	Continued From page 8 facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to report allegations of abuse timely to the state agency for three Residents (Residents #2, #7, and Resident #8) in a survey sample of 8 residents. Resident #4 willfully abused Residents #2, #7 and #8. The facility reported late for Residents #2, and #7, and did not report at all for Resident #8 on one of 2 occasions, specifically 8-4-21.	F 608	2. The Executive Director/designee reviewed grievences and incidents to determine if any resident experienced a negative outcome and/or if the grievence or incident met the reporting requirements. 3. The ED/designee has reviewed, with all staff, the policy to report Abuse, Neglect and Exploitation and specifically reporting the suspicion of a crime to the state agency and law enforcement within the required timelines on 4/18/2022. 4. The ED/designee will review timelines of reporting incidents in morning meeting for 6 weeks and report any identified issues to the QAPI committee. 5. Alleged date of compliance 4/22/2022.	

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F 608	Continued From page 9 The findings included: Resident #2 was admitted with diagnoses that included; spinal stenosis, narcolepsy, mild cognitive impairment, hypertension and dementia. The Resident had decreased mobility and stayed in bed most of the time requiring staff assistance for activities of daily living such as transferring, hygiene and dressing, Resident #7 was admitted with diagnoses that included; stroke, malnutrition, aphasia, dysphagia, weakness, anxiety, depression, severe cognitive impairment, and dementia.. The Resident was total care and non-ambulatory. Resident #8 was admitted with diagnoses that included; atrial fibrillation, cardiac artery disease, hypertension, Alzheimer disease, dementia, severe cognitive impairment, depression, and anxiety. The Resident was total care and non-ambulatory. The aggressor was Resident #4. Resident #4 was admitted to the facility with diagnoses including but not limited to; Alcoholic cirrhosis of the liver, and encephalopathy, bipolar disorder with mixed severe psychotic features, Insulin dependant diabetes, and seizure disorder. The incidents of the three known assaults were not reported to the state agency timely. Wednesday Resident #8 incident 8-4-21 never reported Saturday Resident #2 incident 8-28-21 reported Monday 8-30-21 Sunday Resident #7 incident 10-3-21 reported	F 608		

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F 608	Continued From page 10 Wednesday 10-6-21 The facility Abuse policy was reviewed and revealed under Item #3 "Prevention - the following systems have been implemented - under bullet #3 - Sufficient numbers of staff to meet the resident needs. Under item #6 Protection - under bullet #3 - increased supervision of the alleged victim and residents, bullet #4 - room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Under Item #7 Reporting/Response - report...not later than 24 hours ...to other officials in accordance with state law." In conclusion, the facility staff failed to report all allegations of abuse to the state agency as required by law, and reported late for 2 other known incidents. On 3-30-22, and 3-31-22 at the end of day meetings, the facility failure was reviewed with the Administrator, and Director Of Nursing. No further information was provided. Complaint deficiency.	F 608		
F 656 SS=D	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	F 656	1. The plan of care for Resident #4 was updated to reflect current status. 2. The center MDS personnel will complete an audit of care plans to ensure each reflect the current status of residents.	

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F 656	Continued From page 11 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 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 observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to develop a comprehensive supervision care plan for one Resident (Residents #4) in a survey sample of 8 residents.	F 656	3. The interdisciplinary team was provided education by the Regional Case Mix Coordinator on 4/18/2022 to ensure the care plans are updated to reflect the residents current status. 4. The center MDS personnel will review care plans process for 6 weeks and report findings to the QAPI Committee. 5. Alleged date of compliance 4/22/2022.	

