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	495190	A. BUILDING _____ B. WING _____	R-C 06/22/2022

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CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

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{E 000}	Initial Comments	{E 000}	This plan of correction is respectfully submitted as an allegation of compliance.	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid first revisit to the standard survey conducted 05/10/22 through 05/12/22, was conducted 06/21/22 through 06/22/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint, VA00055281- substantiated with deficiency, was investigated during the survey. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 28 resident reviews.	{F 000}		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622	F622- Transfer and Discharge Requirements 1.Resident #115 discharged from facility on 6/6/2022. The physician entered a note in the clinical record for resident #115 indicating the reason for discharge. 2.Quality review conducted by the DCS (Director of Clinical Services)/designee of Residents discharged in the last 30 days to ensure that facility transfer and discharge requirements and documentation requirements have been met. 3. The Medical Director/designee, Social Services Director/ Unit Managers were re-educated by the DCS/designee related to the Transfer and discharge- Facility requirements and Documentation Requirements. 4.The ED/DCS/designee to conduct quality monitoring of discharged residents' medical record to ensure that facility transfer and discharge requirements and documentation requirements have been met, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	7/14/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
Robin Baschnagel	Digitally signed by Robin Baschnagel DN: cn=Robin Baschnagel, o=Consulate Healthcare, ou=Vice President of Operations | Virginia, email=robin.baschnagel@consulatehc.com, c=US Date: 2022.07.12 11:21:19 -04'00'	Robin Baschnagel Administrator	07/12/22

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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under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

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needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, facility documentation review, and in the course of a complaint investigation, the physician failed to document in the clinical record the need/basis for the facility initiated discharge for one Resident (Resident #115) in a survey sample of 28 Residents.

The findings included:

During the course of a complaint investigation the clinical record of Resident #115 was reviewed on

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6/21/22 and 6/22/22. This review revealed multiple instances of Resident #115 having behaviors towards staff and other Residents. There was also an indication that Resident #115 discharged from the facility on 6/6/22, to another facility.

The progress notes revealed the following entries:

A social services note dated 4/5/22, that read, "Social Services contacted [Resident #115's name redacted] guardian at [guardianship agency name and person's name redacted], to possibly discuss [Resident #115's name redacted] behavior and need for alternative placement. Social Services will continue to follow up".

Another note dated 4/11/22, indicated the guardian had given permission for Resident #115 to be transferred to another location.

A progress note dated 4/14/22, was noted and it read, "Director of Social Services, Administrator, [guardian name redacted], Case Manager Supervisor conferred regarding [Resident #115's name redacted] and the incident on 4/12/2022. [Administrator name redacted] issued a Virginia Involuntary Transfer/Discharge Notice citing that the resident is being discharged due to the health and safety of the resident, other resident, or staff endangerment..."

The next entry into the clinical record for Resident #115 with regards to discharge/discharge planning was on 6/3/22, which read, "writer and ED [executive director/administrator] spoke with [guardian agency name redacted] supervisor in regards to moving [Resident #115's name

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redacted] to a sister facility- [facility name redacted] on Tuesday 6/7. It was explained that [facility name redacted] was able to provide continued 1:1 care and that we would provide transportation. Writer stated she would notify [guardian agency name redacted] if the date and/or time of transport was to change".

On 6/6/22, an entry indicated Resident #115 was transferred to a different sister facility other than the one named in the note dated 6/3/22. There was no indication in the clinical record as to why the change in facilities or the transfer occurring a day earlier than originally discussed.

On 6/22/22 at 9 AM, an interview was conducted with the facility Administrator, in the absence of the social worker. The facility Administrator stated that the facility had issued a discharge notice to Resident #115, because of his behaviors, and he was felt to be a danger to himself and others. He was discharged to a sister facility that was better suited to meet his needs than the one initially planned.

On 6/22/22, the facility Administrator submitted the facility issued discharge notice. This notice was reviewed and revealed it was dated 4/13/22. This notice read, "This is to notify you, you will be transferred/discharged from our facility on May 20, 2022, to an alternate location. You are being discharged because: The health and safety of the resident, other residents or staff is endangered..."

Review of the clinician progress notes from the medical provider/doctor and nurse practitioner revealed no mention of the facility initiating discharge or that Resident #115 was a danger to himself or others and alternate placement was

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F 622	Continued From page 5 being sought. Review of the facility policy titled, "Transfer/Discharge Notification & Right to Appeal" was conducted. This policy read, "The documentation must be made by: The physician when the transfer or discharge is necessary due to: The resident no longer needs the services provided by the center; A physician when transfer or discharge is necessary due to: The safety of individuals in the center is endangered due to clinical or behavioral status of the resident; The health of individuals in the center would otherwise be endangered..." On 6/22/22 at 9:00 AM and again at approximately 10:30 am, the facility Administrator was made aware that the physician had not entered into the clinical record the reason for discharge of Resident #115 as required. No further information was provided. Complaint related deficiency.	F 622		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		

