DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		- <del>03/30/201</del> 7 APPROVED
CENTER	RS FOR MEDICARE	& MEDI SERVICES			OI		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	SURVEY PLETED
	, , , , , , , , , , , , , , , , , , ,	495235	B. WING			i	C 16/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY (	OF WILLIAMSBURG, I	LLC			35 MT VERNON AVENUE LLIAMSBURG, VA 23185		
(V.4) ID	SIMMADVSTA	TEMENT OF DEFICIENCIES		701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION OATE
F 000	INITIAL COMMENT		F 0	000	Preparation and submission of this of correction does not constitute admiration.	ite an	-
	survey was conducted complaints were involved corrections are requested CFR Part 483 Feder	Medicare/Medicaid standard ted on 3/14-16/2017. Two restigated during the survey. United for compliance with 42 ral Long Term Care Safety Code survey/report		- :	admission, or agreement by provider, of the truth of the alleged or the correctness o conclusions set forth on the state of deficiencies. The plan of correction is prepared and subs	facts f the ement f the	
	126 at the time of the consisted of 21 resisted and 3 closed record 483.10(g)(14) NOT		F 1	!	solely because of the require under State and Federal law.	ments	
SS≖D	consult with the res consistent with his or representative(s) what (A) An accident invo- results in injury and physician intervention	of Changes.  mediately inform the resident; ident's physician; and notify, or her authority, the resident nen there is-  plying the resident which has the potential for requiring on;			<ol> <li>Physician was notified resident #10 had 15 finger s that were greater than Resident received a new ord obtain HgbA1c and to inch his Lantus to 24units daily.</li> <li>Residents with a diagnosi diabetes and receive insulin parameters have the potentiabe affected.</li> </ol>	400. er to rease s of with	04/18/2017
-	mental, or psychoso deterioration in heal status in either life-t clinical complication	ange in the resident's physical, beial status (that is, a th, mental, or psychosocial hreatening conditions or as);  reatment significantly (that is,			RECEIVED		
	a need to discontinu treatment due to ad commence a new fo	ue an existing form of verse consequences, or to orm of treatment); or		:	APR 10 2017 VDH/OLC		
ABURATURY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	,	(X6) DATE

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.

		AND HUM SERVICES & MEDIC, SERVICES			$\mathcal{C}$	FORM.	03/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
· · · · · · · · · · · · · · · · · · ·		495235	B. WING				C 16/2017
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG, I	_LC		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	resident from the far §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this sectionall pertinent information is available and prophysician.  (iii) The facility must resident and the resident in §483.  (B) A change in resistate law or regulat (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMENT by:  Based on staff interfacility documentation revidence in condition the facility staff failed change in condition #10) in a survey safe For Resident #10, to finger stick block.	ensfer or discharge the cility as specified in obtification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the obtained the sident representative, if any, and or roommate assignment (a.10(e)(6); or obtained the sident representative, if any, and or roommate assignment (b.10(e)(6); or obtained the rights under Federal or ions as specified in paragraph on.  It record and periodically (mailing and email) and the resident representative(s). The is not met as evidenced rights and clinical record review, on review, hospital ew and clinical record review, and to inform the physician of a for one Resident (Resident ample of 24 Residents.  The physician was not informed and sugar (FSBS) readings are physician's order.	F1	157	•	with These dated a alert neters isulin. Eccive insulin der is ucose, MD. Is insulin new ers to er for neters alert neters isulin. Inplete	

PRINTED: 03/30/2017-

		AND HU! ' V SERVICES & MEDIC, SERVICES		(	FOR	M APPROVED D. 0938-0391	)
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED	]
		495235	B. WING	·	03	C 3/ <b>16/201</b> 7	
	PROVIDER OR SUPPLIER DF <b>WILLIAMSBURG</b> , I	LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION OATE	
F 157	on 8/25/16 and was hospitalization on 1, glaucoma, diabetes seizure disorder.  Resident #10 was of 3/14/17 at 4:30 p.m with a Redskins bla gown. Resident #1 stay in the facility. I want to live in the fathat he had spoken finding another plactioner to northern V acknowledged he wand he said he coul injections.  A review of Reside documentation and initiated on 3/15/17  A quarterly MDS (mwith an ARD (asses 1/20/17 coded Resi interview of mental cognitively intact. Reeding staff super (activities of daily liven an Active Diagnosis Resident #10's contincluded a plan for I Complications r/t (real Interventions includordered. 2. Notify	admitted to the facility initially a readmitted after a /9/17. Diagnoses included hypertension, dementia and observed in his room on the was in his bed covered nate and wearing a hospital of was talkative regarding his Resident #10 said he did not acility, that he was bored and with the staff regarding the to live, a place that was firginia. Resident #10 was receiving insulin injections and learn to give himself of the was at 8:30 a.m.  Ininimum data assessment) assent reference date) of dent #10 a BIMS (brief status) score of "15" out of 15, Resident #10 was coded as vision only with ADLs ving). Diabetes was coded as inprehensive care plan Risk for Metabolic	F	4. The Director of Clinical assigned designee random blood glucose a week for 30 days, week for 30 days to decurrent order is effect management and MD when indicated. Somplete random obstinsulin administration for 30 days, then 2xs 30 days. The results of will be presented committee for represented committee for represented commendations.  5. 04/18/2017	will audit to levels 4xs then 2xs a letermine if tive diabetic is notified SDC will servation of 4xs a week a week for f the audits to QAPI		

### DEPARTMENT OF HEALTH AND HUM I SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTERO I OR MEDICARE	G MEDICAND OF LANCES			OIVID IN	10. 0330-039 I		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
	405225	B. WING			С		
	495235	D. WING			03/16/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
ENVOY OF MALLAMORUBO	110		1235 M⊤ VERNON AVENUE				
ENVOY OF WILLIAMSBURG,	LLC		WILLIAMSBURG, VA 23185				
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
PREFIX (EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF			COMPLETION		
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		PROPRIATE	DATE		
		1	DEFICIENCY)				
F 157 Continued From pa	ao 3		157				
<del>-</del>	_	Г	197				
	#10's hospital documentation						
	1/9/17 revealed he was						
admitted with a diag		ļ					
Ketoacidosis (DKA)							
	dmission to the hospital was	    -					
	anges - "Before a meal:						
80-130 and 1-2 hou	irs after beginning of the meal,						
less than 180." ww	w.diabetes.org)	1					
"DKA is an acute o	amplication of diabates						
	omplication of diabetes	!					
	ed by hyperglycemia"	!					
	of Nursing Practice, 8th	!					
edition, p. 928.	11 10 1 11						
	on't get the glucose they need	!					
	dy begins to burn fat for	! !					
-	uces ketones When the	! !					
	enough insulin, it is taken by	ļ					
	use of an insulin pump to use						
	ones build up in the blood,	!					
they make it more a	acidic. They are a warning sign	! i					
that your diabetes is	s out of control or that you are						
getting sick." www.	diabetes.org						
0 44047 5					i		
	admission to the facility, the						
	insulin order which read,						
	100 unit/ml (milliliter) Inject 5						
	before meals related to Type						
	blood sugar is less than 100.				:		
Contact MD if less	than 60 or greater than 400".				:		
Povious of the January	on, 2017 MAP (modication				:		
	ary 2017 MAR (medication				·		
	rd) revealed finger stick blood						
	ts that were greater than 400						
	81); 1/12 at 5 p.m. (566); 1/17						
	8 at 5 p.m. (506); 1/20 at 5						
	5 p.m.(466); 1/22 at 12 p.m.						
	91); 1/23 at 5 p.m. (583); 1/24						
at 5 p.m. (412); 1/2					1		
Review of the Febru	uary 2017 MAR revealed						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N46M11

Facility ID: VA0274

If continuation sheet Page 4 of 103

APR 10 2017 VDH/OLC

### DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	42 FOR MEDICARE	W MEDICHID SEKAICES				<u> </u>	<u>. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495235	B. WING				C /16/2017	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ENVOV	TE WILLIAM COLLOC	11.0		13	235 MT VERNON AVENUE			
ENVOIC	OF WILLIAMSBURG,			V	VILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 157	Continued From pa	ne 4	∵ F1	57				
	•	ere greater than 400 on 2/10	, , , , , , , , , , , , , , , , , , ,	JI			!	
		2/14 at 12 p.m. (461) and 5					•	
		of the clinical record did not	!			•		
	question.	tification of the blood sugars in	1					
	briefing, the admini- of nursing) were inf						1	
		ater than 400 and without n. The DON said she would						
	with the DON regar in question was cor	a.m., a follow-up interview ding the FSBS measurements aducted. The DON said the						
	therefore the nurse parameters in place	iding scale insulin and didn't expect to see of or physician notification.						
	at the summary tab	They (the nurses) didn't look to read the entire order." The ctation was for the nurses to						
		's order for notification.						
	(licensed practical r	a.m., unit nurse LPN nurse) D was interviewed as						
	10's MAR. LPN D s	top computer to Resident # stated," If you hit the 'MORE'						
		cian order is visible." The eMAR (electronic medication						
		d) included, "Contact MD if						
	less than 60 or grea		1					
	On 2/46/47 -4 40:45	Come the unit manages I DNI	1			-		
		a.m., the unit manager, LPN LPN C said she had reviewed					:	
		cal record and found no	!					

evidence of physician notification of the blood

		AND HUM 11 SERVICES & MEDIC> SERVICES			(	FORM.	APPROVED 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495235	B. WING				C 16/2017
NAME OF I	PROVIOER OR SUPPLIER				REET AOORESS, CITY, STATE, ZIP COOE		
ENVOY	OF WILLIAMSBURG, I	LLC			ILLIAMSBURG, VA 23185		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC !OENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO OEFICIENCY)	.O BE	(X5) COMPLETION OATE
F 157	The facility's Insulin reviewed and did no parameters or phys Guidance for nursin administration of m Mosby's Potter and Nursing 7th Edition responsible for dire Nurses follow physibelieve the orders at On 3/16/17 at 3:00 informed of the staf physician of blood sthan 400, per the plano additional inform 483.12(a)(1) FREE ABUSE/INVOLUNT 483.12  The resident has the neglect, misappropriate and exploitation as includes but is not licorporal punishment.	Administration policy was of include directions regarding ician notification.  In gractice for the edications was included in, Perry, "Fundamentals of p. 336, The physician is cting medical treatment. cian's orders unless they are in error or harm clients."  p.m., the administration was f's failure to notify the sugar measurements greater hysician's order. There was ation provided.  FROM		223	1. Resident #15 was assess physician after being inf that she was "sexually assa by resident #2. No traum bleeding or swelling noted. Service will follow the refor psychosocial support was assessed.	formed aulted" na, no Social esident weekly	04/18/2017
	abuse, corporal pur seclusion; This REQUIREMEN by:				or as needed. Facility subm Facility Reported Incident for OLC of Virginia and appropriate agencies. CNA educated on the proper pro- for resident to resident includes: separate and resident immediately.	orm to d all E was cedure abuse	

DEPARTMENT OF HEALTH A	AND HUMAN SERVICES		(	PRINTED: 03/30/2017— FORM APPROVED
CENTERS FOR MEDICARE			<u> </u>	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495235	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
ENVOY OF WILLIAMSBURG, L	LC		1235 MT VERNON AVENUE	
			WILLIAMSBURG, VA 2318	15
	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE COMPLETION OTHE APPROPRIATE OATE
F 223 Continued From pag	ge 6	F 2		
documentation reviet the facility staff failed (Residents #15) in a residents from anoth after a sexual assau Resident #15 was se #2. The facility staff separate and protect #2 after becoming at The findings include Resident #15 was at 12/20/13. Her diagon non-Alzheimer's den Resident #15's most set) with an ARD (as 3/12/17 was coded at Resident #15 was coded as resident #15 was coded as n assistance of one stractivities of daily living eating she required lactivities of daily living eating she required lactivities and her pher wheelchair. Resident #15 was in bladder. Resident #15 was in bladder. Resident #2 was ad and readmitted from diagnoses included lactivities of daily living she was coded as not set wheelchair. Resident #2 was ad and readmitted from diagnoses included lactical was add and readmitted from diagnoses and diagnoses and diagnoses and diagno	w and clinical record review, d to protect one Resident a survey sample of 24 her resident (Resident #2) alt.  exually assaulted by Resident failed to immediately to Resident #15 from Resident ware of the assault.  d:  dmitted to the facility hoses included hentia and hypertension.  t recent MDS (minimum data assessment reference date) of as a quarterly assessment.  Dedd a BIMS (brief interview ore of 5, severe impairment, heeding extensive to total aff member to perform her had, except for eating. For limited assistance by staff, continent of bowel and 15 had no range of motion rimary mode of mobility was sident #15 was coded for no andering.  Imitted to the facility on 5/4/16 the hospital on 9/28/16. Her hypertension, hemiplegia and g a stroke affecting her left diabetes and major	F 2	<ol> <li>Any resident the resident to reside the potential to be</li> <li>The facility stated educated on complete quiz validate understated and procedure.</li> <li>The DCS/design random audits where the proper produces are week for 30 day</li> </ol>	ent altercation has e affected. aff will be re- company's abuse y staff will on abuse to anding of policy  nee will conduct with facility staff cocdure for abuse Odays, then 2xs a es. The results of be presented to e for review and

#### DEPARTMENT OF HEALTH AND HU! N SERVICES

PRINTED: 03/30/2017 FORM APPROVED

CENTERS FOR MEDICARE	E & MEDIĆ, "D SERVICES	_			Of	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTR	RUCTION			E SURVEY PLETED
	495235	B. WING				l .	C <b>16/2017</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE	, ZIP CODE		
ENVOY OF WILLIAMSBURG,	II C		1235 MT VE	ERNON AVENUE			
			WILLIAMS	SBURG, VA 2318	5		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN C ACH CORRECTIVE A OSS-REFERENCED TO DEFICIEI	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 222 O-#1 F	<b>7</b>						
F 223 Continued From pa		F 2	23				
	t recent MDS (minimum data	:					
	assessment reference date) of as a quarterly assessment.						
	oded a BIMS (brief interview of	!					
	1, moderate cognitive						
	vas coded as needing limited						
	of one staff member to						
	es of daily living except for she required limited						
	f. Resident #2 was incontinent						
	er. Resident #2 had range of						: 
	n one side and her primary						
	as her wheelchair. Resident						
#2 was coded for r wandering.	o behaviors and no						
wandening.		!					
On 3/14/16 at 2:30	p.m., Resident #2 was						
	om in her bed. She was						
	nance staff member as he						
	nditioner in her room. Resident						
	ve and denied having any						
	nfort. Resident #2's bed was and she shared a room with						
	se bed was perpendicular to	į į					
her bed and locate	• •						
	<b>-</b>						
	p.m. Resident #15 was						
	the dining room area in her she was staring out of large						
	sident #2 was appropriately						
	nded quietly, though confused						.
at times, to convers	sation.						
On 3/15/16 at appr	oximately 10:00 a.m., the				•		! !
	unced to the survey team that						
	ally fondled Resident #2 and						
that Resident #15 v	was being sent to the						

FORM CMS-2567(02-99) Previous Versions Obsolete

emergency room for evaluation. The

Event ID: N46M11

Facility ID: VA0274



### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTE	RS FUR MEDICARE	& MEDICA D SERVICES				<u>OMR NO</u>	<u>), 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	CON	TE SURVEY MPLETED
		495235	B. WING	i			C / <b>16/201</b> 7
NAME OF I	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC			WILLIAMSBURG, VA 23185		
	0.19.44.597.624	TEMENT OF REFINENCIES					· ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 223	Continued From pa	ige 8	F 2	223	` }		
		· *	1 4		,		1
		he plan was to separate the					
		a Facility Reported Incident					
		of Licensure and Certification.					
		innouncement, there was a					
		facility addressing the					
		nistrator said Resident #15					
	_	e the one to change rooms					:
		e no private rooms available. aid Resident #2 would be					i :
		room without a roommate.					
	staying in the same	room without a roommate.					
	On 3/15/16 at 10:30	AM, a review of Resident					
		2's clinical record was initiated					1
	and the review reve						
		ogress note dated 3/15/17 at	1				
		edical doctor) and PT (patient)					;
		ble party) MADE AWARE OF					
		OTHER RESIDENT. At 9:56					
		MD examined resident and					:
		ave new orders to send res. to	; ; ;				
		t (related to ) earlier					
		ent with roommate. At 10:25					
		Report from hospital, reports					
	resident is on Antibi	otic for UTI (urinary tract					
	infection). Upon ar	rival, began on 1:1 supervision					
	at all times."						
		progress note dated 3/15/17 at					İ
		ent was found being fondled by					
		At 9:47 a.m., "PATIENT WAS					l
		M AFTER STAFF MEMBER					
		PROPRIATENESS. PATIENT					
		AGINAL TRAUMA-NO					
		OOD COMING FROM					
		ATIENTS BRIEF WAS	•				
		ERICARE COMPLETED-NO					
		R BLOOD WAS NOTED."					İ
	Author: Physician, E	imp. Q					

### DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	43 FOR MEDICARE	& MEDICE SEKAICES				<u> </u>	<u>7. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING	;		03	C 5/ <b>16/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	<del></del>	
				123	5 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC		WIL	LIAMSBURG, VA 23185		
(V.4) ID	! STIMMADV STA	TEMENT OF DEFICIENCIES			<del></del>	)NI	1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 223	Continued From pa	ne 9	' 	223			
		ed Incident dated 3/15/17 was		223			
		nt to Resident incident					
		ent and action taken: "It was					
		g staff observed [Resident					
		her roommate [Resident					
		e and her hand was@					
		me] private area. Two patients					
		nediately. [Resident #2's					
	•	on one on one supervised."					Ī
		nistrator and faxed to the OLC					
	at 10:09 a.m.		:				
			1				
		p.m., a request was made to					
		nd the DON (director of	İ				
		v the staff member that initially					
		ent. The DON said CNA					!
		sistant) E witnessed the					
	incident and she wo	orked on the night shift.					,
	On 3/16/16 at 8:15	a.m., the administrator and					
		ed again to arrange an					
		nterview with CNA E.					
	- <b>P P</b> - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	······································	İ				
	On 3/16/16 at 11:00	a.m., a telephone interview					
	was conducted with	CNA E. When asked what	İ				
	happened when she	e saw the two residents, CNA					
	E stated, "I was doi	ng rounds, passing ice, when I					
		ting at the foot of Resident					
		nand down in Resident #15's					
		what she did after that, CNA					
		ident #15 to not move, stay	1				
		ent down the hallway to the	!				
	<del>-</del>	et two other nurses." CNA E	:				
		e nurses to witness what she	:				
		fter she and the two other	!				
		the room, Resident #15 was					
		and Resident #2 was in and					
	out of sleep. CNA b	E stated, "She (Resident #15)					

is hard to wake up, she is a heavy sleeper." CNA

## DEPARTMENT OF HEALTH AND HUTCH N SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

		T THE BIOKED CENTROLO				<del>1910 140.</del>	<u>. 0330-033 1</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY IPLETED
		495235	B. WING				С
		493233	D. WING			03/	16/2017
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG,			12	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OEFICIENCY)	) BE	(X5) COMPLETION OATE
F 223	residents and the n CNAE said, "She (I her roommate (Resasked how long she she identified the in long, I am tall and I A review of the facil hallway in which Reresided. There were their room and the I On 3/16/16 at 11:30 provided copies of I dated 3/15/17 which a. CNAE wrote, "I #2) from bed B sittin #15's name] I went LPN (licensed practitudes both came down b. LPNE wrote, "C station to report to to myself, LPNE, night	other nurses separated the urse examined Resident #15. Resident #2) said she thought sident #15) was a man." When a left the residents alone after cident, CNA E stated, "Oh not have long legs."  ity floor plan displayed the esident #2 and Resident #15 ie eight resident room between nurse's station.  o a.m., the administrator in the staff Witness Statements in read as follows: notice the resident (Resident in g on the foot of [Resident immediately to tell the nurses tical nurse) E and LPN F and	F	223			
	c. LPN F wrote, "Cl residents room. [Re [Resident 315's nam open fingers were in moving hand. [Res [Resident #15] was name] was not com wash hands and Re Resident #2 placed						

