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	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consulate Health Care of Norfolk	3900 Llewellyn Ave Norfolk, VA 23504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on observation, resident interviews and staff interviews the facility staff failed to maintain a clean, comfortable, homelike environment for 2 of 6 residents (Resident #1 and Resident #2), in the survey sample. The findings included: 1. Resident #1 was originally admitted to the facility 1/26/2007. The current diagnoses included cerebral palsy, major depressive disorder, anxiety disorder, and schizoaffective disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/31/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. On 7/16/24 during an observation tour for room [ROOM NUMBER], it was observed that the air conditioning unit was not functioning. On 7/16/24 at 4:30 PM an interview was conducted with Resident #1. Resident #1 stated that the air conditioning unit has not been working for a while. Resident #1 also stated that she is uncomfortable due to the high temperature in her room. The Maintenance Assistant recorded an ambient temperature in this room at 83.8 Fahrenheit (F). On 7/16/24 at 3:45 PM an interview was conducted with the Administrator and the Maintenance Director. The Maintenance Director stated that there are currently seven (7) to eight (8) rooms that are having air conditioning issues. The Maintenance Director also stated that he did not know exactly what rooms are not functioning properly however the plan is for the Heating and Air Conditioning vendor to repair the air conditioning in these rooms once they acquire the parts for the repair. 2. Resident #2 was originally admitted to the facility 4/3/19. The current diagnoses included; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, vascular dementia, and Alzheimer's disease with early onset. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were moderately impaired. A substantial interview was not conducted due to the resident's cognitive status. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 during an observation tour for room [ROOM NUMBER], it was observed that the air conditioning unit was not functioning. On 7/16/24 at 4:20 PM an interview was conducted with the Maintenance Assistant. The Maintenance Assistant stated that it is hot in room [ROOM NUMBER] and the facility staff did not know the air conditioning was not working properly in the room. The Maintenance Assistant recorded an ambient temperature in this room of 84.4 (F). On 7/17/24 at approximately 4:40 p.m., a final interview was conducted with the Administrator, the Director of Nursing, and Interim Administrator. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a Do Not Resuscitate resident wishes were in place for 1 of 6 residents (Resident #6), in the survey sample. The findings included: Resident #6 was originally admitted to the facility [DATE] after an acute care hospital stay. The current diagnoses included; Thrombocytopenia Unspecified. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #6 cognitive abilities for daily decision making were intact. The person-centered care plan dated [DATE] read that Resident #6 has advance directive indicating Do Not Resuscitate (DNR). The Goal for the resident was to have the advance directive followed. The intervention was a physician order for DNR. In sectionGG(Functional Abilities Goals) the resident was coded as being independent with eating, oral hygiene, toileting hygiene, personal hygiene, walking. A review of the Durable Do Not Resuscitate Order (DDNRO) dated on [DATE] showed that it was signed by resident and physician. A review of the Advance Directives Discussion Document dated [DATE] read withhold Cardiopulmonary Resuscitation. A review of an Order Summary dated [DATE] at 11:45 AM., read Do Not Resuscitate (DNR). Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours for Shortness of Breath; Wheezing Phone Active [DATE]. A review of a Change in Condition Document dated [DATE] at 12:14 PM., read resident had signs and symptoms of wheezing, shortness of breath (sob), notified Nurse Practitioner (NP) on [DATE] at 12:00 noon. The NP recommended a stat chest xray and nebulizer treatment every 4 hours. The vital signs were within normal ranges. Document also read that resident is his own Responsible Party (RP) with no contact information. A review of progress notes dated on [DATE] at 9:58 PM., read: 911 working on him. taking resident to emergency room (ER). Nurse Practitioner (NP) aware, was in building. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Medication Administration Record (MAR), Resident #6 receive Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML for Shortness of Breath (SOB) and wheezing on [DATE]: 1:00 PM., 5:00 PM., and 9:00 PM. [DATE]: 1:00 AM., 5:00 AM., 9:00 AM., 1:00 PM., 5:00 PM and 9:00 PM. [DATE]: 1:00 AM., 5:00 AM., 9:00 AM., 1:00 PM., 5:00 PM and 9:00 PM. A review of a nursing progress note dated [DATE] at 9:08 PM. read that the resident complained of having shortness of breath (sob). Resident was in BR when I brought Nebulizer, came out sat down for nebulizer. Went to get 02 for his sob, returned in minutes and found resident unresponsive. weak pulse, no resp. Code Blue and 911 called. On [DATE] at approximately 1:15 PM., an interview was conducted with the Social Worker (SW). The SW said that the DNR document should have been uploaded into the Medical Record, but her assistant did not upload the document. The resident had been in the facility five months from admission with full code status that should have been DNR. An interview was conducted on [DATE] at approximately 11:43 AM., with Other Staff Member (OSM) #5 concerning Resident #6. OSM #5 said that chest compressions were done on the resident by the Emergency Medical Technicians (EMT's), a pulse was present before the resident was transported to the nearest hospital. OSM #5 also said that Emergency Medical Services (EMS) took over and continued to administer CPR. OSM #5 was asked if he was informed of Resident #6's code status. He said that he was not informed of the resident's code status by the staff. An interview was conducted on [DATE] at approximately 4:15 PM., with Licensed Practical Nurse (LPN) #3 concerning Resident #6. LPN #6 said that about a week ago, Code Blue was called on unit 1A and CPR was initiated on Resident #6. On [DATE] at approximately 12:45 p.m., the above findings were shared with the Administrator, Director of Nursing. The DON said that the Resident's DNR status should have been followed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49917 Based on observation and staff interviews the facility staff failed to maintain a comfortable environment for residents, staff, and the public. The findings included: On 7/16/24 during an observation tour of unit 1A and unit 1B, it was observed that the air conditioning was not functioning properly. During the observation tour on 7/16/24 at 4:00 PM the Maintenance Assistance recorded an ambient temperature of 84.6 degrees Fahrenheit (F) on unit 1A hallway and 85.2 degrees (F). on unit 1B hallway. The Maintenance Assistant stated that the nursing unit hallways are hot due to the temperature outside. On 7/16/24 at 4:05 PM an interview was conducted with the Administrator. The Administrator stated that there are four (4) portable air conditioning units in the building due to the air conditioning system not working properly. The Administrator also stated that the plan is for the heating and air conditioning vendor to repair the air conditioning once they acquire the parts for the repair. On 7/17/24 at approximately 4:40 p.m., a final interview was conducted with the Administrator, the Director of Nursing, and Interim Administrator. An opportunity was offered to the facility's staff to present additional information. The Administrator stated that the facility is currently working with the Occupational Safety and Health Administration in resolving the issue with the air conditioning system and the hot temperatures in sections of the building.