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F 661	Continued From page 6 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a compliant investigation, the facility staff failed to ensure a discharge summary was written after discharge for one Resident (Resident #115) in a survey sample of 28 Residents. The findings include: Resident #115 was discharged from the facility to another long-term care facility on 6/6/22, due to a facility initiated discharge. On 6/21/22 and 6/22/22, a review of the entire clinical record was conducted and revealed no discharge summary was present for Resident #115's discharge on 6/6/2022. On 6/22/22 at 9 AM, the facility Administrator was made aware of the above findings. The	F 661	1.Resident #115 discharged from facility on 6/6/2022. The Social Service Director or licensed clinical staff entered a discharge summary in resident #115's clinical record. 2.Quality review conducted by the DCS/designee of Residents discharged in the last 30 days to ensure that the Discharge summary was completed (A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.) 3.Social Services Director/ Unit Managers re-educated by the DCS/designee related to the Discharge Summary- When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. 4.The ED/DCS/designee to conduct quality monitoring of discharged residents' medical record to ensure that the Discharge summary was completed (A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.), weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services /designee.	7/14/2022

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F 661	Continued From page 7 Administrator confirmed that all discharges should have a discharge summary and if it was not in the clinical chart, they didn't have one. A review of the facility policy titled, "Discharge Planning" was conducted. This policy read, "...4. At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: Current diagnosis, Rehabilitation potential, Summary of prior treatment, Physician ' s orders for immediate care, Pertinent social information, Community referrals as needed (e.g., home health, mental health, adult day care, etc.)..." No further information was provided. Complaint related deficiency.	F 661		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	{F 686}	F686- Treatment/Services to Prevent/Heal Pressure Ulcers 1.Resident #119 currently has Physician orders for treatments to pressure areas, treatments have been implemented. 2.Quality review conducted by the DCS/designee of admissions/re-admissions in the last 30 days to identify residents with pressure areas and ensure treatments are ordered and implemented timely, to not cause a delay in treatment. 3.UMs (Unit Managers)/RN's and LPN's will be re-educated by the DCS/designee related to residents receiving care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 4.The ED/DCS/designee to conduct quality monitoring of admissions/re-admissions to identify residents with pressure areas and ensure treatments are ordered and implemented timely, 3 x weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	7/14/2022

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Based on staff interview, clinical record review and facility documentation review, the facility staff failed to assess, notify the physician, obtain and carry out treatment orders, for a pressure wound for one Resident (Resident #119) in a sample of 4 Residents reviewed for wound care.

The findings included:

On 6/21/22, a clinical record review revealed Resident #119 was admitted to the facility on 6/17/22. The "nursing data collection form" noted the following under in the area of skin: "multiple bruises on body, sacrum and both bottom red small opening to right buttocks [sic], and left stump [end of leg where previous amputation was made] has a unstageable [wound] [where the base of the wound is covered and unable to be observed to determine the depth and wound bed is unable to be observed]". This assessment had a "lock date" of 6/20/22.

The physician orders revealed an order dated 6/20/22, that read, "Left stump - Cleanse left stump with normal saline or commercial wound cleanser pat dry, skin prep peri area then apply honey and calcium alginate boarder form [sic] dressing every day shift for unsteagable [sic] and as needed for wound care". There was an additional order on 6/20/22, that read, "Cleanse Left and Right buttocks with soap and water and apply Zinc, every shift for wiound [sic] care stage 1".

On 6/21/22 at X: PM, an interview was conducted with RN B. RN B stated she had assessed Resident #119's wound on 6/20/22, and noted on the left stump a small wound with slough, so she staged it as unstageable". She added that she

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had obtained the treatment orders and initiated treatment to the stump and sacral areas on 6/20/22. RN B confirmed that she had made the entries on the admission data collection form on 6/20/22. RN B was asked what the "lock date" of 6/20/22, on the nursing admission data collection form indicated, and she said this was the date it was completed. RN B confirmed that Resident #119's wounds were not assessed or treated until 6/20/22.

During the above interview, RN B went on to confirm that Resident #119 had a lot of comorbidities that included but were not limited to: being diabetic, non-compliant, peripheral vascular disease and ETOH [ethyl alcohol] abuse, which all put him at a high risk and will result in slower healing of wounds. RN B also confirmed that wound(s) can deteriorate very rapidly in a matter of a few days.

RN B reviewed the clinical record for Resident #119 and confirmed that no treatment orders had been implemented at the time of admission on 6/17/22, and assessment and treatment of the wounds/skin impairments had not begun until 6/20/22.

The policy titled, "Admissions Assessment" was reviewed. This policy read, "At the time of admission or readmission, the Nurse shall initiate the Admission Data Collection Form or its electronic equivalent. Pertinent information shall be collected by physical review, interview with resident and family and review of the resident's available medical records. The Data Collection Form or its electronic equivalent will be completed within 24 hours".

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{F 686}	Continued From page 10 A review of the facility policy titled, "Clinical Guideline Skin & Wound", was conducted. This policy read, "On admission/re-admission the resident's skin will be evaluated for baseline skin condition and documented in the medical record...Licensed Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record...". On 6/21/22, during an end of day meeting the Administrator, Director of Nursing (DON) and Corporate Nurse Consultant were made aware of the above findings. The DON stated that the admitting nurses should observe skin upon admission, which she indicated as within 24 hours of arriving at the facility. During this same time, treatment orders should be obtained and initiated. No further information was provided prior to survey exit on 6/22/22.	{F 686}		