### DEPARTMENT OF HEALTH AND HUNG N SERVICES CENTERS FOR MEDICARE & MEDIC. .... SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	: & MEDIC:J SERVICES			`	<u> </u>	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	TE SURVEY MPLETED
		495235	B. WING			1	C /1 <b>6/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOV	OF WILLIAMSBURG,	uc		12	35 MT VERNON AVENUE	•	
LIVOI	/ MILLIANISDONG,			W	ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	Continued From pa	ige 11	F 2	223			
	observed in a differ directly next door to was now in a bed b seated in her whee window. Her affect	1:20 a.m., Resident #15 was rent room, it was the room o her prior room. Resident #15 reside the window and she was lichair looking out her bedroom was pleasant and she nen asked if she liked her new					
	interviewed and sai	init manager, RNA, was id Resident #2 was transferred com earlier that morning due mental status.					
	E and the review of shared with the adrindicated that Resident #2 when a occurring sexual as assessment of Res Resident #15 was reasident #15 was regarding this sexual residents and the othe incident should any Resident-to-Re	D p.m., the interview with CNA the witness statements were ministrative staff. All evidence dent #15 was left alone with a staff member witnessed an esault. Based on the sident #15's cognitive status, not cognitively able to consent ion with Resident #2. When a facility's expectation al incident between these two orporate nurse, Emp C, said have been treated just like esident incident and added, rate the residents and keep the					
	read, "Immediately	lity's Resident Abuse policy upon an allegation of abuse or tt(s) shall be segregated from he investigation"					:
	On 3/16/17 at 3:00	p.m., the administration was	:				

informed of the staff's failure to protect Resident

		AND HUMAN SERVICES & MEDICAL SERVICES		· · -	(	FORM	-03/30/2017 APP <b>R</b> OVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 SURVEY
AND PLAN (	)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _	,	COMPLETED	
		495235	B. WING				16/2017
NAME OF	PROVIDER OR SUPPLIER		<u></u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		10,2017
ENVOY	OF WILLIAMSBURG, I	LLC			235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC-IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223 F 225 SS=D	Continued From part #15 immediately aft sexual abuse incided 483.12(a)(3)(4)(c)(1) ALLEGATIONS/IND 483.12(a) The facility (3) Not employ or of who-  (i) Have been found exploitation, misapp mistreatment by a complete of the complete of th	ge 12 er a resident- to- resident ent. )-(4) INVESTIGATE/REPORT DIVIDUALS by must- therwise engage individuals guilty of abuse, neglect, propriation of property, or ourt of law; eng entered into the State concerning abuse, neglect, etment of residents or their property; or ary action in effect against his icense by a state licensure a finding of abuse, neglect, etment of residents or resident property.  ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a facility staff.  legations of abuse, neglect,	F 2	225		ed by at she ent #2. noted. ent for or as Facility LC of encies. proper abuse esident esident esident atted on y staff alidate	04/18/2017
	(1) Ensure that all al abuse, neglect, expl including injuries of	reatment, the facility must: leged violations involving oitation or mistreatment, unknown source and resident property, are					

						PRINTED:	03/30/2017	
DEPART	MENT OF HEALTH	AND HUY 'SERVICES			(		APPROVED	
CENTER	RS FOR MEDICARE	& MEDICکری SERVICES			· .		0938-0391	
	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	٠.		E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
		495235	B. WING				0	
NAME OF F	DOMEST OF AUTOURED	433233	D. WINO		TOTAL CONTROL OF THE TIP OF THE		16/2017	-
NAME OF F	PROVIOER OR SUPPLIER		-		TREET AOORESS, CITY, STATE, ZIP COOE			
ENVOY (	OF WILLIAMSBURG, I	_LC			235 MT VERNON AVENUE VILLIAMSBURG, VA 23185			
()(1)(0)	STIMMADV STA	TEMENT OF OEFICIENCIES	10	$\overline{}$		TION .	(X5)	┨
(X4) IO PREFIX TAG	(EACH OEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO (EACH CORRECTION SHOW) (DEFICIENCY)	gnee will conduct facility staff on the abuse 4xs a week for yeek for 30 days. The will be presented to		,
				_	OEFICIENCY)			╀
F 225	Continued From pa	ge 13 ly, but not later than 2 hours	F 2	25				
	cause the allegation serious bodily injury the events that causabuse and do not rethe administrator of officials (including to adult protective senfor jurisdiction in lor accordance with Staprocedures.  (2) Have evidence to thoroughly investigation is in procedures.  (3) Prevent further pexploitation, or mist investigation is in procedures.	cotential abuse, neglect, reatment while the rogress.  Its of all investigations to the or her designated to other officials in accordance ding to the State Survey			4. The DCS/designee will random audits with facility s proper procedure for abuse 4xs 30days, then 2xs a week for 30 results of the audits will be p QAPI committee for rerecommendations.  5. 04/18/17	taff on the a week for 0 days. The oresented to		
	if the alleged violatic corrective action methods. This REQUIREMENT by: Based on observate documentation reviet the facility staff failed prevention policy for #15 and Resident #15 was selected.  Resident #15 was selected.	orking days of the incident, and on is verified appropriate ust be taken.  No is not met as evidenced ion, staff interview, facility ew and clinical record review, and to implement the abuse of two Residents (Residents 2) in a survey sample of 24 recually assaulted by Resident as failed to immediately of Resident #15 from Resident						

## DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICAL J SERVICES

CLIAIF	NO I ON WILDICANE	G MEDICI "D OFITAIOFO				<u> </u>	<u>/. บฮฺว๐-บฺวฮฺ เ</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	CON	TE SURVEY MPLETED
		495235	B. WING			1	C /1 <b>6/2017</b>
	PROVIDER OR SUPPLIER OF <b>WILLIAMSBURG</b> ,	LLC	<u>L</u> .	123	REET ADDRESS, CITY, STATE, ZIP CODE 35 MT VERNON AVENUE ILLIAMSBURG, VA 23185	1 03	710/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 225	Continued From pa #2 after becoming a	ge 14 aware of the assault.	F 2	225			
	The findings include	ed:					
	12/20/13. Her diag	admitted to the facility noses included mentia and hypertension.	į				
	set) with an ARD (a 3/12/17 was coded Resident #15 was coded of mental status) so She was coded as a assistance of one s activities of daily livit eating she required Resident #15 was in bladder. Resident # limitations and her particular status of the st	st recent MDS (minimum data issessment reference date) of as a quarterly assessment. Coded a BIMS (brief interview core of 5, severe impairment. In the member to perform her ing, except for eating. For limited assistance by staff. In the model of motion primary mode of mobility was sident #15 was coded for no randering.					
	and readmitted from diagnoses included hemiparesis following	dmitted to the facility on 5/4/16 in the hospital on 9/28/16. Her hypertension, hemiplegia anding a stroke affecting her left diabetes and major					
	set) with an ARD (a 1/3/17 was coded a Resident #2 was comental status) of 11 impairment. She with to total assistance of	recent MDS (minimum data ssessment reference date) of s a quarterly assessment. Indeed a BIMS (brief interview of moderate cognitive as coded as needing limited of one staff member to es of daily living except for					

### DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDIC, J SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	E & MEDIC:) SERVICES			`.	<u>O</u> I	<u>MB NO.</u>	<u>0938-0</u> 391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS				SURVEY PLETED
	495235	B. WING				03/1	) 16/2017
NAME OF PROVIDER OR SUPPLIER			STREET /	ADDRESS, CITY, STAT	E, ZIP CODE		
ENVOY OF MULLIANSPURG			1235 MT	VERNON AVENUE			
ENVOY OF WILLIAMSBURG,			WILLIA	MSBURG, VA 231	85		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x C	PROVIDER'S PLAN (EACH CORRECTIVE ROSS-REFERENCED DEFICI	<b>ACTION SHOULD</b>	BE	(X5) COMPLETION DATE
F 225 Continued From pa	- <del>-</del>	F 2	:25			:	
supervision by staf	she required limited f. Resident #2 was incontinent						
motion limitation or	ler. Resident #2 had range of none side and her primary					ļ	
_	as her wheelchair. Resident no behaviors and no						
wandoring.							
	p.m., Resident #2 was om in her bed. She was						į
	nance staff member as he nditioner in her room. Resident						
#2 was very talkativ	ve and denied having any nfort. Resident #2's bed was						
beside the window	and she shared a room with						
Resident #15, who bed and located ne	se bed to perpendicular to her ear the door.						
	p.m. Resident #15 was	:					İ
wheelchair where s	the dining room area in her she was staring out of large						
	sident #2 was appropriately ed quietly, though confused at						
times, to conversat	, ,						
• •	oximately 10:00 a.m., the unced to the survey team that						
Resident #15 sexua	ally fondled Resident #2 and was being sent to the					:	
emergency room fo	or evaluation. The					:	
	the plan was to separate the I a Facility Reported Incident						
(FRI) to the Office	of Licensure and Certification. announcement, there was a						
police officer in the	facility addressing the					!	
	inistrator said Resident #15 e the one to change rooms						
would most likely b	a ma ana la ananga 100ma						

because there were no private rooms available.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. J SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION		
	, a boilb	ING	(X3) DATE SURVEY COMPLETED		
495235	B. WING		·		C / <b>16/2017</b>
		STREE <sup>-</sup>	T ADDRESS, CITY, STATE, ZIP CODE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILT  495235  B. WING  NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF					
JUST BE PRECEDED BY FULL		x	(EACH CORRECTIVE ACTION SHOUL	DBE	(X5) CDMPLETION DATE
e 16 id Resident #2 would be com without a roommate.  a review of Resident #15 nical record was initiated and he following: gress note dated 3/15/17 at PT OWN RP (responsible E OF PT FONDLING NT. At 9:56 a.m. a note resident and found no ders to send res. to ER for nappropriate incident with p.m. a note read, "Report is resident is on Antibiotic for ection). Upon arrival, began all times "	F 2	225			
ogress note dated 3/15/17 at t was found being fondled by 9:47 a.m., "PATIENT WAS AFTER STAFF MEMBER ROPRIATENESS. PATIENT GINAL TRAUMA-NO OD COMING FROM TIENTS BRIEF WAS RICARE COMPLETED-NO BLOOD WAS NOTED." mp. Q d Incident dated 3/15/17 was to Resident incident and action taken: "It was staff observed [Resident er roommate [Resident and her hand was@e] private area. Two patients					
THE STATE OF STATE OF THE STATE	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION)  The 16 A Resident #2 would be come without a roommate.  The a review of Resident #15 A record was initiated and the following: The gress note dated 3/15/17 at PT OWN RP (responsible of PT FONDLING)  The A 9:56 a.m. a note resident and found not ders to send res. to ER for mappropriate incident with p.m. a note read, "Report a resident is on Antibiotic for ction). Upon arrival, began all times."  The presence of the series of the s	MENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)  PREFIT TAG  THE 16  THE 16  THE 16  THE 16  THE 17  T	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL EDENTIFYING INFORMATION)  PREFIX TAG  TAG  F 225  F 2	STREET ADDRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185  ID PREFIX TAG CROSS-REFERENCED TO THE APPROF  124 TAG CROSS-REFERENCED TO THE APPROF  125 TAG CROSS-REFERENCED TO THE APPROF  126 TAG CROSS-REFERENCED TO THE APPROF  127 DEFICIENCY)  127 TAG CROSS-REFERENCED TO THE APPROF  128 TAG CROSS-REFERENCED TO THE APPROF  129 DEFICIENCY)  129 TAG CROSS-REFERENCED TO THE APPROF  120 DEFICIENCY)  130 TAG CROSS-REFERENCED TO THE APPROF  141 DEFICIENCY  152 TAG CROSS-REFERENCED TO THE APPROF  153 DEFICIENCY  154 TAG CROSS-REFERENCED TO THE APPROF  155 DEFICIENCY  155 TAG CROSS-REFERENCED TO THE APPROF  156 DEFICIENCY  157 TAG CROSS-REFERENCED TO THE APPROF  157 DEFICIENCY  158 TAG CROSS-REFERENCED TO THE APPROF  158 DEFICIENCY  158 TAG CROSS-REFERENCED TO THE APPROF  158 DEFICIENCY  158 TAG CROSS-REFERENCED TO THE APPROF  158 DEFICIENCY  158 DEFICIENCY  158 TAG CROSS-REFERENCED TO THE APPROF  158 DEFICIENCY	STREET ADDRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  B. 16  d. Resident #2 would be com without a roommate.  a review of Resident #15 nical record was initiated and the following: gress note dated 3/15/17 at PT OWN RP (responsible COF PT FONDLING HT. At 9:56 a.m. a note resident and found no ders to send res. to ER for nappropriate incident with p.m. a note read, "Report resident is on Antibiotic for ction). Upon arrival, began all times."  Digress note dated 3/15/17 at t was found being fondled by 9:47 a.m., "PATIENT WAS IAFTER STAFF MEMBER COPRIATENESS. PATIENT GINAL TRAUMA-NO OD COMING FROM TINAL TRAUMA-NO OD COMING FROM TINAL TRAUMA-NO OD COMING FROM TINAL TRAUMA-NO OD COMPLETED-NO BLOOD WAS NOTED." np. Q  d. Incident dated 3/15/17 was to Resident incident t and action taken: "It was staff observed [Resident er roommate [Resident and her hand was@ 2] private area. Two patients

name] was placed on one on one supervised."

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

OFIAIF	TO I OIL WILDIOAKE	C MEDIC: "D OFICEO"				OIVID IV	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495235	B. WING			o	3/16/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
ENVOY	OF WILLIAMSBURG,	LLC			5 MT VERNON AVENUE LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 225	at 10:09 a.m.  On 3/15/16 at 2:00 the administrator ar nursing) to interview witnessed the incide (certified nursing as incident and she would not be a sincident and she was conducted with happened when she is stated, "I was do it is a saw Resident #2 sit #15's bed with her happened when she is stated, "I told Resight there, and I we nurse's station to go said she wanted the saw. CNA E said ar nurses, returned to in the same position out of sleep. CNA E said are not said she and the residents and the nurse is said she and the residents and the nurse saked how long she she identified the in	p.m., a request was made to ad the DON (director of a the staff member that initially ent. The DON said CNA esistant) E witnessed the orked on the night shift.  a.m., the administrator and ed again to arrange an atterview with CNA E.  a.m., a telephone interview a CNA E. When asked what e saw the two residents, CNA and rounds, passing ice, when I sting at the foot of Resident and down in Resident #15's I what she did after that, CNA exident #15 to not move, stay ent down the hallway to the ent two other nurses." CNA E enurses to witness what she fter she and the two other the room, Resident #15 was a and Resident #2 was in and E stated, "She (Resident #15) she is a heavy sleeper." CNA other nurses separated the curse examined Resident #15. Resident #2) said she thought ident #15) was a man." When a left the residents alone after cident, CNA E stated, "Oh not		225			
	long, I am tall and I	nave lung legs.					:

A review of the facility floor plan displayed the

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495235	B. WING			C <b>03/16/2017</b>
	PROVIDER OR SUPPLIER OF <b>WILLIAMSBURG</b> ,	LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		55,16,2517
(X4) ID PR <b>E</b> FIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	resided. There we between their room  On 3/16/16 at 11:30 provided copies of the dated 3/15/17 which are considered as a considered and considered as a considered and considered as a conside	esident #2 and Resident #15 ere eight resident room and the nurse's station.  I a.m., the administrator the staff Witness Statements read as follows: notice the resident (Resident ing on the foot of[ Resident timmediately to tell the nurses tical nurse) E and LPN F and vn to the room."  NA E came to the nurse's the charge nurse, LPN F and ht supervisor that [Resident ing on her roommates bed	F 2	25		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC J SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		40-00-		•			С	
		495235	B. WING			03/	<u>/16/2017</u>	
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG, I	LLC		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE VILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 225	Continued From pa	ige 19	F:	225	ı			
	nurse) A, was intervals transferred to t	unit manager, RN (registered viewed and said Resident #2 the emergency room earlier o a change in her mental						
	E and the review of shared with the admindicated that Resident #2 when a occurring sexual as assessment of Res Resident #15 was not a sexual interaction asked what was the regarding this sexual residents and the country the incident should any Resident-to-Re	O p.m., the interview with CNA f the witness statements were ministrative staff. All evidence dent #15 was left alone with a staff member witnessed an sault. Based on the sident #15's cognitive status, not cognitively able to consent ion with Resident #2. When a facility's expectation all incident between these two corporate nurse, Emp C, said have been treated just like esident incident and added, rate the residents and keep the						
	read, "Immediately	lity's Resident Abuse policy upon an allegation of abuse or ct(s) shall be segregated from the investigation"						
	informed of the staf abuse policy to immafter a resident- to- incident. No addition	p.m., the administration was ffs failure to implement their nediately protect Resident #15 resident sexual abuse onal information was provided. ONABLE ACCOMMODATION ERENCES	: F:	246				
	483.10(e) Respect	and Dignity. The resident has					1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495235		1	TIPLE CONSTRUCTION ING	FORM OMB NO. (X3) DATE COM	03/30/2017 APPROVED 0938-0391 E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER ENVOY OF WILLIAMSBURG,	LLC .		STREET ADDRESS, CITY, STATE, ZIP CO 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX		SHOULD BE	(X5) COMPLETION DATE
including:  (e)(3) The right to resident needs and do so would end an resident or other resident or other resident or other resident or other resident or other resident or other resident or other resident or other resident or other resident or other resident second interviews, facility a in the course of a consurvey sample of 2 reasonable accommodate resident #4 was not the right side of his The findings included Resident #4 was as 8/24/16 with diagnoral limited to, spinal coneurogenic bowel as dysreflexia.  Resident #4's most (MDS) assessment with an Assessment with a Assessment with a Assessment with a Assessment with a Assessment with a Assessment	d with respect and dignity, reside and receive services in sonable accommodation of I preferences except when to ger the health or safety of the sidents.  NT is not met as evidenced tion, resident and staff and clinical record review and complaint investigation, the resident (Resident #4) in a 4 residents, to ensure modation of needs.  of provided with a footrest for electric wheelchair.	F 2	1. DME company staff has a new footrest for red DMAS has approved power chair application.  2. Residents with power need footrests have potentiated.  3. An audit was company residents that have posted to assure they have footrests. Staff will educated on P/P reprepairing broken equipped. Mock surveyors will power chairs for proped for a week for 30 days, week for 30 days, week for 30 days. The results of the audit presented to QAPI correview and recommend.  5. 04/18/2017	chairs that tential to be chairs that tential to be chairs the proper l be re-orting and ment.  audit the er footrests, then 2xs a Any repair ted to the follow up. dits will be mmittee for	04/18/2017

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N46M11

Facility ID: VA0274

If continuation sheet Page 21 of 103



## DEPARTMENT OF HEALTH AND HUN'N SERVICES CENTERS FOR MEDICARE & MEDIC. J SERVICES

<u>OLIVILI</u>	13 FOR MEDICARE	SERVICES USERVICES				<u>OMR NC</u>	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495235	B. WING			03	C <b>3/16/201</b> 7
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1	
	CE MULLIAMODUDO			123	35 MT VERNON AVENUE		
ENVOT	OF WILLIAMSBURG, I	LLC		Wi	LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 246	observed in his room splint was in place of splint was on his lay foot rest and pedal right leg dangling in his right foot and leg. The resident stated days." When asked resident stated, "It has resident stated, the rapy) note dated (wheel chair); getting legs fall off footrest, the FREE Foundation.	t:05 PM, Resident #4 was im in his electric wheelchair. A on the right hand, and the left p. He was missing the right on the wheelchair, with his in space. He was able to cross ig to rest on the left side pedal. It, "It's been gone over 110 d how did it make him feel, the	F 2	:46			
	conducted with the COTA (certified occ and has been employears. She stated, he was complaining broken." "I can see On 3/16/17 at 9:30 aroom, up in the pow been removed and pedal had been place wheel chair. The refeet on the pedal Ham getting the new business office had of medical assistance	PM, an interview was rehab manager who is a supational therapist assistant) oyed at this facility for two "This is the first time I know g that the wheel chair leg had a if they will fix it."  AM, Resident #4 was in his wer chair. The left footrest had the wheel chair leg rest/ foot ced in the center front of the esident was able to rest both He stated, "I am OK with it, I wheel chair soon." The contacted DMAS (department ce) on 3/15/17 and his en approved this week.					

