State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2767	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare standard survey and biennial state licensure survey was conducted 1-20-16 through 1-21-16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 12 bed facility was 12 at the time of survey. The survey sample consisted of 7 current Resident reviews (Residents 1 through 7) and 3 closed record reviews (Residents 8 through 10).	F 000	WindsorMeade respectfully submits this Plan of Correction in response to findings of the survey ending January 21, 2016. The submission of this POC does not acknowledge agreement with the findings but demonstrates our on-going commitment for compliance with all regulations.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Resident Rights 12 VAC 5-371-150 (B, D) Cross-Reference to F-156 Management and Administration 12 VAC 5-371-110 (B 1,2, 3) Cross Reference to F-225	F 001	12 VAC 5-371-150 [B, D], Cross reference to F-156 12 VAC 5-371—110 [B 1, 2, 3] Cross Reference to F-225	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]   TITLE: Administrator   (X6) DATE: 2/8/16

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	495402	A. BUILDING ______ B. WING ______	01/21/2016

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WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 1-20-16 through 1-21-16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 12 certified bed facility was 12 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents 1 through 7) and 3 closed record reviews (Residents 8 through 10).	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156	RECEIVED FEB 16 2016 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 2/8/16

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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the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and

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misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility, written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a timely ABN (Advanced Beneficiary Notice) was delivered at least 2 calendar days before Medicare covered services end, to one Resident (Residents #10) in a survey sample of 10 Residents.

For Resident #10 the ABN was delivered to the Resident one day before the Resident's benefits expired.

The findings included:

Resident #10, was initially admitted to the facility 12-4-15. Diagnoses included; Difficulty breathing, hypertension, high cholesterol, anemia, and difficulty walking. The Resident was admitted after a hospitalization for strengthening,

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Criterion #1
Resident #10 has been discharged from the facility.

Criterion #2
Other residents being discharged from skilled care may have potentially been affected. Discharged residents from Part A services in December 2015 and January 2016 have been reviewed to ensure that appropriate notice was provided.

Criterion #3
The social worker has reviewed the facility protocol for giving notice to residents when they are completing their Part A stay.

The social worker will document the resident's discharge plan including anticipated length of stay for Part A residents during the admission process and/or initial plan of care.

Criterion #4
The administrator / designee will review 50% of the residents discharged from Part A services x 2 months to ensure that proper and timely notice has been provided to the resident. Variances will be investigated and staff re-educated as needed.

Criterion #5 – Completion Date 2/12/2016

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and was discharged home on 12-9-15, after only five days.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-4-15 was coded as an admission assessment, and had no functional assessment completed before discharge. Resident #10 required limited physical assistance with activities of daily living, during the five day stay. According to staff, the Resident required assistance every day she was there, and was really not ready to be discharged, however, the Resident insisted on going home, and being discharged.

Review of Resident #10's clinical record revealed the Resident was determined to no longer require skilled services, and was informed of this decision by the facility Social Worker on 12-7-15. The Resident's Medicare covered services would end on 12-8-15, the next day. The QIO (Quality Improvement Organization) is responsible for handling the appeal process and without the federally required time to appeal the decision, Resident #10 would not have been afforded his/her right to appeal the decision to end their Medicare covered services.

When interviewed on 1-21-16, the Administrator reviewed the ABN. The Administrator was asked what guidance they used to administer the ABN (NOMNC) Notice of Medicare Non-Coverage. The response was "We use the CMS (Centers for Medicare & Medicaid Services) website", and delivered to surveyors a copy of the federally required mandate. The document stated that "The NOMNC must be delivered at least two calendar days before Medicare covered services end, or the second to last day of service if care is

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F 156	Continued From page 4 not being provided daily." The facility provided no further information.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

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incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed, for 2 residents (Resident #1 and Resident #5) of the survey sample of 10 residents, to assess, investigate and report injuries of unknown origin in a timely manner.

1. For Resident #1, the facility staff failed to submit a Facility Reported Incident to the Office of Licensure and Certification (OLC) within 24 hours of the incident.

2. For Resident # 5, the facility staff failed to submit a follow-up report to OLC within 5 days of the incident report.

The Findings included:

1. Resident #1 was an 89 year old who was admitted to the facility on 12/26/13. Resident #1 ' s diagnoses included Spinal Stenosis, Joint Pain of Lower Leg, Osteoarthros, and Depressive Disorder.

The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 12/30/15, coded Resident #1 as being able to understand and be understood by others.

On 1/20/16 a review was conducted of facility documentation, revealing a social services note dated 6/16/15. The staff documented that Resident #1 informed her that she was experiencing ankle pain. The Social Worker immediately informed the nurse, who assessed the resident's ankle and pain level. She had already administered scheduled pain medications to Resident #1 for osteoarthritis.

F 225

Criterion #1
An initial and follow up report was submitted to all required entities for Resident #1. The follow up report for Resident #5 was submitted to the required entities.

Criterion #2
Incident reports for the past 2 months have been reviewed to determine if any needed investigation or reporting to required entities that had not been done; none were found.

Criterion #3
Guidance for conducting comprehensive investigation and reporting to required entities has been reviewed with the facility by an outside consultant using the OLC guidance sheet from December 2015 and the CMS guidelines.

Criterion #4
The administrator and/or DON will review all incident reports to determine the need for possible reporting. A quarterly review of reportable events will be included in the organization's Quality Assurance review and report given to the QAPI Committee for additional oversight and recommendation.

Criterion #5 Completion date February 29, 2016

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F 225	Continued From page 6 The facility staff didn't submit a FRI until 6/25/15. According to the FRI the Administrator was made aware that Resident #1's ankle was fractured on 6/23/15, which was when an X ray was taken of the ankle. On 1/21/16 an interview was conducted with the Administrator, (Administration A) who stated that she was aware of the facility 's responsibility to submit the FRI to OLC within 24 hours of becoming aware of the injury of unknown origin. She stated that it was her responsibility to submit the report in a timely manner. 2. Resident #5 was an 86 year old who was admitted to the facility on 1/30/14. Resident #5 ' s diagnoses included Altered Mental Status, and Osteoporosis. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 4/17/15, coded Resident #1 as sometimes being able to understand and be understood by others. On 1/20/16 a review was conducted of facility documentation, revealing a Facility Reported Incident received at OLC on 6/25/15. The incident involved a lumbar compression fracture. The facility staff didn 't submit a FRI until 6/25/15. According to the FRI the Administrator was made aware of the injury of unknown origin on 6/24/15. The Follow-up report was submitted 6 days later (6/31), instead of 5 days. On 1/21/16 an interview was conducted with the Administrator, (Administration A) who stated that she was aware of the facility ' s responsibility to submit the FRI to OLC within 5 working days of becoming aware of the injury of unknown origin. She stated that it was her responsibility to submit the report in a timely manner.	F 225		

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