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F 656	Continued From page 12 Staff supervision was not adequate for Resident #4, and not care planned in a person centered nor measurable way. The findings included: Resident #4 was admitted to the facility with diagnoses including but not limited to; Alcoholic cirrhosis of the liver, and encephalopathy, bipolar disorder with mixed severe psychotic features, Insulin dependant diabetes, and seizure disorder. The Full Admission Assessment indicated that the Resident was ambulatory and oriented to himself with a BIMS (brief interview of mental status) of "10" out of a possible 15, or moderate cognitive impairment. The Resident was able to feed and dress himself with supervision. The Residents care plan was reviewed and initiated on 6-25-21, and indicated behaviors including; "yelling, negative statements, hallucinations, hitting at staff, refusing medications, threatening staff and others, yelling at staff for his money, cursing at staff, agitation, wandering around unit, aggressive with staff, attempts to get room mate out of bed, sitting on room mate, packing up belongings, demanding a cab (transportation), yelling at residents, pacing unit, struck resident, pulling down pants peeing on floor and wall, jumping at staff, inappropriate language, paranoid behavior, threatening/attempting to strike other residents and staff, delusions, attempts to climb fence in courtyard, banging chairs against window. Interventions in the care plan included 1:1 (one staff member with the Resident) or 15 minute	F 656		

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safety checks as indicated for behavior monitoring initiated on 9-14-21, after 2 assaults had occurred. The intervention was revised on 3-1-22 to discontinue 1:1.

Nursing Progress Notes describe that during staff attempts at redirection for these behaviors, the Resident becomes agitated and strikes out verbally and physically at staff. Notes describe the staff inability to redirect successfully, and also describe 15 minute checks and 1:1 used interchangeably and randomly at staff discretion. The care plan did not direct under what circumstances it is appropriate to apply continuous 1:1 monitoring, versus just 15 minute checks, and thus staff are unaware of how to apply the interventions.

On 3-28-21 Staff members, and the Activity Director on the Dementia care locked unit, were interviewed and stated that redirecting Resident #4 was very difficult and didn't work most of the time. They further stated that he would escalate and turn his aggression on the staff when they attempted to get him out of other resident's rooms, or keep him from yelling and cursing. They stated 1:1 and 15 minute checks were still used as needed; however, they could not describe what situation would warrant 1:1 as opposed to 15 minute safety checks.

Supervision interventions for this Resident were not described as to how and when to perform them in the care plan. No specific supervision direction was specified in the care plan for behaviors, such as, who will supervise, when to supervise, and how to supervise this Resident was not included, and are not person centered or measurable indicating staff is unaware of

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F 656	Continued From page 14 Resident need and how to meet it. On 3-30-22, and 3-31-22 at the end of day meetings, the facility failure was reviewed with the Administrator, and Director Of Nursing. No further information was provided. Complaint deficiency.	F 656		
F 778 SS=D	Assist w/ Transport Arrangements to Radiology CFR(s): 483.50(b)(2)(iii) §483.50(b)(2)(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, staff interview, and in the course of a complaint investigation, the facility staff failed to assist with transport to diagnostic appointments for one Resident (Resident #1) in a survey sample of 8 Residents. The facility failed to assist Resident #1 secure transportation to eye appointments. The findings included; Resident #1 was admitted with a retinal detachment & "Giant Retinal tear" of the left eye. The Resident's eye sight was severely impaired and so the Resident required medication management and meal preparation, however, could ambulate, and was independent in toileting and hygiene needs.	F 778	1. Resident #1 has discharged from the center. 2. Resident with external appointment records were reviewed to determine an appropriate schedule for transportation needs is completed. 3. The DON/designee provided education of 4/18/2022 to tranportation manager and RN/LPN staff in reference to scheduling and completion of transportation services to meet residents' need. 4. The DON/designee will review transportation services completion for 6 weeks and report the findings to the QAPI Committee. 5. Alleged date of compliance 4/22/2022.	

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On 3-17-21, and 3-23-21 the Resident had appointments with her Ophthalmologist (eye doctor) and was unable to go to the appointments as transportation was not obtained for her.

On 3-29-22 at 2:00 P.M., an interview was conducted with the Transportation manager Employee (K). The employee stated that Employee (G) was the transportation person at that time, and that she had not taken the position until October of 2021. Employee (K) stated that the same situation had happened with the same Resident on 12-21-21 during a later stay. She stated that the Resident did not have insurance that would pay for transportation, so the Resident wanted to pay with a credit card, or be billed with the room in the facility.