		AND HUI I SERVICES & MEDICALD SERVICES		(	FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
NAME OF F	PROVIDER OR SUPPLIER	495235	B. WING	C /16/2017		
ENVOY	OF WILLIAMSBURG, I	LLC		1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION).	ID PREFIX	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS_REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 251	Administrator and Enotified of above fin 483.70(p)(1)(2) QU WORKER > 120 BE (p) Social worker.  Any facility with more a qualified social worker qualified social worker (1) An individual with degree in social worker enabilitation couns (2) One year of supexperience in a head directly with individual this REQUIREMENT by:  Based on staff intereview, clinical record a complaint investigensure the facility eworker.  The social worker et to have any prior social worker at the facility experience at the facility experience at the facility experience and the facility experience at the facility experience and the facil	eximately 5:15 PM, the DON (director of nursing) were dings. ALIFICATIONS OF SOCIAL EDS  The than 120 beds must employ orker on a full-time basis. A ker is:  The a minimum of a bachelor's rk or a bachelor's degree in a dincluding, but not limited to, orgy, special education, eling, and psychology; and pervised social work work alth care setting working wals. The is not met as evidenced review, facility documentation rd review, and in the course of pation, the facility staff failed to employed by the facility failed exial work experience prior to acility.  The individuals of the facility failed exial work experience prior to acility.	F 2		working at 16, 2017. For full time er with the 3, 2017 ential to be a signed worker signed will iance. The ts will be mmittee for	04/18/2017
	regarding questiona	of a complaint investigation while inappropriate sexual alof the Residents, the staff	<b>!</b>			

## DEPARTMENT OF HEALTH AND HUT IN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	TO TOTA MIEDIO: TITLE	)				IVID IVO	<u>. 0330-039 i</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495235	B. WING				C / <b>16/2017</b>
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2017
					235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC			VILLIAMSBURG, VA 23185		
					· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 251	Continued From pa	rae 23	F 2	51	'		
. 201	•	=	Г	.51			
		by the administrator as being was interviewed, 3/15/17 at					
		, stated he had been					
		cility for approximately three					
		ited he had been initially hired					•
		sistant. The social worker at					
		had been at the facility for a					
		d had been his supervisor.					
	-	·					
		ad a BS (bachelor of science)					
	in sociology and a r						
		P. J stated this facility was his					
	previous experience	the social work field, with his e in retail. He stated he had					!
	done internships in	business.					
	EMP. J stated, with	the leaving of the previous					İ
		ad been assigned her duties					
	including:	<u>-</u>					
		s regarding Residents,					
	families, and staff;						1
	2. Arrange transpo						
		on C, D, E, Q in the MDS					
		(cognition, delirium, and					
		st with care planning for those					
	concerns in the care	es and discharge planning;					
		bending concerns in					
		business office; and					
		overall advocate for the					
	Residents.						:
		than his orientation at the					
		nad not had any additional					
		inities that focused on his job					
		worker. Review of EMP J's					
	employment information	ation revealed he was hired as					1

a social work assistant on 11/28/16.

### DEPARTMENT OF HEALTH AND HUT IN SERVICES CENTERS FOR MEDICARE & MEDICARU SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CENTER	<u>KS FUR MEDICARE</u>	& MEDICAID SERVICES			<u> </u>	<u>IMB NO</u>	<u>. 0938-0391</u>
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILO		E CONSTRUCTION	COM	E SURVEY MPLETEO
		495235	B. WING				C / <b>16/2017</b>
NAME OF F	PROVIOER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COOE		
ENVOVO	OF WILLIAMSBURG, I	u.c		12	35 MT VERNON AVENUE		
LIVOT	// WILLIAMODUKO, I			W	ILLIAMSBURG, VA 23185		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG		PROVIOER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 251	Continued From pa	ge 24	F 2	251			
	a degree in sociolog masters degree in phad one four month readiness intern" arinternship as "huma his employment at ta "sales associate"  EMP A, the facility a 10:30 a.m., she fun supervisor. EMP A degree in nursing worker left at the enstated EMP J had be facility's social work worker left at the enstated that EMP J cocial worker as he EMP A said that the experience was an "an appropriate degree of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that. Elsework experience, he evidence of that experience has a his job requirement sections of MDS.	stated she had a bachelor's with a master's degree in ion and health policy. EMP A leen functioning as the er since the other social and of February, 2017. EMP. A could function as the facility had a degree in sociology. Indeed for one years "OR" in the requirements as gree or one year's experience.  J had been to some of the green care facilities for social owever there was no MP A also stated EMP J was in MDS inservice to facilitate to complete the appropriate all records of Residents within that after the previous social of the green that after the previous social and the social of the social complete the appropriate all records of Residents within that after the previous social of the soci					
	worker." An examp	signed his notes as "social le of his notes included: viors of delusion of being					· ! ! :

Jesus, noncompliance with care or treatment,

						DUNTED.	00/00/0047
	MENT OF HEALTH	1			C	FORM.	03/30/2017 APPROVED
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICA, SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMI	0938-0391 SURVEY PLETED
		495235	B. WING			03/	16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ENVOY OF WILLIAMSBURG, LLC					AT VERNON AVENUE IAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS, REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 251	DX (diagnoses) of s known physiologica schizophrenia. Res was last seen by ps The administrator, I corporate consultar	priate behavior. Resident has schizoaffective, delirium, all condition, and disorganized sident is stable. The resident sych"  DON (director of nursing), and ats were informed of the failure ploy a qualified social worker,	F 2	251			
	483.10(e)(2)(i)(1)(i) SAFE/CLEAN/COMENVIRONMENT  (e)(2) The right to repossessions, includes as space permits, upon the rights or heresidents.  §483.10(i) Safe enveright to a safe, clear environment, include treatment and support facility must proving the facility must proving the personal belong (i) This includes energial environment, allowing the personal belong (ii) This includes energial environment and sephysical layout of the independence and (iii) The facility shall	(ii)  MFORTABLE/HOMELIKE  etain and use personal ling furnishings, and clothing, unless to do so would infringe lealth and safety of other  vironment. The resident has a n, comfortable and homelike ling but not limited to receiving lorts for daily living safely.	F 2		air vents covers are cleaned re-painted. Both vents working properly. Housekeeping staff have cleaning the rooms, hallweliminate any odor. There more pervasive odor noticed. All residents have potential affected.  A) Maintenance staff will all resident room ceiling air to assure there is no rust works properly. B) Surveyors and staff that not the odor will notify hou staff or administrative staff or administrative staff and the solutions. Staff will educated on P/P of keepi environmental safe and odo.	bed and are B) been ays to is no d. I to be I audit r vents and it Mock bice of sekeep taff to e odor II be re ng the	04/18/2017

							MTED.	03/30/2017	
DEPART	MENT OF HEALTH	AND HUY SERVICES			(			APPROVED	
CENTER	S FOR MEDICARE	& MEDICA, J SERVICES			(			0938-0391	
	OF OEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUL	LTIPLE	CONSTRUCTION	(	X3) DATE	SURVEY	
AND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING _			COM	PLETED	
							(		l
		495235	B. WING	·	·		03/	16/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, 2	ZIP CODE			
ENVOY O	F WILLIAMSBURG, I	10		123	35 MT VERNON AVENUE				
LIVO. O	, WELIAMOBOKO,			WI	ILLIAMSBURG, VA 23185				
(X4) ID		TEMENT OF DEFICIENCIES	01		PROVIDER'S PLAN OF			(X5)	
PREFIX TAG		' MUST BE PRECEDEO BY FULL SC-IOENTIFYING INFORMATION)	PREFI - TAG	IX	EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD E	BE	COMPLETION DATE	
" IAG	NEOOEAFORTHORNE	SO IOEN IE ENOUGHER MATION)	170		OEFICIEN		AT E T-COA		2
									Γ
F 252	Continued From pa	ge 26	F:	252					
i	•	NT is not met as evidenced							
	by:	VI IS NOT MET as evidenced			4. A) Maintenance	staff will a	udit		
:		ion, resident interview, staff		•	resident room ce	iling air ve	ents		
		y documentation review, the			weekly for 4	_			
	facility staff failed to				•	•			
!	environment for 2 re	esidents(Residents #8 and #9)		:	monthly. B) M				
		e survey sample, and failed to			will monitor the or	dors 4xs a w	eek		
	prevent pervasive of	dor throughout the facility.			for 30 days, then	2xs a week	for		
					30 days. The resul	lts of the au	dits		
		eiling air vent cover was rusted			will be present		į		l
	and per the residen				•	·-			
		iling air vent cover was			committee for	review	and		
	rusted.	tour of the facility on			recommendations.				
		M, foul odors were noted on 2			5. 04/18/2017				
		erty and Freedom Unit.							
i		of the survey, foul odors							
	persisted on the Fre								
į	•								
	The findings include	ed:							
	1 Dooidaat #01:	ling oir vont source was a start							
	and, per the resider	ling air vent cover was rusted		:					1
	and, per the resider	it, not functional.							
ļ	On 3/14/17 at 2:25	p.m., during initial tour of the							
:		was observed sitting in a							
		room, next to the wall, facing		:					
		She was alert and talkative.		•					
	During general conv	versation, Resident #8 pointed							
į		ear the window and stated							1
		that way since I've been here."		!					
		ent was covered with							
		slotted cover was placed over		:					
		g on her. The ceiling vent							1
		ne described and it had rusted		;					1
		e slots. Resident #8 stated							-
		ed so the vent could not be			•				1
		stated she told maintenance						 	1
	(⊏πριοyee-r) and r	ne said he'd fix it but stated						[	1

### DEPARTMENT OF HEALTH AND HULT N SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTE	49 FOR MEDICARE	& MEDICEAD SERVICES			<u>`</u>	<u>INB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495235	B. WING	i			C 1 <b>6/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
<b>ENVOY</b> (	OF WILLIAMSBURG,	LLC		l	35 MT VERNON AVENUE		
				W	ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 252	was also observed and on the ceiling.  On 3/15/17 at 10:05 vent cover was observed areas properties of the cover was observed areas properties. On 3/15/17 at 2:40 Licensed Practical I shown the taped areasked if she knew if she explained "Main sheet and could tell When asked how not work that needed would be informed of work that needed would be informed of work that needed would be informed of work that needed would be informed of work that needed would be informed of work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed would be informed or work that needed work that needed would be informed or work that needed would be informed	ne time." A piece of white tape on the left edge of the vent of a.m. Resident #8's ceiling erved again with the taped	F 2	252			
	on 3/15/17 at 3:50 surveyor and stated vent covers becaus	p.m. Employee-F approached I he "Just ordered the ceiling e due to the weather					
	"Just replace them."	ck." Employee-F stated he'll " Employee-F presented an 15/1 <b>7</b> for "35 12x6" Single 'Ceiling Register."					

## DEPARTMENT OF HEALTH AND HUP N SERVICES CENTERS FOR MEDICARE & MEDICARE

CENTE	RS FOR MEDICARE	& MEDIU: "D SERVICES		<u> </u>	OMR NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	CON	TE SURVEY MPLETED
		495235	B. WING			C /1 <b>6/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	,	T	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
ENVOY	OF WILLIAMSBURG,	II C		1235 M⊤ VERNON AVENUE		
				WILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE
F 252	Continued From pa	age 28	: F2	252		
	•	and Director of Nursing were		-02		
		ted ceiling vent cover. No	4			
	2. Resident #9's ce	iling air vent cover was rusted.				
		the facility on 3/14/17 at				
		p.m., Resident #9 was				
		in bed with the television on. alkative with forgetfulness.				
	The ceiling air vent	cover was observed near the				
		areas on the slots and around ident #9 did not mention the urveyor.				
	her room. Upon ins	D a.m., Resident #9 was out of spection, the ceiling vent cover n with the rusted areas				
		onses were conducted as				
		Resident #8's writing. ion was provided by the facility				
	3. During the initial	tour of the facility on				
	3/14/2017 at 2:00 F	PM, foul odors were noted on 2				
		perty and Freedom Unit.				
	persisted on the Fre	of the survey, foul odors eedom Unit.				
		00 PM during the initial tour of				:
		surveyors noticed foul odors yand Freedom Units).				

# DEPARTMENT OF HEALTH AND HUM N SERVICES CENTERS FOR MEDICARE & MEDIC, ... SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUCTION			E SURVEY PLETED
		495235	B. WING		_		C 16/2017
	PROVIDER OR SUPPLIEF OF <b>WILLIAMSBURG</b>			STREET ADDRESS, CITY, STA 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23	,	03/	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION OATE
F 252	sitting at the nurse A very pungent, for interview was constated there was a refused to bathe of that might be the swould ensure that shower.  The Unit Manager came to the unit as smell. RN A state adjacent to the Nurcould be coming for there were a coup regular showers a determine the cau. On 3/15/2017 at 4 stated she also not Freedom Unit and unit often refused Administrator state staff to use creative the resident to correct on 3/15/2017 at 5 noticed on the Free The Director of Nu Department utilized were cleaned regulated the nursing to include to rotate work with the resident on 3/16/2017 at 9 on 3/16/2017 at 9	es station on the Freedom Unit. Freedom Unit	F 2	:52			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495235					C <b>16/2017</b>
OVIDER OR SUPPLIER	LLC		1:	235 MT VERNON AVENUE	1 03/	10/2017
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Employee P) who sesidents on the Free or shower. The House Housekeeping shalls daily. Employee the room per house expectation. Employee P. Cleaning every 4 we had General Observation onducted on 3/16/2 M with the Mainten and Employee P. In the Weren of	stated there were a couple of seedom Unit who often refused seedom Unit who often refused seedom Unit who often refused staff cleaned the rooms and see P stated deep cleaning of sekeeper per day was the oyee P presented a copy of the edule. Review of the schedule room was scheduled for deep seks.  Itions of the Facility Tour was 2017 at approximately 9:45 mance Director (Employee F) During the Tour, foul odors of sed on the Liberty and seral housekeeping staff eved to be cleaning rooms and during the Facility Tour.  By Administrator, Director of state Consultant (Employee C) se findings.  On was provided.  INICES PROVIDED MEET TANDARDS  Ve Care Plans  ed or arranged by the facility omprehensive care plan,  all standards of quality.	F2				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Employee P) who sesidents on the Free constituted From particles on the Free constituted From particles on the Free constituted From particles on the Free constituted From particles on the Free constituted From particles on the Free constituted From particles on the Free constituted From particles constitut	A95235  OVIDER OR SUPPLIER  WILLIAMSBURG, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30  Employee P) who stated there were a couple of esidents on the Freedom Unit who often refused to shower. The Housekeeping Manager stated the Housekeeping staff cleaned the rooms and alls daily. Employee P stated deep cleaning of the room per housekeeper per day was the expectation. Employee P presented a copy of the expectation. Employee P presented a copy of the level cleaning schedule. Review of the schedule evealed that every room was scheduled for deep leaning every 4 weeks.  A General Observations of the Facility Tour was onducted on 3/16/2017 at approximately 9:45  M with the Maintenance Director (Employee F) and Employee P. During the Tour, foul odors of rine were not noticed on the Liberty and reedom units. Several housekeeping staff tersons were observed to be cleaning rooms and nopping hallways during the Facility Tour.  During the end of day debriefing on 3/16/2017 at 2:10 PM, the facility Administrator, Director of lursing and Corporate Consultant (Employee C) were informed of the findings.  It of further information was provided.  83.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  D)(3) Comprehensive Care Plans  The services provided or arranged by the facility is outlined by the comprehensive care plan, must-  Meet professional standards of quality, this REQUIREMENT is not met as evidenced	A BUILD  495235  B. WING  OVIDER OR SUPPLIER  WILLIAMSBURG, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30  Employee P) who stated there were a couple of esidents on the Freedom Unit who often refused to shower. The Housekeeping Manager stated ne Housekeeping staff cleaned the rooms and italis daily. Employee P stated deep cleaning of one room per housekeeper per day was the expectation. Employee P presented a copy of the Deep Cleaning schedule. Review of the schedule evealed that every room was scheduled for deep Ileaning every 4 weeks.  A General Observations of the Facility Tour was conducted on 3/16/2017 at approximately 9:45  AM with the Maintenance Director (Employee F) and Employee P. During the Tour, foul odors of rine were not noticed on the Liberty and reedom units. Several housekeeping staff ersons were observed to be cleaning rooms and nopping hallways during the Facility Tour.  During the end of day debriefing on 3/16/2017 at 2:10 PM, the facility Administrator, Director of lursing and Corporate Consultant (Employee C) were informed of the findings.  Ito further information was provided.  83.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  D)(3) Comprehensive Care Plans  The services provided or arranged by the facility, so outlined by the comprehensive care plan, itust-  ) Meet professional standards of quality, his REQUIREMENT is not met as evidenced	OVIDER OR SUPPLIER  WILLIAMSBURG, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 30  Employee P) who stated there were a couple of esidents on the Freedom Unit who often refused to shower. The Housekeeping Manager stated the Housekeeping staff cleaned the rooms and alls daily. Employee P stated deep cleaning of one room per housekeeper per day was the expectation. 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Join Gruther information was provided.  83.21(b)(3)(i) SERVICES PROVIDED MEET ROFESSIONAL STANDARDS  DO(3) Comprehensive Care Plans  The services provided or arranged by the facility, is outlined by the comprehensive care plan, must-  Meet professional standards of quality, his REQUIREMENT is not met as evidenced	OVIDER OR SUPPLIER  WILLIAMSBURG, LLC  SUMMARY STATEMENT OF DETICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY THULL REGULATORY OR LSO IDENTIFYING INFORMATION)  Continued From page 30  Comployee P) who stated there were a couple of sidents on the Freedom Unit who often refused to shower. The Housekeeping Manager stated ne Housekeeping staff Cleaned the rooms and alls daily. Employee P presented a copy of the leep Cleaning schedule. Review of the schedule svealed that every room was scheduled for deep leaning every 4 weeks.  General Observations of the Facility Tour was onducted on 3/16/2017 at approximately 9:45  Mid with the Maintenance Director (Employee F) and Employee P. 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F 281  WILLIAMSBURG, VA 23185  B PROVIDERS PROVIDED MEET ROFESSIONAL STANDARDS  D)(3) Comprehensive Care Plans  The services provided or arranged by the facility, so utilined by the comprehensive care plan, unst-	A BUILDING  495235  B. WING  37 STREET ADDRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE  WILLIAMSBURG, LLC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 30  Employee P) who stated there were a couple of esidents on the Freedom Unit who often refused a shower. The Housekeeping Manager stated he Housekeeping staff cleaned the rooms and alls daily. Employee P stated deep cleaning of ne room per housekeeping ready as the expectation. Employee P presented a copy of the leven Cleaning of the Schedule evealed that every room was scheduled for deep leaning overy 4 weeks.  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A SULDING  A STREET ADPRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, LLC  ENVOY OF WILLIAMSBURG, VA 23185  EQUALITY STATE AND CORRECTION  REGULATORY OF LISC DEATURY MUST BE PRECEDED BY FULL  Based on staff interview, clinical record review, and facility documentation, the facility staff failed to follow professional standards of nursing for medication and treatment administration for four Residents (Residents #7, #8, #1 and #21) in a survey sample of 24 Residents.  1. For Resident #7, the facility staff failed to ensure medications and treatments were administered and documented on 37/1/7 and 3/12/17.  2. For Resident #8, the facility staff failed to ensure medications and treatments were administered and commented on 37/1/7 and 3/12/17.  2. For Resident #8, the facility staff failed to ensure medications and readment were administered and commented on 37/1/7 and 3/12/17.  2. For Resident #8, the facility staff failed to administration, however, the Percocet was listed as available in the facility with failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medication for Hypertension, and Hypothyroidigm.  The facility staff stated the facility utilized "Lepincot" as their professional nursing standard.  Williams Providers Sciency starte, zip code 123/16/2017  STREET ADDRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE  WILLIAMSBURG, VA 23185  STREET ADDRESS, CITY, STATE, ZIP CODE  1236 MT VERNON AVENUE  WILLIAMSBURG, VA 23185  (EACH DEPROPERIALE.  PREFIX  PREFIX  PREFIX  PREFIX  PREFIX  PREFIX  PREFIX  Residents #7, #8, #1 and #21 have received their medications and treatments as ordered. Resident #1 orders for Atorvastatin, Depakote, Lantus, Brimonidine, Clonidine, Gabapentin, Levetinaceta			AND HUN I SERVICES			(	FORM /	<del>-03/30/2017 -</del> APPROVED
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NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH COPRECTIVE ACTION SHOULD BE (PREFIX TAG). BEGILATORY OR LSC DEATH (Inc.) And the facility staff failed to administered and documented on 377/17 and 3/12/17;  1. For Resident #8, the facility staff failed to administered and documented on 377/17 and 3/12/17;  2. For Resident #8, the facility staff failed to administered and documented on 377/17 and 3/12/17;  3. The facility staff failed to document the administration of medications was not available for administration of medications was not available for administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medication for Hypertension, and Hypothyroidism.  The facility staff stated the facility utilized "Lippincott" as their professional nursing  **Total VERNON AVENUE WILLIAMSBURG, VA 23185  **STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185  **STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185  **STREET ADDRESS CITY, \$TATE, ZIP CODE 1235 MT VERNON CORPORATION (PECC) COPS, 20,000, 20							COM	PLETED
Table   Summary statement of Deficiencies   Proposes Plannor Correction   Precision   Pr			495235	B. WING				
Continued From page 31   Based on staff interview, clinical record review, and facility documentation, the facility staff failed to follow professional standards of nursing for medication and treatment administration for ensure medications and treatments were administered and documented on 3/7/17 and 3/12/17;  2. For Resident #8, the facility staff failed to administration, however, the Percocet was listed as available in the facility emergency box, and situation of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medication for Hypertension, and Hypothyroidism.  The facility staff stated the facility utilized Lippincott" as their professional nursing	NAME OF	PROVIDER OR SUPPLIER			I		-	
F 281 Continued From page 31 Based on staff interview, clinical record review, and facility documentation, the facility staff failed to ensure medications and treatments were administered and documented on 3/7/17 and 3/12/17;  2. For Resident #8, the facility staff failed to ensure medication, oxycodone-acetaminophen (Percocet), on 6 occasions citing the medication was not available for administration of medication of medications of medications of medications of medication of medications of medication of medication of medication of medication of medication of medication of medication of medication of medication of medication of medication. No adverse effects noted from omission of medications. Resident #8 of medications and treatments. No adverse effects noted from omission of medications. Resident #8 of medications and treatments. No adverse effects noted from omission of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #8 of medications. Resident #1 or ders for medications. Resident #1 or ders for Atorvastatin, Depakote, Lantus, Brimonidine, Clonidine, Gabapentin, Levetiracetam, Levetiracet	ENVOY	DF WILLIAMSBURG, I	LLC					
Based on staff interview, clinical record review, and facility documentation, the facility staff failed to follow professional standards of nursing for medication and treatment administration for four Residents (Residents #7, #8, #1 and #21) in a survey sample of 24 Residents.  1. For Resident #7, the facility staff failed to ensure medications and treatments were administered and documented on 3/7/17 and 3/12/17;  2. For Resident #8, the facility staff failed to administer the physician ordered pain medication, oxycodone-acetaminophen (Percocet), on 6 occasions citing the medication was not available for administration, however, the Percocet was listed as available in the facility emergency box;  3. The facility staff failed to document the administration of medications for Resident #1; and  4. For Resident #21, the facility staff failed to document the administration of medication for Hypertension, and Hypothyroidism.  The facility staff stated the facility utilized "Lippincott" as their professional nursing "Lippincott" as their professional nursing  The facility documentation for four fractions and treatments as ordered. Resident #7 orders for Atorvastatin, Levemir, Senna, Moisture barrier cream have been administration of medications and treatments as ordered. Physician was notified of the omitted administration. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medications. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medications. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medications. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medications. Resident #8 orders for Percocet has been administered as ordered. Physician was notified of the omitted administration of medications. Resident #8 orders for Percocet	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX.	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
The findings included:  1. For Resident #7, the facility staff failed to ensure medications and treatments were administered and documented.  Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia,  Isosorbide Dinitrate have been administered as ordered.  Physician was notified of the omitted administration of medications. No adverse effects noted from omission of medications.	F 281	Based on staff inte and facility docume to follow profession medication and treat Residents (Resident survey sample of 24 1. For Resident #7 ensure medications administered and dia/12/17;  2. For Resident #8 administer the physic oxycodone-acetamic occasions citing the for administration; histed as available in 3. The facility staff administration of meand  4. For Resident #21 document the administration, and historial the facility staff stare "Lippincott" as their standard.  The findings included 1. For Resident #7, ensure medications administered and diagrams administered and diagrams administered and diagrams administered and diagrams and the standard and diagrams administered and diagrams administered and diagrams administered and diagrams administered and diagrams administered and diagrams administered and diagrams and the standard and diagrams administered and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams are standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams are standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and diagrams and the standard and the st	rview, clinical record review, ntation, the facility staff failed al standards of nursing for atment administration for four ats' #7, #8, #1 and #21) in a 4 Residents.  The facility staff failed to and treatments were ocumented on 3/7/17 and  The facility staff failed to ician ordered pain medication, nophen (Percocet), on 6 medication was not available nowever, the Percocet was a the facility emergency box; failed to document the edications for Resident #1;  The facility staff failed to inistration of medication for Hypothyroidism.  The facility staff failed to inistration of medication for Hypothyroidism.  The facility staff failed to and treatments were ocumented.  The facility staff failed to and treatments were ocumented.  The facility staff failed to and treatments were ocumented.  The facility staff failed to and treatments were ocumented.	F2	281	received their medications treatments as ordered. Resi #7 orders for Atorvast Levemir, Senna, Moisture bacream have been administered ordered. Physician was notified the omitted administration medications and treatments. adverse effects noted omission of medicat Resident #8 orders for Perchas been administered as ord Physician was notified of omitted administration medication. No adverse effects noted from omission medications. Pain assessment completed on resident #8. Resident #1 orders Atorvastatin, Depakote, La Brimonidine, Clonic Gabapentin, Levetirac Humalog, Hydralazine Isosorbide Dinitrate have administered as ord Physician was notified of omitted administration medications. No adverse entoted from omission	and ident tatin, arrier ed as ed of No from tions. cocet ered. the of ffects of t was for antus, idine, etam, and been dered. If the of ffects of the of ffects from the tank and tank and tank a	04/18/2017

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞΥ ,
		495235	B. WING	i		C 03/16/201	17
NAME OF	PROVIDER OR SUPPLIER		ü	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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F 281	disturbances, hypotosteoporosis, major hypertension, seizu anemia.  Resident #7's most set) with an ARD (a 12/17/16 was coded with a subsequent coded as having shedeficits and require daily life decisions. requiring extensive two staff members daily living.  Review of Resident no evidence the foll treatments were addiabetes mellitus): Senna 8.6-50 mg (in (constipation): 3/7/17 Levemir insulin 15 in diabetes mellitus): Senna 8.6-50 mg (in (constipation): 3/7/17 Moisture Barrier apafter each incontined A valid physician's in medications and treatments were addiabeted in the contined and incontined and	ellitus, hemiplegia, cular dementia with behavioral chyroidism, hyperlipidemia, redepressive disorder, res, and iron deficiency  recent MDS (minimum data assessment reference date) of das a quarterly assessment modification. Resident #7 was cort and long term memory distoral assistance with making Resident #7 was coded as to total assistance of one to to perform his activities of  ##7's clinical record revealed lowing medications and ministered:  at bedtime (hyperlipidemia):  units at bedtime (type II 3/7/17 milligrams) at bedtime  17  ply to buttocks every shift and ent episode: 3/12/17 day shift order was evident for the eatments in question.  Ey's policy entitled "Medications of" included:		281	Resident #21 orders Levothyroxine, Clonidine Hydralazine have administered as ore Physician was notified of omitted administration medications. No adverse es noted from omission medications.  2. Residents that reside in facility that have orders medications and treatments the potential to be affected.  3. The facility licensed nurses be in-serviced on document for medication and treat administration given. Lice nursing staff in-serviced on dash board to check completion of documentati MAR/TAR prior to leavin the day.	been dered. f the of effects of the s for have s will tation tment ensed using for on in	

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F 281	12:28 p.m., the exp document medicati administered on the Guidance for nursing administration of m "Fundamentals of Norther-Perry, p. 705 such as the America Nursing: Scope an Practice (2004) appadministration. To follow the six rights medication errors on inconsistency in medication administration.	of nursing) stated 3/16/17 at pectation was for the staff cons when they are the eMAR (electronic MAR).  In the standards for the pedication is provided by the Nursing, 7th Edition, so the professional standards, can Nurses Association's and Standards of Nursing poly to the activity of medication prevent medication errors, and the standards of the standards of the six rights of stration. The six rights of estration include the following: edication one the standards of the stration include the following: edication one the standards of the stration include the following: edication one the standards of the stration include the following: edication one the standards of the stration include the following: edication one the standards of the stration include the following: edication one the standards of the standards	F 2	4. The DCS/ designee will a documentation in MAR/TAF medication and treat administration 4xs a week for days, then 2xs a week for days. The results of the a will be presented to 0 committee for review recommendations.  5. 0 4/18/17	R for ment or 30 r 30	
	consultants were a to ensure staff adn medications and tr	DON, and corporate advised of the staff ninistered and documented eatments as having been esident #7, 3/16/17 at 11:35				
	administer the phy oxycodone-acetam occasions citing th	3, the facility staff failed to sician ordered pain medication, ninophen (Percocet), on 6 e medication was not available however, the Percocet was		! : : :		

### DEPARTMENT OF HEALTH AND HUP IN SERVICES CENTERS FOR MEDICARE & ME

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION		E SURVEY MPLETED
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F 281	Continued From pa	ge 34	F:	281			
	•	the facility emergency box.	!				
	4/20/15 with the dia	lmitted to the facility on gnoses of, but not limited to, eoarthritis, lower back pain					
	quarterly assessme Reference Date (Af coded Resident #8 required set up to n daily living; was cor	nimum Data Set (MDS) was a ent with an Assessment RD) of 12/16/16. The MDS with no cognitive impairment; o assistance with activities of a bladder; pain with an average pain D).					
	observed in her roo 2 visitors exiting the talkative. A Reside and when asked ab stated she has seen	p.m., Resident #8 was m sitting in a lounge chair with e room. She was alert and nt interview was conducted out physician visits, she n her doctor and "He ordered " Resident #8 did not					
	record was reviewe assessments were months of February	a.m. Resident #8's clinical d. The review revealed pain completed each shift for the r and March 2017. Physician ed and revealed the following m management:					
	5-325 MG (milligran every 8 hours for Pa Voltaren Gel 1 % (D gram transdermally elbows and knees a	oiclofenac Sodium) Apply 4 as needed for Pain apply to			•		

### DEPARTMENT OF HEALTH AND HUM IN SERVICES CENTERS FOR MEDICARE & MEDIC. ILL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	· · Continued From pa	nge 35	' F 2	221	1		
. 20.	•	ery 4 hours as needed for Pain.	1 4	.01			
	-						
		cation Administration Record his of February and March					
	2017 were reviewed	d. The review revealed the					
	Percocet was admi						:
		oth of February and the as page was administered on 3					!
	occasions (2/11, 2/2						
	Review of March 20 following:	017's MAR revealed the					
	3/1-3/11 at 6 a.m., 2 3/12/17 at 10 p.m. t medication was doo Nurse Notes." Rev the corresponding of read "Not available	administered as ordered 2 p.m. and 10 p.m. From through 3/14/17 at 10 p.m. the cumented as "9=Other/See iew of the Progress Notes for dates had documentation that awaiting pharmacy to deliver." mentation that the pharmacy alled.					
	of back pain or hea 3/11 at 9:06 p.m., 3, p.m. and 3/14/17 at	ed PRN Mapap for complaints dache on 3/9/17 at 11 p.m., /12 at 9:28 p.m., 3/13 at 4:38 : 6:11 a.m. The PRN pain cumented as effective.					
	conducted with Lice (LPN-B). LPN-B sh the blisterpack (mer Resident #8's perco the package 3/14/1 There were 2 tablet would have corresp	p.m. an interview was ensed Practical Nurse-B nowed surveyor upon request dication package) containing ocet. The processing date on 17 with a quantity of 9 tablets. It is missing from package which conded to the doses given on and 2 p.m. LPN-B explained					

that Resident #8 gets the pain medication every 8

# DEPARTMENT OF HEALTH AND HUP N SERVICES CENTERS FOR MEDICARE & MEDIC, ... SERVICES

		- CAMEDIOF ID CERTIFICE				1110 110.	0000-0001
STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		495235	B. WING		•	1	C
		4,90230	D. WING			03/	16/2017
NAME OF PROVIDER O		LLC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
PREFIX (EACH	DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
When as medication medication medication good, (where we have a stated "If doctor to hard (paper unable to stated the (Employee asked to brought stated in with a co	d she gave ked about on if it was on cart she e) fill out p code to g no active call it into per) script. get a resp ey could ca ee-Q) or th see the st curveyor in a cabinet de lock prey y needed to	age 36 be the 2 p.m. dose today. The process to obtain the not available in the estated "If (the) script is still harmacy sheet and they would et it out of the stat box." She script we need to wait for the the pharmacy and then write a "When asked if she was conse from the doctor, LPN-B all the medical director e covering physician. When at box process, LPN-B to the medication room and was a "pharmacy control box" esent. LPN-B explained the to give the code to open the	F2	281			
Review of but was not Oxycodo ORAL with Oxycodo Oxycodo On 3/15/conducte p.m. (LPI the Percodue, LPN they state blisterpace LPN-A state	f the stat to the finited the first	Percocet) 5MG/325MG TAB					

### DEPARTMENT OF HEALTH AND HU! N SERVICES CENTERS FOR MEDICARE & MEDIC. N SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CLIVILI	10 LON MEDICANE	A MILDIO OLIVICES				<u>Oivid i</u>	<u>10. 0936-039 I</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495235	B. WING	·			C <b>03/16/2017</b>	
NAME OF I	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
FNVOY	OF WILLIAMSBURG,	LLC		l	1235 MT VERNON AVENUE			
2	57 THEED WHO 55 (10)			۷	WILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE	
F 281	Continued From pa	ge 3 <b>7</b>	· F:	281				
		plan revised on 10/18/16						
	included:	•					į	
		eration in pain/comfort r/t					•	
		tenosis, DJD (degenerative						
		itis, anxiety, depression. fective pain management						
		entions"Administer analgesia	1					
		rior to treatment or care prn'	1				ŀ	
	0-04547-4455						ļ	
		p.m., the Director of Nursing the Administrator were	Ì					
		cocet not administered due to	•					
		being available. When asked	1					
		tandard reference was used						
	by the facility, Empl	oyee-B stated "Lippincott."						
	Facility policy titled	"Medications- Oral						
	Administration Of" of	dated 11/30/14 was reviewed.					;	
	The policy included		1					
		licy that the resident can curate administration of oral						
	medication."	curate administration of oral	1					
		ate prescribed medication in						
	Medication Cart"	·						
		notes: Pertinent observations					;	
	immediately after a	dministration."	!					
	Guidance given from	m Potter and Perry,	• :					
	Fundamentals of N	ursing, Eighth Edition, page	, ; ;				·	
		ollow health care providers'						
		believe the orders are in error	i					
		herefore you need to assess done to be erroneous or						
		rification from the health care						
	•	ry. Page 584 read: To						
		errors, follow the six rights of						
	medication adminis	tration consistently every time						
	you administer med	lications. Many medication			•			

errors can be linked, in some way, to an

## DEPARTMENT OF HEALTH AND HUM N SERVICES CENTERS FOR MEDICARE & MEDIC, ... SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	49 LOK MEDICAKE	A MEDICY "7 SEKAICES		``.	ONR M	<u>J. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		495235	B. WING		o:	C 3/ <b>16/2017</b>
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
				1235 MT VERNON AVENUE		
ENVOY (	OF WILLIAMSBURG,	LLC		WILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 281	Continued From pa	nge 38	, F 2	' '81		
	•	<u>-</u>	1 4	.01		
		hering to these rights:				
	1. The right medica	ation				Į –
	2. The right dose					ļ
	3. The right patient					
	<ol> <li>The right route</li> <li>The right time</li> </ol>					
	•	antation				
	6. The right docum	remation				
	On 3/16/17 at 9:10	a.m. an interview was				
	conducted with the					
	(Employee-B). Wh					
	expectations were i		!			
		yee-B stated she would				1
		to get a new script if needed				1
		it was running out." She				÷
		Expect the nurses to document				
		(doctor) and pharmacy, get the				
		x if able or get another med				
		e-B stated she spoke with the	:			
		entified and they have been				
	educated on the pro		i			
		1				
			1			
			i			
			:			
		ailed to document the	:			
	administration of m	edications for Resident #1.	:			
	D1114 #4 05					
		year old female, was admitted	:			
		/2015 and readmitted on				
		agnoses included diabetes,	1			
		artery disease, muscle	:			
		e communication deficit,				
		nagia, seizures, anemia,				
	glaucoma and hype	ertension.				
	Resident #1's MDS	(Minimum Data Set) with an				