Employee (G) was interviewed immediately after Employee (K) and stated that the Resident had missed those appointments, due to lack of transportation and that she had transported the Resident in her own car on 3-25-21 so the Resident's appointment would not be missed. Both employees stated that the Resident and her responsible party had asked that the Resident's credit card or room charge be billed for transportation, however, the business office refused, and transportation companies in the area had not been paid by the parent corporation of the facility so they would no longer provide transportation services to the facility.

The Administrator was made aware of the findings at the end of day debriefing on 3-29-22. A facility policy on transportation was requested, and supplied.

The policy stated "The Residence assists in

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F 778	Continued From page 16 making appointments for the Resident." "Procedure" The Director of Wellness will post a reminder to direct care staff and the Executive Director, of the request in the log book and work calendar located in the Wellness Center." The document went on to state the Director of Wellness was responsible for arranging transportation. Employee (K) was asked where the Wellness Center was located and where the log book could be found. Further she was asked who the Director of Wellness was. She stated "We don't have a Wellness Center that I am aware of, and I don't know of any log book, or Director of Wellness." On 3-31-22 the Administrator and Director of Nursing were made aware of findings. The Administrator stated he had no further information to provide. Complaint Deficiency.	F 778		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882	1. An Infection Preventionist (IP) has been indentified and placed in the role at the center. 2.An alternate IP has been indentified and will provide back up when necessary. 3. The Executive Director will provide education on 4/18/2022 to clinical leadership on the requirement to have an IP in place at the center. 4. The Executive Director/designee will monitor the IP role for 6 weeks to ensure compliance and report finding to the QAPI Committee. 5. Alleged date of compliance 4/22/2022.	

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F 882	Continued From page 17 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to employ a certified infection preventionist to mitigate the spread of COVID-19. There was no Certified infection preventionist for the facility. The findings included: On 3/28/2022 at approximately 1:00 P.M., The Administrator, and Director of Nursing (DON) were interviewed. When asked who the Infection Preventionist was, the Administrator stated that the Assistant Director of Nursing (ADON) was responsible. The Administrator also stated that the Assistant Director of Nursing (ADON) keeps track of all vaccinations, and went on to say it was the DON's first day in the facility. On 3/31/22 at 10:00 A.M. the administrator was interviewed, and stated, there was no education completed for the ADON infection preventionist	F 882		

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F 882	Continued From page 18 as yet, and the course was being scheduled for her. On 3/31/22 at approximately 12:00 noon, an end of day meeting was held with the Administrator and DON, they were notified of findings and asked if they wished to provide any further documentation. They both stated no. On 3/31/22 at 12:45 P.M., The exit conference was conducted, the administrator and DON confirmed they had no further information or documentation to submit.	F 882		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or	F 888	1. A vaccination spreedsheet was created and provided by the end of the survey. 2. A vaccination spreedsheet and Matrix has been updated to ensure accuracy and protection of residents from unvaccinated staff. 3. The Executive Director/designee will maintain a current listing of employees/contractors and update their vaccination status on the matrix weekly. 4. The Executive Director will monitor the matrix weekly for 6 weeks and report accuracy to the QAPI Committee. 5. Alleged date of compliance 4/22/2022.	

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F 888	Continued From page 19 other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of	F 888		

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all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be

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temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to develop its Policies and Procedures for "Covid additional precautions for those not fully vaccinated" to mitigate the spread of COVID-19.

There was no contingency plan for staff and Residents not fully vaccinated.

The findings included:

On 3/28/2022 at approximately 1:00 P.M., The Administrator, and Director of Nursing (DON) were interviewed. When asked about the additional precautions for facility staff with an exemption from the COVID-19 vaccine, the Administrator stated that staff with an exemption

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are expected to wear a surgical mask. When asked who the Infection Preventionist was, the Administrator stated that the Assistant Director of Nursing (ADON) was responsible. The Administrator also stated that the Assistant Director of Nursing (ADON) keeps track of all vaccinations, and went on to say it was the DON's first day in the facility.

A request was made at that time for; A list of all staff to include facility staff, contractors and agency staff, a list of all of those staff with vaccinations, all of those staff with exemptions, the infection Preventionist credentials and education record, an alphabetical list of all Residents, a record of all Resident immunizations, and COVID-19 policies.