ARD (Assessment Reference Date) of 1/3/2017

#### DEPARTMENT OF HEALTH AND HUY I SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	COT OTT MEDIO, WE	A MEDICE"D SEKVICES				OIVID IV	<u>J. 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495235	B. WING	i		0	3/1 <b>6/20</b> 17	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	Ē.		
ENVOY (	OF WILLIAMSDUDG			1	235 MT VERNON AVENUE			
ENVOTO	OF WILLIAMSBURG,	LLC		v	VILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 281	Continued From pa	age 39	; F'	281	1			
1 201	was coded as a qua a BIMS (Brief Interv 6/15, indicating sev required extensive her activities of dail	arterly assessment. She had view of Mental Status) score of vere cognitive impairment. She assistance of one person for ly living and was frequently and always incontinent of		201				
	3/13/2017 at 4:40 F (Medication Admini 2017 showing no de	view was conducted on PM and revealed MAR's stration Records) for March ocumentation for physician ving medication on the dates						
	mouth at bedtime-3 Depakote 500 mg k PM Lantus solution inje PM Brimonidine solutio times per day-3/7 5	oy mouth at bedtime-3/7 9:00 ect 34 units at bedtime-3/7 9:00 n 2% one drop in left eye two :00 PM						
	Clonidine 0.3 mg by PM Depakote 250 mg of a day-3/7 5:00 PM Gabapentin 100 mg times a day-3/7 5:00 Levetiracetam 500 hours-3/7 9:00 PM Humalog Insulin so subcutaneously beff Hydralazine 50 mg hours-3/7 9:00 PM;	y mouth 2 times a day-3/7 5:00 one tablet by mouth two times g one capsule by mouth two 00 PM mg by mouth every 12 lution inject 5 units fore meals-3/7 4:30 PM one tablet by mouth every 8 3/9 9:00 PM 5 mg one tablet by mouth 3						

A review of the physician orders revealed current

# DEPARTMENT OF HEALTH AND HUNT I SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		495235	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	450200	1	STREET ADDRESS, CITY, STAT	E ZIP CODE	03/11	6/2017
	OF WILLIAMSBURG,	LLC		1235 MT VERNON AVENUE WILLIAMSBURG, VA 231			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION OATE
F 281	Employee B. Direct these omissions on offered no explanate Facility Policies and oral administration policy that the resid accurate administration of medication administration of medication administration of medication administration of medication administration of the activity of medication administratio	or the above mentioned sident #1.  or of Nursing was informed of 3/15/2017 at 4:10 PM. She ion for this situation.  d Procedures regarding the of medications stated "It is the ent can expect safe and ation of oral medication".  In g standards for the edication is provided by ursing, 7th Edition, Potter and sional standards such as the association, Nursing: Scope ursing Practice (2004) apply dication administration. "To errors, follow the six rights of tration. Many medication d, in some way, to an hering to the six rights of tration. The six rights of tration include the following:  tion  entation"	<del> </del> F2	281			
	4. For Resident #21	, the facility staff failed to	:				

#### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARU SERVICES

CENTER	RS FOR MEDICARE	& MEDICへの SERVICES				<u>)MB NO</u>	<u>). 0938-0391                                    </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	COV	TE SURVEY MPLETED
		495235	B. WING				C / <b>16/2017</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENNOV (	OF MALLIAMODUDO		ĺ	12	235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG, I	LLG		V	VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINCED TO THE APPROINCE (CROSS)	D BE	(X5) COMPLETION DATE
F 281	Continued From pa	ne 41	   F2	21			
		nistration of medications for	' ~	.01			
	thyroid, and high blo						:
	ingroid, dira mgm bi	ood procedus.					·
	Resident #21 was a	a 52 year old who was					
		lity on 5/30/16. Resident #21's					
	diagnoses included						
		d Generalized Muscle					
	Weakness.						
	The Minimum Data	Set, which was a Quarterly					
		Assessment Reference Date					
		Resident #21 as having a Brief					
		Status Score of 15, indicating					
	that she was cognit	ively intact, without					
	impairment.						
	On 3/15/17 a review	v was completed of Resident					
		d, revealing the following care					
		esident will be free of					
		symptoms, elevated blood					
	pressure through ne	ext review."					
	Decident #04's Dhu	ninian Ordana rood: "O/4/47					
		sician Orders read: "2/1/17. 5 MCG (micrograms). Give 1					
		he morning related to					
		specified. Clonidine HCl					
		gram). Give 1 tablet by mouth					
	three times a day re						'
		alazine HCl Tablet 100 MG.					
		uth three times a day related					
	to Essential Hyperte	ension."					
	On 3/15/17 a review	v of Resident #21's Medication					
		ord (MAR) was conducted,					
	revealing missing de						
		e following medications:					!
		_					•
		75 MCG (micrograms). Give the morning related to					

PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HULF **I SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICみの SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495235 B. WING 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE **ENVOY OF WILLIAMSBURG, LLC** WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE OATE TAG TAG DEFICIENCY) F 281 Continued From page 42 F 281 Hypothyroidism, Unspecified, 2/8/17 at 6:00 A.M. 2. Clonidine HCl Tablet 0.1 MG (milligram). Give 1 tablet by mouth three times a day related to Essential Hypertension. 2/8/17 at 6:00 A.M. 3. Hydralazine HCI Tablet 100 MG. Give 1 tablet by mouth three times a day related to Essential Hypertension, 2/8/17 at 6:00 A.M. A review of the Nursing Notes for February, 2017 revealed that the medication administration had not been documented. A review of facility documentation was conducted on 3/15/17, the Oral Administration of Medications Policy, dated 11/30/14 read, "It is the policy that the resident can expect safe and accurate administration of oral medication. Chart on MAR according to policy." On 3/16/17 at 12:30 P.M. an interview was conducted with the Director of Nursing (Employee) B). When asked to clarify the facility's policy on documentation of medication administration, the Director of Nursing stated, "You document on the MAR at the time of administration or on nursing notes."

On 3/16/17 at 12:45 P.M. the facility Administrator (Employee A) was informed of the findings. No

further information was received.

SS=E FOR HIGHEST WELL BEING

483.24 Quality of life

F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES

Quality of life is a fundamental principle that applies to all care and services provided to facility

F 309

	MENT OF HEALTH			(		4PPROVED 0938-0391
		& MEDICAID SERVICES			1	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	SURVEY PLETED
		495235	B. WING		03/	16/2017
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		•	1:	235 MT VERNON AVENUE		
ENVOY 0	OF WILLIAMSBURG, I	LLC 	W	/ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC-IDENTIFYING-INFORMATION}-	ID PREFIX - TAG -	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPER  DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 309	Continued From pa	ne 43	F 309			1
1 000	<u> </u>	sident must receive and the	. 555	1 A) Dhysisian was notified	that	04/18/2017
		e the necessary care and		1. A) Physician was notified		
		maintain the highest		resident #10 had 15 finger s		
		I, mental, and psychosocial		that were greater than	400.	
		ent with the resident's		Resident #10 received a	new	
		sessment and plan of care.		order to obtain HgbAlc ar	id to	
	'	·		increase his Lantus to 24		
	483.25 Quality of c					1
		fundamental principle that		daily. Physician was also no		
	applies to all treatm	nent and care provided to		that the order for Trazadone		
	facility residents. B	ased on the comprehensive		not implemented. Res	ident	,
	assessment of a re	sident, the facility must ensure ve treatment and care in		Trazadone order was discont	inued	
		ofessional standards of		by psych NP. Upon inter		
	practice the comp	ehensive person-centered		with resident #10 there ha		
		residents' choices, including			5 1101	
	but not limited to th			been any sleep disturbances.	_	
		0		B) Resident #7 drug regime	n for	
	(k) Pain Manageme			diabetic control was implem	ented	
		nsure that pain management is		and will be reviewed eve	ery 2	•
	provided to resider	ts who require such services,		weeks by physician for effe		
		fessional standards of practice,				
		person-centered care plan,		diabetic control.		
	and the residents	goals and preferences.		C) Resident #13 care plan	n has	
	(I) Dialysis The fa	cility must ensure that		been updated with	non-	
	residents who requ	ire dialysis receive such		pharmacological intervention	ns for	
		it with professional standards		behaviors associated	with	
		nprehensive person-centered		anxiety/aggression. Residen	t #13	
		residents' goals and		has not been administered A		
	preferences.			*****		
	:	NT is not met as evidenced		without non-pharmacol	ogicai	
	by:			intervention documented.		
	Based on resident	interview, staff interview,				
	tacility document re	eview and clinical record review	'			
	the facility staff fall	ed to provide the necessary to maintain the highest				
	practicable well be	ing for five residents		•		
	(Residents #10, #7					
	(Izesidellis #10, #1	, #10, #1 unu #11 J 01 24	ļ			<u> </u>

	ENT OF HEALTH	AND HUM SERVICES & MEDICALD SERVICES			(	FORM A	APPROVED 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
		495235	B. WING			03/1	16/2017
	OVIDER OR SUPPLIER WILLIAMSBURG, I	LLC		123	REET ADDRESS, CITY, STATE, ZIP CODE 35 MT VERNON AVENUE LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCHDENTIFYING INFORMATION) -	ID PREFI TAG		PROVIDER'S PLAN OF CDRRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED-TO-THE-APPROR DEFICIENCY)	BE	(X5) COMPLETION DATE
ro 1 as 4 b c n 2 um n 3 n c a 4 c F 5 p n 1 iii h 9 s F	tick blood sugar (F. 00, per physician' of the facility staff forder for Trazodone nedication), per physician's. For Resident #7 apon a monthly drugecommendation for nanner;  B. For Resident #1 apon pharmacological eveloped and implementation of arms. The facility staff orders for the admirates for the admirates for the admirates for the admirates for the physicial physicial physicial forces for the physicial forces for the physicial forces of head of the findings included as the physicial physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the physicial forces for the findings included as the f	vey sample.  0, as not informed of 15 finger (SBS) readings greater than s order and ailed to implement a physician e (an anti-depressant ysician.  1, the facility staff failed to act g regimen review r diabetic control in a timely  3, the facility failed to ensure al interventions were lemented prior to attanxiety medications;  failed to follow physician mistration of insulin for  pain management was not visician ordered. She missed er Fentanyl (pain) patch.	F3	309	D) MD notified of the omadministrations of resident fentanyl patch. Residentanyl patch order has discontinued. Resident #17 I new pain management order place and has been administanted as order. License nursing will continue to monitor paineffectiveness. Pain assess has been completed on restanted with a diagnost diabetes and receive insuling parameters have the potential be affected. Residents with psychotropic medications pain medications have a pot to be affected.	#17 lents' been has a er in tered staff n for ment ident is of with ial to PRN and	

	MENT OF HEALTH	AND HUM SERVICES & MEDICALD SERVICES			l'	FORM A	03/30/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED
	·	495235	B. WING			03/1	6/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY (	OF WILLIAMSBURG, 1	LLC			235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFEBENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	gown. Resident #1 stay in the facility. want to live in the facility. want to live in the facility want to live in the facility. Want to live in the facility in the facility in the facility and he had be said he could injections.  A review of Resided documentation and initiated on 3/15/17  A quarterly MDS (rewith an ARD (asset 1/20/17 coded Resinterview of mental cognitively intact. In needing staff super (activities of daily lian Active Diagnosi Resident #10's coincluded a plan for Complications r/t (Interventions included a plan for Complications r/t (Interventions r/t (Interventions r/t (Interventions r/t	nket and wearing a hospital 0 was talkative regarding his Resident #10 said he did not acility, that he was bored and with the staff regarding be to live, a place that was //irginia. Resident #10 was receiving insulin injections ld learn to give himself facility clinical record was at 8:30 a.m.  minimum data assessment) assment reference date) of ident #10 a BIMS (brief status) score of "15" out of 15, Resident #10 was coded as revision only with ADLs ving). Diabetes was coded as some marked to diabetes.  Imprehensive care plan Risk for Metabolic related to) diabetes.  Indeed to diabetes.  Indeed to detect of the diabetes of the diabetes.  Indeed to diabetes ordered ".  It #10's hospital documentation the 1/9/17 revealed he was agnosis of Diabetic of the hospital was genosis of Diabetic or Before a meal: urs after beginning of the meal, was after beginning of the meal, was also as the property of the meal, was after beginning of the meal, was		309	3. A) DCS instituted a procedure to ensure all pharmacommendations are given to unit managers prior to scanned in PCC to e recommendation orders entered. B) Licensed nursing will be re-educated on policiprocedure for in administration and document in MAR. C) In-service will include documentation of pharmacological intervel prior to administration of psychotropic medication; procedure for when medicate low or not available.  4. DCS/designee will commended and audits on respectiving insulin, psychotropic medication and medication omissions and	back being nsure are staff y and nsulin tation I also non- ntions PRN D) ations onduct idents PRN ations, order psych ek for for 30 audits	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

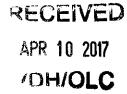
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
			71. 20122	<u> </u>		С
		495235	B. WING	3	03	/ <b>16/201</b> 7
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG, I	LLC		STREET ADDRESS, CITY, STATE, ZIP 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	EX (EACH CORRECTIVE ACTION	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 46	F:	309		
	mellitus characteriz Lippincott's Manual edition, p. 928. "When your cells d for energy, your bod energy, which produ body cannot make d injection or through glucose. When ket they make it more a	omplication of diabetes ed by hyperglycemia" of Nursing Practice, 8th on't get the glucose they need dy begins to burn fat for uces ketones When the enough insulin, it is taken by use of an insulin pump to use ones build up in the blood, acidic. They are a warning sign s out of control or that you are diabetes.org				
	physician wrote an "Humalog Solution unit subcutaneously 2 Diabetes. Hold if	radmission to the facility, the insulin order which read, 100 unit/ml (milliter) Inject 5 before meals related to Type blood sugar is less than 100. than 60 or greater than 400".				:
	administration recording and ministration recording at 5 p.m. (4 at 5 p.m. (576); 1/18 p.m. (491); 1/21 at 8 (479) and 5 p.m. (412); 1/26 Review of the February FSBS results that we	ary 2017 MAR (medication rd) revealed finger stick blood ts that were greater than 400 81); 1/12 at 5 p.m. (566); 1/17 at 5 p.m. (566); 1/20 at 5 p.m. (466); 1/22 at 12 p.m. 91); 1/23 at 5 p.m. (583); 1/24 at 5 p.m. (488).  Luary 2017 MAR revealed rere greater than 400 on 2/10 2/14 at 12 p.m. (461) and 5				
		of the clinical record did not dification of the blood sugars in				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N46M11

Facility ID: VA0274

If continuation sheet Page 47 of 103



### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICA D SERVICES				<u> JMB NC</u>	<u>). 0938-039</u> 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION		TE SURVEY MPLETED
	İ	495235	B. WING			03	C 3/ <b>16/201</b> 7
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENN/OV/	NE WILLIAMODUDO			13	235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG, I			V	VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 309	briefing, the administ of nursing) were informeasurements great	p.m., during an end of day strator and the DON (director	F 3	i09			
	with the DON regar in question was cor order was not for sli therefore the nurse parameters in place The DON stated, " at the summary tab DON said the expec	a.m., a follow-up interview ding the FSBS measurements inducted. The DON said the iding scale insulin and didn't expect to see for physician notification. They (the nurses) didn't look to read the entire order." The ctation was for the nurses to 's order for notification.					
	(licensed practical r she opened the lap 10's MAR. LPN D s tab, the entire physi entire order on the a administration recor	a.m., unit nurse LPN nurse) D was interviewed as top computer to Resident # stated," If you hit the 'MORE' cian order is visible." The eMAR (electronic medication rd) included, "Contact MD ess than 60 or greater than					
	C was interviewed. Resident #10's clinic evidence of physicia	5 a.m., the unit manager, LPN LPN C said she had reviewed cal record and found no an notification of the blood ts that were greater than 400.					
		Administration policy was of include directions regarding ician notification.					

Guidance for nursing practice for the

#### DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	10 I OI WILDIOAIL	A MICDIOAID SCIVICES				MD MO.	0936-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495235	B. WING			1	C <b>16/2017</b>
	PROVIDER OR SUPPLIER DF WILLIAMSBURG, I			12	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX :	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) CDMPLETION DATE
F 309	administration of me Mosby's Potter and Nursing 7th Edition, responsible for direct Nurses follow physical believe the orders at On 3/16/17 at 3:00 informed of the staff physician of blood sthan 400 (milligrams order. There was in provided.  1. b. For Resident implement a physical anti-depressant), per Trazodone is a present the treatment of deposition of the staff physician and the staff physician of the staff physician of the staff physician of the staff physical p	dedications was included in, Perry, "Fundamentals of a, p. 336, The physician is ecting medical treatment. ician's orders unless they are in error or harm clients."  p.m., the administration was ff's failure to notify the sugar measurements greater as/deciliter), per the physician's no additional information  #10, the facility staff failed to cian order for Trazodone (an er physician orders. escription medicine used for pression, however, it is also ep aid.  t #10's clinical record revealed ation dated 9/1/16. Under	F3	809	DEPOLITOT)		
	'sleeping pill'." Und "Insomnia and Agita Adjustment read, "V	oor sleep, request for a der Symptoms/Problems read, ation". Under Medication Will add Trazodone 50 mg by mouth) Qhs (at bedtime)."					:
	Trazodone 50 mg h	ician orders revealed nad not been transcribed on list for administration.					
-	administration recor	ember 2016 MAR (medication and) revealed Trazodone was ication for administration.					

Review of a Pharmacy Consultation dated 9/6/16

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

CLIVILL	TO I OIL MILDICAIL	. Q MILDIONID OLIVIOLO				IVID NO.	0900-0091
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	СОМ	E SURVEY PLETED
		495235	B. WING		<u> </u>		C <b>16/2017</b>
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1:	235 MT VERNON AVENUE		
ENVOY (	OF WILLIAMSBURG, I	LLC			VILLIAMSBURG, VA 23185		
				V	VILLIAIVISBURG, VA 23165		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	nge <b>4</b> 9	E 4	309	ı		
1 000	•	_	Г	505			)
		0's name] had a psych consult					1
	and [Physician's na						
		ng qhs to his drug regimen,					
		has not been implemented."					
		igned by the director of					!
		A hand written note on the					!
		t signed by the mental health	İ				i i
		n 9/23/16 read, "Resident ne not needed. Will change dx					
		dol (an antipsychotic					
	medication)."	doi (an antipsychotic					:
	medication).						:
		ress Note revealed a Social d 3/6/17 which read,					
		ughter's name] would like to					
		ch nurse concerning Resident					
		d why Trazodone was d/c					
	(discontinued) in Se	eptember 2016."					
	0 04047 1050						
		a.m., an interview was					
		sident #10 regarding his sleep					
		10 stated, "I used to have					
	some nouble sleep	ing, but not so much now."					
	On 3/16/17 at 11:50	a.m., an interview was					
		DON (director of nursing)					
		y briefing. When asked about					1
	the Trazodone that						:
		ver implemented, the DON					• 1
		a breakdown in getting the					:
	psychiatrist's consu						:
	p= y 0.1101.101.0 001100	at to the physicians					
	On 3/16/17 at 3:00	p.m., the administration was	!				i :
		f's failure to implement a	 				
		Trazodone. There was no	! :				į l
	additional information				,		1
		•	:				

#### PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HU! **1 SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495235 B. WING 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE **ENVOY OF WILLIAMSBURG, LLC** WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 309 Continued From page 50 F 309 2. For Resident #7, the facility staff failed to act upon a monthly drug regimen review recommendation for diabetic control in a timely manner. Resident #7, a male, was initially admitted to the facility 3/2/01. His diagnoses included aphasia. type II diabetes mellitus, hemiplegia, monoarthritis, vascular dementia with behavioral disturbances, hypothyroidism, hyperlipidemia, osteoporosis, major depressive disorder, hypertension, seizures, and iron deficiency anemia. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/17/16 was coded as a quarterly assessment

daily living.

with a subsequent modification. Resident #7 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #7 was coded as requiring extensive to total assistance of one to two staff members to perform his activities of

Resident #7 was observed 3/14/17 at 4:08 p.m. He was lying on his back and alert. Resident #7

#### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

CENTE	12 LOV MEDICHISE	A MEDICAID SERVICES				<u>IVID IVO.</u>	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		495235	B. WING		<u>.</u>		C 16/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		_		1:	235 MT VERNON AVENUE		
ENVOY (	OF WILLIAMSBURG,	LLC			VILLIAMSBURG, VA 23185		
					·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 309	Continued From pa	nge 51	F	309	!		
, 000	•	r unable to make his needs		505			
			!				
	care at the time of t	administering incontinence	i				
	odro di ino inno on	mo obool valion.					
	Review of Resident	t #7's clinical record revealed a					
		ation Report" that was	 				
		harmacist after the monthly					
		npleted on on 9/6/16. The					
	pharmacist made th	ne following recommendations:					
		ne) frequently requires insulin					
	Levemir 20 units qa	espite routine therapy with am (every morning) and 15 ne) and novolin R 5 units					
	Recommendation:						
	discontinuing sliding	proving glycemic control by g scale insulin and novolin R mir to 20 units twice a day.					
		mmendation: Prolonged use	:				
		ılin is ineffective for long-term an ∣ead to hypo (low) or					  -
		h blood sugar), increases					
		, increases cost, requires					
		may increase morbidity and					
		n to improve glycemic control					
	in the long-term car						
	If this thousant is to	andinua it is resourceded					
		continue, it is recommended					
		er document an assessment fit, indicating that it continues					
		eutic intervention for this					
		e facility interdisciplinary team					
		nitoring for effectiveness and					: 
	potential adverse of						:

#### DEPARTMENT OF HEALTH AND HUT I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR MEDICARE	A MEDICAID SELVICES				NIO INC	<u>7. 0936-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING			03	C 3/16/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1:	235 M⊤ VERNON AVENUE		
ENVOY	OF WILLIAMSBURG, I	LLC			VILLIAMSBURG, VA 23185		
(24) 15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	I		· · · · · · · · · · · · · · · · · · ·	201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	nge 52	· - = 1	309	I		
		*		003			
	Glucose monitoring should continue following any change in diabetic therapy."						
	The physician notes	d the recommendation and	:				
		he recommendation(s) above					
	•	WING MODIFICATIONS(S):					
	D/C S/S (sliding sca						
		20 u (units) qam (every					
		s (at bedtime). BS (blood					
		before dinner only. Notify MD					
	(less than) <50 or >	· (greater than) 400."					
	The endor for the el	congos in Posident #7's					
		nanges in Resident #7's ent was dated as having been	:				
		ysician 9/28/16 (22 days after	i i				
		nmendation was developed).					
	and pharmady root.	imendation was developed).	:				
	Sliding scale insulin	is a dose of insulin					İ
	predetermined by the	ne physician based on a finger	i.				
	stick blood sugar re	eading.					!
		"Levemir®, a long-acting					
		des blood sugar control for up so with type 2 diabetes"					
	to 24 Hours III aguit	s with type 2 diabetes					İ
	www.lantus.com.als	so provides guidance that					
		ong acting insulin that may be					
		or Type II diabetes.					
	•	• .					
		C was available for review					
	•	uestion. A hemoglobin A1C is					
		ed to determine long term					
	diabetic control.						
	When intensioned a	egarding the 22 day lag					
		pharmacy recommendation					
		n reviewed by the physician,					

the DON (director of nursing) stated 3/15/17 at

#### DEPARTMENT OF HEALTH AND HU I SERVICES CENTERS FOR MEDICARE & MEDICARIO SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICALD SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING	i		l l	C /1 <b>6/2017</b>
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
	DE MULLIAMODUDO (	110		12	35 M⊤ VERNON AVENUE		
ENVOY	OF WILLIAMSBURG, I			W	ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	ILD BE	(X5) COMPLETION DATE
F 309	Continued From pa	go 53	F /	,			
L 209	· · · · · · · · · · · · · · · · ·	<del>-</del>	i Fa	309			
		macy reviews are emailed to					
		ey are printed out and given to					
	the unit managers f						
		ember 2016, would put the bok" that contained Resident					
		to be addressed. The DON					
		n's would come to the facility to	!				
		and often times would leave					
		hat had been put in their					
	"book." The DON s	tated the recommendation					İ
	had been put in the	"book" and the floor nurses					
		the physician had reviewed	İ				
		n. Additionally, the DON	!				
		ther Resident concerns that	i I				
		pook" that were not handled in					
		he DON stated she was					
		e floor nurses to "round" with					
	concerns were hand	nsure all identified Resident					
	concerns were name	uleu limely.	 				
	Guidance was provi	ided at www.medline.nih.gov:					
	"People with diabet	es are living longer and	i I				
		now have a much lower	! :				
	chance of developing	ng kidney failure, heart	İ				!
		tation than they did in the past,	:				!
	thanks to advances	in controlling blood glucose,					1
		d cholesterol, and greater					
		cation efforts. Now, more than					
		to see your healthcare					
	, ,	to treat diabetes effectively.	:				
		r cholesterol, blood sugar,					
		d weight. You may be asked to					
		ealthy lifestyle, especially					
		you eat and exercising every					
		ent heart attack and stroke. A k can help you manage					
		your chances of developing					
	arabetes arta lewer	Agos cualifica of acaciobiliti					i

problems associated with diabetes, such as heart

# DEPARTMENT OF HEALTH AND HU/ N SERVICES CENTERS FOR MEDICARE & MEDIC, "D SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495235	B. WING_		03	C 3/ <b>16/2017</b>	
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG,			STREET ADDRESS, CITY, STATE, ZIF 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		, 10.201.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 309	attack and stroke. People with diabete glucose (sugar) as soon after they are attacks later in life their eyes, nerves,  The administrator, consultants were a to ensure a pharma improve diabetic coreviewed and acted timely manner, 9/1:  3. For Resident #1 non pharmacologic developed and impadministration of an Resident #13, a mafacility 9/24/15 and hospitalization 2/20 unspecified demendisturbances, Alzhe weakness, unspecified demendisturbances, and weakness, unspeci	tes who keep their blood so close to normal as possible diagnosed have fewer heart and far fewer problems with and kidneys."  DON, and corporate advised of the failure of the staff acy recommendation to ontrol for Resident #7 was diagnosed upon by the physician in a 15/17 at 4:50 p.m.  13, the facility failed to ensure call interventions were plemented prior to antianxiety medications.  ale, was initially admitted to the direadmitted after a 10/16. His diagnoses included that with behavioral eimer's disease, muscle cified lack of coordination, pation, epilepsy, and mood that assessment reference date) of diagnoses an annual assessment, coded as having short and deficits and required total aking daily life decisions, also coded as needing total to two staff members to					

## DEPARTMENT OF HEALTH AND HU! V SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

OLITICI	CO I OIL WILDIOMICE	A MEDIO GO OCITATORO				INID HO	. 0330-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	COM	E SURVEY IPLETED
		495235	B. WING			1	C <b>16/201</b> 7
NAME OF I	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017
NAIVIL OI I	MOVIDER OR SOFFEIER						
ENVOY (	OF WILLIAMSBURG,	LLC			235 MT VERNON AVENUE		
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			٧	WILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION OATE
F 309	Continued From pa	ge 55	E 1	309	I		: !
. 000	·	_	1 1	508			i
		back with the head of the bed esident #13 appeared to be					:
		#4.0115-51					:
		:#13's clinical record revealed					,
		d "Ativan solution 2 mg/ml					
		liter) Give 0.25 ml orally every for anxiety" on 2/9/17 8:44					
		., 2/13/17 8:30 p.m., 2/19 8:42					
		a.m., 2/24/17 8:43 a.m.,					!
		d 9:30 p.m., 3/2/17 8:17 a.m.					1
	and 8:23 p.m., and						
	www.drugs.com sta	ated:					· : !
	called benzodiazepi	belongs to a group of drugs ines. Lorazepam affects ain that may be unbalanced in					
		eat anxiety disorders."					!
		-					:
	every six hours as r	nt to discontinue the Ativan needed and changed to every ed on 3/3/17 with Resident gitation."					
	Ativan was adminis 8:23 p.m. and 3/3/1	tered 3/2/17 at 8:17 a.m. and 7 at 5:21 a.m.					
	On 3/3/17 an entry notes that included:	was evident within the nursing					
	"Resident had incre ADL (activities of da	ased anxiety while performing aily living) care"					
		ased Resident #13's Ativan to					

for Agitation/Pain." Documentation was evident

## DEPARTMENT OF HEALTH AND HUT I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С
		495235	B, WING	_		03	/16/2017
	PROVIDER OR SUPPLIER  DF WILLIAMSBURG,	LLC		12	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	12:17 p.m., 3/4/17 4:44 p.m. and 11:03 6:38 a.m., and 3/8/  Due to increasing the physician then order (milligram)/ml 0.5 magitation and Seroe (every bedtime) dx 3/8/17  Haldol was administ 3/8/17 at 8:01 a.m., p.m.  Guidance for the act www.drugs.com:  "WARNING Increased Mortality Dementia-Related Increased Mortality Dementia-Related Increased risk of deplacebo-controlled weeks), largely in pantipsychotic drugs drug-treated patient the risk of death in the course of a typic the rate of death in about 4.5%, compating the placebo group. Were varied, most deither cardiovascular distributions of the course of a typic the rate of death in about 4.5%, compating the placebo group.	was administered 3/3/17 at 12:06 a.m., 4:53 a.m., 3/5/17 3 p.m., 3/7/17 2:27 a.m. and 17 at 10:25 a.m.  The "agitation" Resident #13's ared "Haldol 2 mg and q 6 hrs PRN (as needed) quel 25 mg po (by mouth) qhs (diagnoses) agitation. on a stered to Resident #13 on a 3/11/17 6:14 P.M. and 11:36 and a ministration of Haldol at a ministration of Haldol at a metal. Analyses of seventeen trials (modal duration of 10 atients taking atypical prevealed a risk of death in the of between 1.6 to 1.7 times placebo-treated patients. Over cal 10-week controlled trial, drug-treated patients was ared to a rate of about 2.6% in Although the causes of death of the deaths appeared to be ar (e.g., heart failure, sudden	F:	309			
	death) or infectious	ar (e.g., heart failure, sudden (e.g., pneumonia) in nature. es suggest that, similar to	1 1 2 2				

atypical antipsychotic drugs, treatment with

# DEPARTMENT OF HEALTH AND HU[ I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		405025		-			C .	
		495235	B. WING			03/	16/2017	
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG, I	LLC		12	TREET ADDRESS, CITY, STATE, ZIP CODE  235 MT VERNON AVENUE  VILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 309	mortality. The exterincreased mortality be attributed to the to some characteristiclear. Haldol Injection treatment of patient psychosis (see WA) Haldol (haloperidol) treatment of schizol Haldol is indicated futterances of Toure Increased Mortality Dementia-Related Filderly patients with treated with antipsycincreased risk of deapproved for the treated worth and the second seco	ychotic drugs may increase nt to which the findings of in observational studies may antipsychotic drug as opposed stic(s) of the patients is not on is not approved for the is with dementia-related. RNINGS).  It is indicated for use in the phrenia. For the control of tics and vocal tie's Disorder.  In Elderly Patients with	F	809				
	WARNING)." Haldol is an antipsy	•						
	that for all the times Haldol were adminis the facility staff had	ng progress notes revealed Ativan (lorazepam) and stered, there was no evidence clear definition of what on" symptoms were.						
		ster.com defines anxiety as s about what might happen"						
	and www.medical d	ictionary.com defines anxiety:					:	
		and the diagnosis and the diagnosis and the diagnosis and						

#### DEPARTMENT OF HEALTH AND HU 1 SERVICES CENTERS FOR MEDICARE & MEDICARIO SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR MEDICARE	A MEDICAID SEKVICES				<u> </u>	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING			03	C /1 <b>6/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1:	235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG, I	LLC		٧	VILLIAMSBURG, VA 23185		
	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	<u> </u>				<del></del>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION OATE
F 309	Continued From pa	ae 58	   F3	เกด	1		•
	understanding of its	=		,00			
	COMMIN The see						
		natic or physical symptoms of					
		daches, dizziness or ausea and/or vomiting,					:
	_	ale complexion, sweating,					
		/ in breathing, and sensations	ĺ				
		hest, neck, shoulders, or					
		otoms are produced by the					
		r, and cardiovascular					
		n the fight-or-flight reaction.					
		scents with generalized					
	anxiety disorder sho physical complaints	ow a high percentage of					
	REHAVIORAL Reh	avioral symptoms of anxiety					
		nbling, general restlessness,	!				
		essured speech, hand	İ				
	wringing, or finger to						ľ
	COGNITIVE Cogni	tive symptoms of anxiety					
		obsessive thoughts, feelings					
		fear-inducing thoughts or					
		n, or inability to concentrate.					
	·	,					
		ng states associated with	 				
		ion or nervousness, feeling					
		, and feelings of unreality,					
	panic, or terror."						
	Agitation is defined	by www.medlineplus.gov:	<b>]</b>				
	"Agitation is an uppl	leasant state of extreme					
		person may feel stirred up,					
	excited, tense, conf						
	,,	- , · · · · · · · · · · · · · · · · ·	[				
	Review of nursing p	rogress notes revealed no					
		harmacological interventions					

were attempted prior to the administration of

#### PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HU! I SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICから SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495235 B. WING 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE **ENVOY OF WILLIAMSBURG, LLC** WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) OATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 59 F 309 antianxiety medication and ultimately an antipsychotic medication (Haldol). Review of Resident #13's care plan revealed the following concerns were identified and care-planned regarding Resident #13's behavior: "Potential for impaired or inappropriate behaviors r/t (related to) dementia with behavioral disturbance, Alzheimer's, history of combative behavior of hitting, kicking. Date initiated 3/1/17 **INTERVENTIONS** \*Anticipate and address resident needs \*Approach resident in a calm manner \*Assess resident for pain and treat as indicated \*Explain procedures to resident before providing care \*Introduce self when providing care \*Labs as ordered, report results to physician \*Medications per physician orders

Revised 3/1/17

**INTERVENTIONS** 

weakness, sedation

treatment

\*Monitor for increase in behaviors or unsafe

\*Remove sources of agitation as possible \*Wait and reattempt when refusing care or

Anti-anxiety medication used PRN for dx

\*Anti-anxiety Non-drug interventions-Monitor behavioral symptoms and side effects such as appetite changes, memory impairment, muscle

\*Provide calm, quiet environment during periods

behavior and report to physician prn

of agitation or violent behavior \*Psychological consult as needed

(diagnoses) of: anxiety

# DEPARTMENT OF HEALTH AND HUT I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

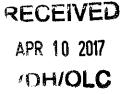
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495235	B. WING	•		C 03/46/304	7	
_	PROVIDER OR SUPPLIER  DF WILLIAMSBURG,			03/16/201	<u>.                                    </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV	ON SHOULD HE APPROPE	BE COMPLE	ETION	
F 309	*Dose reduction att clinically indicated *Evaluate medication response quarterly *Medication as orde *Non-Drug Intervent management care While a few of the anon-pharmacologic proceduresIntroduction environmentwait acare) there was nattempted the intervent When interviewed, 11:35 a.m., the staff aggressive behavior evidence they had a non-pharmacologic administering medical to identify what for the administration, I consultants were in staff to identify what for the administration antipsychotic medical implement non-pharmacologic implement non-pharmacologic antipsychotic medical im	empts per evaluation if on use and resident's ered (see MAR) tions-see behavior plan"  above interventions included al intervention (explain uce selfprovide cal quiet and reattempt when refusing o evidence the staff had ventions.  the DON stated 3/16/17 at f had identified some rs, however there was no attempted al interventions prior to cations.  DON, and corporate formed of the failure of the t behaviors were appropriate on of antianxiety and cation and to develop and rmacological interventions tration of same medications,	F3	09				
		ailed to follow physician Iministration for Resident #1.				·		
		year old female, was admitted /2015 and readmitted on						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N46Mt1

Facility ID: VA0274

If continuation sheet Page 61 of 103



#### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  C  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE	-ETEĎ
495235 B. WING 03/16/2	6/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
	_
1235 MT VERNON AVENUE	
ENVOY OF WILLIAMSBURG, LLC WILLIAMSBURG, VA 23185	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5] COMPLETION DATE
F 309 Continued From page 61  11/27/2016. Her diagnoses included diabetes, dementia, coronary artery disease, muscle weakness, cognitive communication deficit, osteoporosis, dysphagia, seizures, anemia, glaucoma, and hypertension.  Resident #1's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/2017 was coded as a quarterly assessment. She had a BIMS (Birel Interview of Mental Status) score of 6/15, indicating severe cognitive impairment. She required extensive assistance of one person for her activities of daily living and was frequently incontinent of bowel and always incontinent of bladder.  A clinical record review was conducted 3/13/2017 at 4-40 PM. It revealed a physician's order for insulin administration dated 12/5/2016 as follows:  "Humalog solution 100 units/ml (milliliter) (Insulin Lispro). Inject 5 units subcutaneously before meals. Call MD if (blood sugar readings) are less than 50 or greater than 350(milligrams per deciliter). Hold if blood sugar is less than 150."  A review of the MAR (Medication Administration Record) for Jan 2017 revealed that insulin was administered when the blood sugar reading was below 150 (milligrams per deciliter) on the following dates and times during. Blood sugar readings are in parenthesis:  111-8:00 AM (123), 4:30 PM (82) 11/3-8:00 AM (123), 1:30 AM (144) 11/4-8:00 AM (136)	

1/7-8:00 AM (140), 4:30 PM (140)

# DEPARTMENT OF HEALTH AND HU[ I SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495235	B. WING		<del></del>		C
NAME OF	PROVIDER OR SUPPLIER	40200			TREET ADDRESS, CITY, STATE, ZIP CODE	<u>  US/</u>	16/2017
					235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC			VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION OATE
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	0				<u> </u>		
F 309	Continued From pa	•	; F3	309			
	1/8-8:00 AM (139),						
		11:30 AM (146), 4:30 (113)	•				
	1/10-11:30 AM (130						
	1/11-8:00 AM (124)	· ·	1				
	1/12-11:30 AM (135 1/13-8:00 AM (131)		•				,
	1/13-8:00 AM (131)						<u> </u>
	1/15-4:30 PM (98)	i, 11.50 AM (140)					
	1/16-11:30 AM (138	3)					ļ l
	1/17-4:30 PM (137)	•					Į.
		, , 11:30 AM (132), 4:30 PM					
	(142)	, 11:00 AW (102), 4:00 1 W					
	1/19-4:30 PM (136)		i				
	1/21-11:30 AM (128		;				1
	1/22-4:30 PM (134)		i				
	1/23-11:30 AM (134						
	1/24-4:30 PM (114)						:
	1/25-8:00 AM (113)						•
	1/26-4:30 PM (63)	,					
		:30 AM Employee B, Director					
	O.	hat the nurses were not					ļ
	reviewing the entire insulin.	order when administering the					:
	Eggility Dollaige and	Dropoduros rospedina institu					
		Procedures regarding insulin					
		ed: "The clinical nurse will	1				
		ubcutaneously per physician's	1				
	order."		1				
	Clinical Diabates Is	an 2016 pp 25-33 published by	:				
		etes Association offered	i				
		insulin administration as	!				
	follows:	mount authiniotration as	i				
	TOHOWS.						
	"Incorrect administr	ration of insulin (e.g. too little	İ				ļ
		ration of insulin (e.g., too little, wrong times) can result in	:				
		us hypo- and hyperglycemia,	1				
		rsions, and diabetic	:				