On 3/28/2022 at approximately 3:30 P.M., the administrator supplied an alphabetical list of Residents, and a list of Resident COVID-19 vaccinations. The lists did not match, with the alphabetical roster revealing 86 Residents, the census revealing 85 Residents, and the immunization roster revealing 65 Residents, and Residents which were no longer in the facility. A corrected copy was requested. No staff records were provided, and the Administrator stated "We are working on them.".

On 3/29/22 at approximately 1:00 P.M. a corrected Resident roster was received, and did not match the immunization record. A corrected copy of both resident & staff rosters were again requested. The Administrator stated "We are working on them." The Administrator stated the ADON was not able to complete the Staff vaccination record as she had no training.

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F 888	Continued From page 23 On 3/30/22 at approximately 12:00 P.M. The third version revealed errors, however, after discussion with the Administrator, Human Resource Director, and MDS (minimum data set) assessment Director, the errors were discussed and accepted. A second corrected version of staff vaccination records were provided, and the records were missing staff names and vaccination status. A corrected copy was requested. On 3/30/22 at approximately 4:00 P.M., The Administrator supplied the third version of the staff roster and vaccination records to include those with exemptions. Some of the documents were handwritten on note paper, some were documented in an excel spread sheet, and some were from a human resources "Starters & Leavers" report system. Observations were conducted all 4 days of survey, and the following un-vaccinated exempted staff were observed to be on duty, in resident care areas, and wearing only surgical masks: On 3/28/22, 3/29/22, 3/30/22 Certified Nursing Aide (CNA B). On 3/29/22, 3/30/22, and 3/31/22 (Employee J dietary) The current Centers for Disease Control (CDC) and Centers for Medicare/Medicaid Services (CMS) guidance requires weekly testing, and the use of N-95 NIOSH approved masks to be worn by all staff who are not fully vaccinated. On 3/31/22 at 10:00 A.M. the administrator was interviewed, and stated, there was no education	F 888		

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F 888	Continued From page 24 completed for the ADON infection preventionist as yet, and the course was being scheduled for her. He went on to state that the corporation had not instituted a policy to direct how those staff who refused vaccination should practice in the facility, and under what safe guards, restrictions, or requirements the un-vaccinated staff would work with the resident population. A fourth version of corrected employee vaccination documents were supplied to the surveyor, and 129 employees were listed, however the report was inaccurate as the "starters/leavers" report included an employee not listed, facility dietary contracted staff names were not listed, one Rehab contract name was missing, and facility hired staff names were not listed. The final employee vaccination matrix document received, revealed 119 employees, with 113 fully vaccinated, 3 accepted religious exemptions, and 3 pending second dose of a double dose vaccine, that were new hires. On 3/31/22 at approximately 12:00 noon, an end of day meeting was held with the Administrator and DON, they were notified of findings and asked if they wished to provide any further documentation. They both stated no, and stated that the information provided to the NHSN (National Health Safety Network) would be corrected. On 3/31/22 at 12:45 P.M., The exit conference was conducted, the administrator and DON confirmed they had no further information or documentation to submit.	F 888		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921	1. Walls and baseboards have been cleaned to remove noticeable blemishes.	

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 25 §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 and in the course of a complaint investigation, the facility staff failed to maintain a functional and comfortable environment. The findings included; During 4 days of observation, the facility was not dirty, however, it was found to be in general disrepair with black scuff marks on the base boards, and walls. Walls had peeling paint, scraped off paint, metal picture hangers without pictures on the walls. Hand rails had been screwed into the walls with large unsightly bolted heads, and the furnishings were worn with threads broken on couches and chairs, and cushions on the furniture had large dips in the centers of them from use. Complaint Deficiency	F 921	2. Maintenance personnel rounded center to identify areas needing repair or cleaning. 3. Enviromental Services Director [EVS]/designee provided education to housekeeping staff on 4/18/2022 on observance and actions to clean or organize areas of concerns. 4. EVS Director will complete weekly audits for 6 weeks of cleanliness and appearance and report findings to QAPI Committee. 5. Alleged date of compliance 4/22/2022.	