# DEPARTMENT OF HEALTH AND HUT I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495235	B. WING			1	C <b>16/201</b> 7
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC			12	REET ADDRESS, CITY, STATE, ZIP CODE 35 MT VERNON AVENUE ILLIAMSBURG, VA 23185	1 03/	10/20 17	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	3/16/2017 at 3:00 F  5. Resident #17's p provided as the phy multiple doses of he Resident #17, a fer	informed of findings on	F3	309			
	fracture, Alzheimer depression.  Resident #17's mos set) with an ARD (a 11/16/16 was coded as memory deficits an with making daily lift coded as requiring of one staff member daily living. Reside	st recent MDS (minimum data assessment reference date) of d as a quarterly assessment. having short and long term d required total assistance fe decisions. She was also extensive to total assistance for to perform her activities of an title and the manner of the manne					
	observed in the bed The medication nur complaints of pain.  Review of the clinic (medication adminis and March of 2017 had a physician's of Fentanyl patch ever	AM, Resident #17 was d. She stated, "I hurt so bad." se was notified of resident's al record, to include MAR's stration record) for February was conducted. The resident rder dated 3/18/16 for ry 72 hours. Fentanyl is an harcotic used to treat chronic					

# DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7. Boilesino		С	
	495235	B. WING	i		03/	16/2017
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG,	LLC	·	STREET ADDRESS, CITY, STATE, ZIP O 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	ODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
2/5/17 at 1:00 PM: 6 notes. Nurses note Resident's medicati the pharmacy." He no documentation was been applied. Tyler given at 6:00 PM wi PM, the nurses note medication was ine "8". At 8:38 PM, No given with relief and later. The Fentanyl given on 2/7/17 at 9:3/5/17 at 7:58 PM: 1/2 left on." Pain level was documented was documented as "7" was given.  On 3/16/17 at 9:23 PM, with documented as "7" was given.  On 3/16/17 at 12:07 conducted with the She described the pharmacy. physician for a scripted included the following negative physical ar	available are below:  coded as a "9" or see nurses as dated 2/5/17 included: ion is on afternoon run from r pain score was left blank and was evident the patch had not 650 mg (milligrams) was ith a pain score of "8". At 7:00 re read, "prn (as needed) pain ffective." Pain scale was still prco 5/325 mg one tablet was do a pain scale of "2" an hour patch was documented as 0:50 AM.  Tho patch available old patch was scored as a "10". No need as given until 3/8/17 at medication was given until which the pain level was and Norco 7.5/325 mg pill  T PM, an interview was DON (director of nursing). Procedure for obtaining available. She stated, "We we may need to call the of (prescription)."  Y on Pain Management ng: "Unrelieved pain has nd psychological uding the potential for	F3	309			
On 3/16/17 at 12:10 DON were notified t	PM, the Administrator and of above findings.					

	MENT OF HEALTH	AND HUM SERVICES  & MEDICAL SERVICES					APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI A. BUILDIN		(X3) DATE COMF	SURVEY PLETED		
		495235	B. WING_			03/1	C 16/2017
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY	OF WILLIAMSBURG,	LLC			MT VERNON AVENUE LIAMSBURG, VA 23185		
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F 323 SS=E	(d) Accidents. The facility must er  (1) The resident enfrom accident haza  (2) Each resident reand assistance dev  (n) - Bed Rails. The appropriate alternated bed rail. If a bed of must ensure correct maintenance of betto the following electrone bed rails prior  (2) Review the risk the resident or resident or resident or resident or resident or selectrone documentation reverse the facility staff fails population from bid syringes/needles, a supervise/monitor protocol (Resident residents.	vironment remains as free rds as is possible; and eccives adequate supervision rices to prevent accidents.  e facility must attempt to use tives prior to installing a side or side rail is used, the facility of installation, use, and drails, including but not limited ments.  dent for risk of entrapment to installation.  Is and benefits of bed rails with dent representative and obtain prior to installation.  bed's dimensions are resident's size and weight.  NT is not met as evidenced tion, staff interview, facility iew, and clinical record review, and to protect the resident obtain phazardous waste, and used	F 32		1. A) Biohazard door has lock on it that is secun prevent anyone from opit without a key. All Biolowaste, recepticals and articles are put up proper biohazard containers removed per protocological Resident #6's wandergar checked and it works proceed and it works proceed.  2. A) All biohazard doors facility have the potential affected. B) All resident wandergards have potent be affected.  3. A) All housekeeping stallicensed nursing staff win-serviced on making staff win-serviced on making staff win-serviced on making staff win-serviced when closing the and hazards associated blood borne pathogen biohazard closets. B) Lienurses and Customer Liaison (CCL) (AKA M on Duty) will be re-ed on monitor wanderguard document the outcompolicy.	red to pening hazard sharp erly in and l. B) rd was perly. in the l to be as with tial to aff and will be are the ecurely e door l with ms in censed Care anager ucated rd and	04/18/2017

PRINTED: 03/30/2017

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ABUILDING  A BUILDING  A BUILDING  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZP CODE  123S MT VERNON AVENUE  WILLIAMSBURG, VA 23185  BROWLEGE FROWLEGE SERVING STATEMENT OF DEFICIENCES REACH CORRECTION SHOULD BE REACH DEFICIENCY MAIST BE PRECEDED BY FULL  FROUNDED FROWLEGE TAKEN TO TO DEFICIENCES REACH CORRECTION SHOULD BE REACH DEFICIENCY MAIST BE PRECEDED BY FULL  FROUNDED FLOW STATEMENT OF DEFICIENCES REACH CORRECTION SHOULD BE REACH CORRECTION AND THE PRECEDED BY FULL  FROWLEGE STATEMENT OF DEFICIENCES REACH CORRECTION SHOULD BE REACH CORRECTION SHOULD BE RECOVERED TO THE ADMINISTRATION OF THE PROVIDED FLOW AND THE PROV			`.			o		
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  1235 MT VERNON AVENUE  WILLIAMSBURG, VA 23185  WILLIAMSBURG, VA 23185  ICACH OFFICIENCY MUST SEP PRECEDED BY RULL  (PACH) OF REGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY SAY INFORMATION  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY SAY INFORMATION  FREGULATION SAY INFORMATION  FREGULATORY SAY INFORMATIO				` ′			СОМ	PLETED
STREET ADDRESS, CITY, STATE LIP CODE  1235 MT VERNOM MENUE  WILLIAMSBURG, VA 23185    PROPIDE   PROPIDE   PROPIDER   PROPIDER ACTION SHOULD BE   COMPLETION   PROPIDER PRANCE OF PREPERLY   PROPIDER PROPIDER ACTION SHOULD BE   COMPLETION   PROPIDER ACTION SHOULD BE   COMPLETION   CO			495235	B. WING	s		1	l l
Summary statement or Deficiencies   Summary statement or Deficiencies   PREFIX TAG	NAME OF F	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
F323 Continued From page 66 to Residents who were wandering unsupervised in the hallway. The closet contained, scattered on the floor, and sitting on top of red biohazardous waste receptacles, multiple forms of biohazardous waste and used sharp articles that would be an infection control and injury hazard to the resident population.  2. Resident #6's wandergard bracelet was not monitored for placement and function as ordered, and per policy multiple times, and the biohazardous waste closet was open and able to be accessed by this confused Resident.  The findings included:  1. On 3-14-17 during initial tour of the facility at 2:15 p.m., with the Director of Nursing (DON), the biohazard closet was found to be open and unlocked. Nursing staff members were at the end of the hallway and around a corner in the nursing station, not in view for the biohazard closet, nor able to view the residents on that hallway. Multiple residents were wandering in the hallway unsupervised entering different rooms, to include Resident #6, who was found to be confused, agitated, ambulatory, and was walking aimlessly into rooms, opening doors, and leaving her rolling walker in the hallway, as she forgot to use it at times. Resident #6 was entered into the survey sample. Upon opening the door fully to expose it's contents, the following was found scattered on the floor and slitting on red biohazardous waste bins;  Blood borne pathogen contaminated used	ENVOY C	OF WILLIAMSBURG, I	LLC		ı			
to Residents who were wandering unsupervised in the hallway. The closet contained, scattered on the floor, and sitting on top of red biohazardous waste receptacles, multiple forms of biohazardous waste, and used sharp articles that would be an infection control and injury hazard to the resident population.  2. Resident #6's wandergard bracelet was not monitored for placement and function as ordered, and per policy multiple times, and the biohazardous waste closet was open and able to be accessed by this confused Resident.  The findings included:  1. On 3-14-17 during initial tour of the facility at 2:15 p.m., with the Director of Nursing (DON), the biohazard closet was found to be open and unlocked. Nursing staff members were at the end of the hallway and around a comer in the nursing station, not in view of the biohazard closet, nor able to view the residents were wandering in the hallway unsupervised entering different rooms, to include Resident #6, who was found to be confused, agitated, ambulatory, and was walking aimlessly into rooms, opening doors, and leaving her rolling walker in the hallway, as she forgot to use it at times. Resident #6 was entered into the survey sample. Upon opening the door fully to expose it's contents, the following was found scattered on the floor and sitting on red biohazardous waste bins;  Blood bome pathogen contaminated used	PREFIX	(FACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	ix	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APRICO	) BE	COMPLÉTION
filled with used needles, blood filled IV tubing, medications, etc. Also in the room scattered on	F 323	to Residents who we in the hallway. The on the floor, and sit biohazardous waste of biohazardous waste of biohazardous waste of biohazardous waste of biohazardous waste of biohazard to the resident and per policy multiplicate of the policy multiplicate of the policy multiplicate of the findings included accessed by this. The findings included 1. On 3-14-17 during 2:15 p.m., with the biohazard closet was unlocked. Nursing end of the hallway and unursing station, not closet, nor able to whallway. Multiple rehallway unsupervisinglude Resident #6 confused, agitated, aimlessly into room her rolling walker in use it at times. Resurvey sample. Up expose it's contents scattered on the flobiohazardous wastered with used needles, (4) overflot filled with used needles.	rere wandering unsupervised closet contained, scattered ting on top of red receptacles, multiple forms aste, and used sharp articles rection control and injury ent population.  andergard bracelet was not ment and function as ordered, tiple times, and the closet was open and able to confused Resident.  and initial tour of the facility at Director of Nursing (DON), the as found to be open and staff members were at the and around a corner in the in view of the biohazard view the residents on that esidents were wandering in the ed entering different rooms, to 6, who was found to be ambulatory, and was walking as, opening doors, and leaving in the hallway, as she forgot to sident #6 was entered into the son opening the door fully to so, the following was found for and sitting on red e bins;  gen contaminated used owing used sharps containers, addes, blood filled IV tubing, and the properties of the prope	F	323	4. A) The DCS/designee monitor biohazard doors biohazard waste dispaudits on the doors becurely locked and biohawaste disposed properly 4 week for 30 days, then 2 week for 30 days. B) Managers and CCL will awanderguard check documentations 4xs a week 30 days, then 2xs a week 30 days. The results of audits will be presented QAPI committee for revand recommendations.	and cosal cing zard xs a xs a Unit and c for for the to	

#### DEPARTMENT OF HEALTH AND HU I SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			<u> </u>	<u>OMR MC</u>	<u>). 0938-03</u> 91	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495235	B. WING			02	C 3/ <b>16/2017</b>	
NAME OF F	PROVIDER OR SUPPLIER		т Т	_ {	STREET ADDRESS, CITY, STATE, ZIP CODE		71072011	
					1235 MT VERNON AVENUE			
ENVOY (	OF WILLIAMSBURG,	LLC			WILLIAMSBURG, VA 23185			
					<u>,                                      </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	nge 67	; = = = = = = = = = = = = = = = = = = =	323				
. 323	the floor and in the and visibly soiled gi medication vials, (3 isolation waste and plastic), Intravenou vacutainers with ne filled with blood, us testing lancets, use glass, and (1) large vials of used injects contained some me soiled wet hand tow containers had red containment of the closet had a strong	open waste bins were used loves, used glass insulin soiled red infection control linen cans (2 metal, and 1 solood drawing tubing and redles affixed to them, and red shaving razors, broken are bin trash can with (5) able insulin which still redication in them, and a visibly wel. None of the waste bag liners in them for closed biohazardous materials. The foul human waste odor, rected in the hallway outside of		,23				
	for staff to help, and always be locked. numbered punch be was inoperable, and maintenance depar room and removed and stated that he will them to the outside area to be picked u DON went with him was left in the room room door was clost locked, and the sur observe the room. other residents in the p.m. the Maintenan and inspected the instated this is broken.	of Nursing) immediately called d stated that this room should The lock on the door was a atton electronic lock, and it d could not be locked. A tment employee came to the 3 of the 4 sharps containers, would box them and remove of the building in a storage p for incineration, and the . The fourth sharps container is, with the other items. The sed, however, could not be veyor stood there alone to Resident #6 remained as did not he hallway wandering. At 2:45 ce director came to the room noperable door lock, and n, and I will have to replace it; as broken. When asked how						

long the door lock had been inoperable, staff

## DEPARTMENT OF HEALTH AND HU! N SERVICES CENTERS FOR MEDICARE & MEDICARU SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICへい SERVICES			<u> </u>	<u>ON</u>	<u> 18 NO</u>	). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION			TE SURVEY MPLETED
		495235	B. WING	;				C 5 <b>/16/2017</b>
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZII	P CODE		
CHILOV (	DE MALLIAMODIDO	110		1	1235 MT VERNON AVENUE			
ENVOIC	OF WILLIAMSBURG, I	LLC		۱ ۱	WILLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPR	BE	(X5) COMPLETION OATE
F 323	Continued From pa	ane 68	' . F:	323	\ \tag{\tau}		_	
•	•	know. At 2:45 p.m. a second	1 \	J_ U	,			
		or joined the observation. The						
		for left the area to obtain a new						
		ck. At 3:00 p.m. the						
		or returned and fixed the lock,						
	and locked the door	г.						
	T /	0.45.47.=4.0:00.=						:
		on 3-15-17 at 9:00 a.m., the						
		ard closet was checked and nlocked again. All of the items						:
		day were found in the closet,						
	•	arps containers which were						
		st observation, however, the						:
		ainer which was full to						
	overflowing also, st	till remained in the closet. The						
		ed Nurse (RN) Employee G	:					
		ed the surveyor check the door,	:					
		ame to the room, and checked	:					!
		been unlocked from the inside						
		ft open, and unlocked. her residents were again in the	:					
		The maintenance director	:					
		the area, and changed the	1					
		hat could not be left unlocked,						
		accessed with a key.						
		stated that the staff would be	•					!
		cated immediately on the						-
		with blood borne pathogens						
		oset, and to emphasize the						
	importance of it alw	ays remaining locked.						
	Paviou of the facilit	ty infection control program						:
		at The Centers for Disease						
		dards would be followed.						
		uire that all contaminated						
		e, and blood borne pathogens						
		in an inaccessible area to						

prevent the spread of infection.

# DEPARTMENT OF HEALTH AND HU \( \times \) SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						- 0000-000		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495235	B. WING		I	C 4 <i>6/</i> 2047		
NAME OF I	PROVIDER OR SUPPLIER	400200			TEET ADDRESS OFT STATE TO SOCIE	03/	16/2017	
NAIVIE OF I	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE			
ENVOY (	OF WILLIAMSBURG, I	LLC		1	35 MT VERNON AVENUE			
				VVI	LLIAMSBURG, VA 23185			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 69	F:	323				
	,		-					
	The facility Adminis	tration was made aware of the						
		nd 3-16-17 at the end of day						
		further information was						
	available to be prov	ided by the facility.						
		i						
		!						
	2 Resident #6's w	andergard bracelet was not						
		ment and function as ordered,			•			
	and per policy multi						:	
		e closet was open and able to						
		confused Resident.						
		idmitted to the facility on						
		included; Vascular dementia						
		urbance, anemia, altered						
	mental status, chroi							
	hypertension, diabe	tes, and high cholesterol.					į	
	Resident #6's most	recent MDS (minimum data					!	
		ssessment reference date) of						
		as an admission assessment.						
		ded as having a BIMS (brief						
		status) score of "8" out of a						
	possible 15, or mod	lerate cognitive impairment.						
	Resident #6 was als	so coded as having behaviors						
		y look back period not						
		include pacing, rummaging,						
		ig food or bodily waste. The						
		d as needing supervision only					į l	
		Resident was coded as						
		nt of bowel and bladder, and						
	wore adult incontine	ence oners.						
	Review of the Resid	lents care plan revealed a					!	
	"Focus" for "Potenti						i	

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

OLITICI	TO I OIT WEDIONITE	C MILDIONID OF LAICE			<u></u>	<u>.VID 140.</u>	<u> </u>
AND DIAN DE CODDECTION DENTIFICATION NUMBERS				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495235	B. WING	i			C <b>16/201</b> 7
NAME OF E	PROVIDER OR SUPPLIER			- e	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2017
	DF WILLIAMSBURG,	LLC		1:	235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 323	disruptive/aggressivo of wandering at hor vascular dementia a "Resident seeks are toileting needs." "Gesident will not ex "Interventions" includaily, elopement risincrease in behavio report to physician a bathroom seeking and assistance as reper doctor's order, devery shift and as never was conducted as a substance of the evening shift (3:00 plants) during the evening shift.  The Administrator sat the end of day defouty (MOD) also chouse forms. The deshowed that the MC completed for Resides 3-3-17, 3-4-17, 3-5-3-13-17, and 3-15-1	viors R/T (related to) history of the behaviors at home, history ne. Cognitive loss- R/T and psychotropic drug use. the eas other than bathroom for its included; "Resident will blence toward others or self, it the facility unattended." It is included, "Check exit door alarms it is assessment, Monitor for resor unsafe behaviors and as needed, monitor for rechaviors and offer redirection needed, wandergard bracelet check function and placement eeded."  In and Treatment reds (MAR's &TAR's) revealed of the Resident's wandergard cted on 2-26-17 during the c.m., to 11:00 p.m.), 3-1-17 shift, nor on 3-13-17 during that the Manager on the eday shift every day, and for might be documented on ocuments were retrieved and DD daily checks were not dent #6 on; 3-1-17, 3-2-17, 17, 3-6-17, 3-7-17, 3-12-17, 7.  In p.m., Resident #6 was	F	323			
		itial tour, in the hallway of the it closet, ambulating without					! :

# DEPARTMENT OF HEALTH AND HU 1 SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			i ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405225	B. WING	,			0
		495235	D. WING			03/	<b>16/20</b> 17
	NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 323	nursing station, as observation. The Fresident's rooms, ohallway, and seem or someone. When approached by the was looking for some can't find sh!(curson to the next door intervene, and were however, multiple of hallway, some sitting others self propellin.  On 3-15-17 at 9:00 observed wandering biohazardous wasterolling walker, exhibited behavior that was a spoken to, the Resi "little boy" in the halt hat someone shou was no child of eith.  The facility policy of wandergard braceled placement and function. The facility Administ issues of not monite for Resident #6, and of at the end of day defined the service of	which she had left in front of the stated by staff later, after the Resident was entering other pening doors along the ingly searching for something in the Resident was surveyor, and asked if she nething, she stated "Yes, I sing expletive), and she moved and opened it. Staff did not enot present on the hallway, ther residents were in the grationary in wheel chairs, and in wheel chairs.  a.m., Resident #6 was again gring in the hallway of the ecloset ambulating without her biting the same searching een the day before. When dent began talking about a llway "making a racket", and ld make him be quiet. There er gender in the hallway.  In elopement stated that ets would be checked for ctioning every shift.  It ration was made aware of the pring the wandergard bracelet did the open biohazardous could have been accessed by thers on 3-15-17, and 3-16-17 ebriefings. No further	F3	323			
E 320	facility.	allable to be provided by the	E 4	220			

	MICHI OF HEALTH				· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY IPLETED
		495235	B. WING			1	C /16/2017
NAME OF F	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY C	DF WILLIAMSBURG, I	LLC		123	5 MT VERNON AVENUE LIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI; TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
			ĺ	- 1			
F 329	Continued From pa	ge 72	F3	329			
,	FROM UNNECESS	_					!
, , , , , , , , , , , , , , , , , , ,	483.45(d) Unnecess Each resident's dru unnecessary drugs drug when used—  (1) In excessive dostherapy); or  (2) For excessive d  (3) Without adequal  (4) Without adequal  (5) In the presence which indicate the odiscontinued; or  (6) Any combination paragraphs (d)(1) the	sary Drugs-General. g regimen must be free from An unnecessary drug is any se (including duplicate drug uration; or te monitoring; or te indications for its use; or of adverse consequences lose should be reduced or as of the reasons stated in brough (5) of this section.			1. Physician was notified of a #1 receiving insulin who was below her para Resident has new ord implemented to alert licens to check parameters padministering insulin. No effects noted from insuling given outside of parameters. Residents with the diagn diabetes and receive insulparameters have the pote be affected.	en she meters. der set se nurse rior to adverse n being s. osis of in with	04/18/2017
	drugs are not given medication is neces	nave not used psychotropic these drugs unless the ssary to treat a specific sed and documented in the					
	gradual dose reduc	use psychotropic drugs receive tions, and behavioral s clinically contraindicated, in					

		<del></del>			DDINITED - 09/90/90+7
	MENT OF HEALTH	AND HUI( SERVICES  & MEDICAID SERVICES		(	PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495235	B. WING _		C 03/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
ENVOY (	OF WILLIAMSBURG,	LLC	į	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ION SHOULD BE COMPLETION
,,,,_		<u> </u>		DEFICIENC	
F 329	Continued From pa		F 32		
	This REQUIREMENT by: Based on staff intereview, and clinical failed to ensure that	rview, facility documentation record review the facility staff tunnecessary medications red to one Resident (#1).		3. An audit will be residents who receive blood glucose paragrees are residents orders with new standing of the standing of th	ve insulin with meters. These
	#1 when it was not	ministered insulin to Resident required per physician's order.		nurses to check for prior to administration.  The nursing staff education on effer	ating insulin. will receive
	to the facility on 6/1 11/27/2016. Her did dementia, coronary weakness, cognitive	year old female, was admitted /2015 and readmitted on agnoses included diabetes, artery disease, muscle communication deficit, nagia, seizures, anemia,		management. If curnot controlling bluicense nurse will Licensed nursing statements are viced when expression insulin orders with choose the new ba	rrent order is ood glucose, notify MD. aff will be in- entering new parameters to
	ARD (Assessment was coded as a qual a BIMS (Brief Intervented) BIMS (Brief Intervented), indicating sever equired extensive the activities of daily	(Minimum Data Set) with an Reference Date) of 1/3/2017 arterly assessment. She had riew of Mental Status) score of ere cognitive impairment. She assistance of one person for y living and was frequently I and always incontinent of		insulin, which allow to be entered. The nursing staff to che before administer Licensed staff we medication administ validate competency	ws parameters his will alert ck parameters ring insulin. rill complete tration quiz to
	at 4:40 PM. It revea	iew was conducted 3/13/2017 aled a physician's order for on dated 12/5/2016 as follows:			
; ;	Lispro). Inject 5 unimeals. Call MD if (I	100 units/ml (milliliter) (Insulin its subcutaneously before blood sugar readings) are less han 350. Hold if blood sugar			

	NT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			FORM	. 03/30/2017 APPROVED . 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DAT COM	E SURVEY IPLETED
		495235	B. WING	<u> </u>	03/16/2017	
	VIDER OR SUPPLIER	_LC		STREET ADDRESS, CITY, STATE, ZIP CO 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	<del></del>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	ID PREFI	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
is A   Re ac be du   1/	ecord) for Jan 20° ministered when flow 150 on the foring. Blood sugar 1-8:00 AM (123), 3-8:00 AM (126), 4-8:00 AM (136), 5-11:30 AM (136), 7-8:00 AM (139), 9-8:00 AM (139), 9-8:00 AM (139), 10-11:30 AM (136), 11-8:00 AM (131), 14-8:00 AM (131), 14-8:00 AM (131), 14-8:00 AM (131), 15-4:30 PM (137), 18-8:00 AM (137), 18-8:00 AM (138), 10-11:30 AM (138), 15-4:30 PM (137), 18-8:00 AM (138), 16-11:30 AM (138), 16	R (Medication Administration I7 revealed that insulin was the blood sugar reading was allowing dates and times readings are in parenthesis: 4:30 PM (82) 11:30 AM (144) 11:30 AM (144) 11:30 AM (146) 11:30 AM (146), 4:30 (113) 11:30 AM (140) 11:30 AM (140) 11:30 AM (140) 11:30 AM (140) 11:30 AM (146) 11:30	F	4. The DCS/designee random blood glucose a week for 30 days, week for 30 days to current order is effect management and MD when indicated. complete random audits on insulin ad 4xs a week for 30 days. The audits will be part QAPI committee for recommendations.  5. 04/18/17	then 2xs a determine if ive diabetic is notified SDC will observation ministration ys, then 2xs he results of presented to	

FORM CMS-2567(02-99) Previous Versions Obsolete

EvenI ID: N46M11

Facility ID: VA0274

If continuation sheet Page 75 of 103

RECEIVED

APR 10 2017

		AND HUM SERVICES				$\cap$	AR NO (	0938-0391
STATEMENT	S FOR MEDICARE  OF DEFICIENCIES  CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		495235	B. WING				03/1	6/2017
NAME OF P	ROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE VERNON AVENUE		
ENVOY C	F WILLIAMSBURG,	LLC				ASBURG, VA 23185		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENT报外GUNFORMATION)。	ID PREFI TAG	X constants	( CR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 SS=E	administration state administer insulin sorder."  Clinical Diabetes Jathe American Diabete guidance regarding follows:  "Incorrect administ too much, or at the transient and seriowide glycemic exclude glycemic exclude follows:  Administration was 3/16/2017 at 3:00 follows:  Administration was 3/16/2017 per 3:00 follows:  (i) This may include from local produce and local laws or refacilities from using gardens, subject to safe growing and follows or provision.	d Procedures regarding insulined: "The clinical nurse will ubcutaneously per physician's an 2016 pp 25-33 published by etes Association offered insulin administration as ration of insulin (e.g., too little, wrong times) can result in us hypo- and hyperglycemia, ursions, and diabetic informed of findings on PM.  ODD PROCURE, CSERVE - SANITARY  d from sources approved or ctory by federal, state or local erood items obtained directly ers, subject to applicable State		371	2.	Dietary manager discarded contaminated pureed pasta substituted with another item puree starch. The soiled mitt discarded. Employee N has in serviced on food handlin prevent contamination. All residents have potential affected. Dietary manager or designed in service dietary staff on handling to prontamination.	and n for t was been ng to to be e will	04/18/2017
	(i)(2) - Store, prep	are, distribute and serve food in	1	:	•		<u>.</u>	

					PRINT	<b>≓∩</b> ····	03/30/2017
DEPAR1	MENT OF HEALTH	AND HUN SERVICES					PPROVED
		& MEDICAID SERVICES					0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION (X3)	DATE	SURVEY
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:	A. BUILD	NG		COMP	LETED
			]			С	; .
		495235	B. WING	<u> </u>		03/1	6/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY (	SE MULLIAMODUDO:	11.0		1	1235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC		V	WILLIAMSBURG, VA 23185		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
TAG	REGULATORT OR E	SCIDENTIFY ING-INFORMATION;	TAG		DEFICIENCY)		
	<u>.                                    </u>		1			$\neg \dagger$	
E 371	Continued From pa	nge 76	   E1	371			Ī
1 37 1	1	_	'`	ווכ		1	İ
	service safety.	ofessional standards for food			4. Dietary manager or designee will		
	Service salety.				monitor one meal 4xs a week for	1	
	(i)(3) Have a policy	regarding use and storage of			30 days, then 2xs a week for 30	)	
		sidents by family and other			days. The results of the audits	s	
		afe and sanitary storage,			will be presented to QAP		
	handling, and cons				committee for review and	- 1	
		NT is not met as evidenced			•	1	
	by:				recommendations.		
		tion, and staff interview, the			5. 04/18/2017		
		o prepare food in accordance tandards for food service				Ì	
	safety.	andards for food service					
	Salety.						ļ
	The facility staff fail	led to follow proper sanitation					l
		practices to prevent the	:				
	outbreak of foodbo	rne illness. The facility staff					
	contaminated food	with a heavily soiled oven mitt.					
	The Findings include	ded.					
•	i inc i mango mois.				1 1	•	
	On 3/15/17 at 11:2	0 A.M. an observation was					
		tchen of the trayline for lunch				ŀ	
		cook (Employee N) was					Į.
		that were heavily soiled with					
		ubstances. She was observed					
		container of pureed pasta from				ļ	
	Approximately one	ng it on the steam tablethird of the container was not			:	İ	
		lastic wrap. The cook					
		led oven mitt into the food					
		nitt with pureed white colored			i		
		sed a spoon to place the					
	contaminated past	a on a residents plate, the	-				-
	plate was covered	by another staff member and					
		to be sent to the dining room.					
		(F. )			1		
		ger (Employee M) was present	1				
	. during the kitchen	observation. She stated that	1				1

	MENT OF HEALTH	& MEDICAID SERVICES		\		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		СОМЕ	PLETED
		495235	B. WING _		03/1	; 16/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY 0	F WILLIAMSBURG,	LLC		1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCHDENTIFYING INPORMATION)	ID PREFIX		JLD BE	(X5) COMPLETION
F 371	Continued From pashe identified the sibeing pureed pasta.  On 3/16/17 at 12 N was informed of the the surveyor left the food had been discussed 483.60(i)(4) DISPOPROPERLY  (i)(4)- Dispose of grands and House kept closed.  During General Observations and House keeping.  A General Observation and House keeping.  On the left of the bocover or lid was observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducter of the server observed inside. Tas #3202. The Madumpster was a conducted on the server observed inside.	ge 77 ubstance on the oven mitt as oon, the facility Administrator e findings. She stated that after e kitchen, the contaminated arded. SE GARBAGE & REFUSE  arbage and refuse properly. NT is not met as evidenced tion, staff interview, the facility e the dumpster doors and lids servations Tour of the facility, sters were not closed properly.  Itions of the Facility Tour was 2017 at approximately 9:45 mance Director (Employee F) Director (Employee P).  uilding, one dumpster with no served. Several old beds, old chairs were the dumpster was numbered intenance Director stated that instruction dumpster and no	F 37	Z1	t side of loved by pster on ling with replaced dietary iced on ids/doors fol. tential to designee atenance, ary staffids/doors monitor ik for 30 k for 30 k for 30	04/18/2017
i	that dumpster.  On the right side of	dietary foods were placed in the building, there were 3 are not closed properly.		will be presented to committee for review recommendations.  5. 04/18/2017	-	

		AND HOIL SERVICES			<b>\</b>		APPROVED
		& MEDICAID SERVICES	1				0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG _			
							0
		495235	B. WING _			03/	16/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
END/03/	OF WILLIAMODUDO	11.0		12:	35 MT VERNON AVENUE		
ENVUY	OF WILLIAMSBURG,	LLC		WI	ILLIAMSBURG, VA 23185		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ION	(X5)
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOU	LD BE	COMPLETION
TAG "		SC-IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO: THE APPRIC DEFICIENCY)	PRIATE	DATE
			<del> </del>	$\perp$	BETTOLENOT)		
F 372	Continued From pa	ge 78	F 3	72			
	One was marked a	s a 6 yard dumpster and only					
		o. Another dumpster marked		:			
		" had the side doors open					
	, ,	flipped back and uncovered.					
	and the top he was	ppou paok alia alias (ci sal		- 1			
	Maintenance Direct	tor (Employee F) stated the					
	Maintenance department was informed that the						
	top was broken on one of the dumpsters.			İ			
		it must have happened during		i			
		r Saturday of the previous		i			
		stated he had contacted the					
		formation Systems" on					
		d reported the need to have		:			
		red. Employee F stated he					1
	was waiting for a re	sponse.					
	: : :			į			
	During the Conord	Observations tour outside		İ			
		Observations tour outside		į			
		ne Dietary staff cook		) :			
		observed pushing a trash can					
		the dumpsters to the right of					
		ed Employee L throwing trash	ĺ	i			
		hrough the slot near the top.		İ			
		served pushing the emptied		:			
		ard the kitchen door. The					
		still open and the top lid was					
		ee F stated the dumpster was					
		ee L approached it but					
		have closed the door and lid				•	
		er using it. Employee F stated					
		vere expected to make sure					
	the dumpster doors	and lids were kept closed.					
		ietary Services manager who					
		been instructed to keep the					
		d lids closed at all times. The		:			ļ
	Dietary Services M	anager (Employee M) stated			•		1
		aintenance repair slip the		:	•		
		eport that a new top was		i			

	<del></del>	·			,DI	OINTETY"	03/30/2017	
DEPART	MENT OF HEALTH	AND HUN SERVICES			(		APPROVED	
		& MEDICAID SERVICES			O)		0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE		
		495235	B. WING		<del>.</del>	03/1	6/2017	
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		0,201,	İ
TO GIVE OF T	(10)				MT VERNON AVENUE			
ENVOY (	F WILLIAMSBURG,	LLC			LIAMSBURG, VA 23185			
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		lD		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES	BE	COMPLETION DATE	
TAG	REGULATORY OR D	S@ IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	VIN(1452 AD - 14		
E 070	A	70						ĺ
F 372	•	<del>-</del>		372			ļ	
		he dumpsters. Employee M		1				
	presented a copy o	f the Maintenance Repair		1				
		/8/17 which stated "Item in	İ	Ī				
		npster top off" and "Problem:		ŀ				
		oyee M stated she was waiting						
·	for the dumpster to	be repaired.						
	Employee E preser	ited a copy of an email dated						Ì
		AM from the CASS company						İ
		ds will be on the containers on						l
		dicated Employee F had						
		pany on Monday 3/13/17 and						ļ
	"left a message for	this to be completed as soon						
	as possible."			İ				
		ay debriefing, the facility						
		ctor of Nursing and Corporate		!				ļ
	Consultant were in	formed of the findings.						
	No further informat	ion was provided						
E 386		YSICIAN VISITS - REVIEW	F	386		l ;		
66-D	CARE/NOTES/OR	DERS			1. All Physician Progress Note	a <b>f</b> a-	04/18/2017	
33-0	OAKENOTES OK	BLIC		;			<i>• ., 2</i> - ,	
	(b) Physician Visits			:	Resident # 3 have been si	-		
	The physician mus				and dated, by the resid	ent's		
			1	:	Physician.			
		dent's total program of care,		:	2. All residents within the fac	cility		
		ons and treatments, at each			have the potential to be affect	-	[ [	İ
	visit required by pa	ragraph (c) of this section;	ļ		<del>-</del>			1
	(0) 15( 2)			•	3. The ED/Designee, will in-ser			
		date progress notes at each			the Physicians, on signing			1
	visit; and				dating progress notes after	each	,	
	(3) Sign and data a	Il orders with the exception of			visit.		]	
		III orders with the exception of mococcal vaccines, which may		-				1
		r physician-approved facility		:				1
		essment for contraindications.						
		NT is not met as evidenced					ļ	
				:			-	1

	AND HUIL SERVICES		(		APPROVED	
CENTERS FOR MEDICARE	& MEDICAID SERVICES	F	· · · · · · · · · · · · · · · · · · ·		0938-0391	_
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTRUCTION	СОМ	E SURVEY PLETED	
	495235	B. WING		l l	C <b>16/2017</b>	
NAME OF PROVIDER OR SUPPLIER	430200	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		10/2017	┪
			1235 MT VERNON AVENUE			
ENVOY OF WILLIAMSBURG,	LLC	,	WILLIAMSBURG, VA 23185			
	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SG-IDENTIFYING-INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH = CROSS-REFERENCED TO THE ART DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	* 12.5
						$\top$
interview, the facilit physician signed hi Resident (Resident Residents.  EMP Q, the physici notes for Resident 11/28/16, and 1/18/ The findings includ Resident #3, a mal 8/16/16. His diagn Alzheimer's demen communication def Resident #3's most set) with an ARD (a 2/7/17 was coded a Resident #3 was coterm memory defic assistance with ma Resident #3 was contact the sident #4 was contact the sident #4 was c	ecord review and staff by staff failed to ensure the s progress notes for one at #3) in a survey sample of 24  an, failed to sign progress an, failed to sign progress an 9/28/16, 10/12/16, an 9/28/16, 10/12/16, and as admitted to the facility as included atrial fibrillation, atia, and cognitive as included atrial fibrillation, atia, and cognitive as a quarterly assessment, and as a quarterly assessment, and as having long and short aits and required total aking daily life decisions, and ded as needing limited to total as two staff members to	F 386	4. Medical Records/Desig monitor progress notes, they are signed, and daudits of Physician Notes 4x/week for 30 days. Twill be presented to review and recommenda 5. 04/18/2017	to ensure ated with Progress lays, then he results QAPI for		
Resident #3's phys notes on 9/28/16, 1 Review of the note	at #3's clinical record revealed sician completed progress 10/12/16, 11/28/16 and 1/18/16. s revealed none of the notes or ink signed. An entry on the ot signed."					
completed the prog	5/17 at 10:18 a.m., he gress notes after the visit and ne facility from his office.		· .			

	MENT OF HEALTH	AND HUM 3ERVICES & MEDICAID SERVICES	,		(	FORM.	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED	
		495235	B. WING			03/	16/2017
	ROVIDER OR SUPPLIER OF <b>WILLIAMSBURG,</b> I	LLC		1235 MT	ADDRESS, CITY, STATE, ZIP CODE VERNON AVENUE MSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED-TO-THE-APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
	11:52 a.m. "Dr (EM notes but didn't sign The administrator, consultants were in Q to sign progress at 11:35 a.m.	of nursing) stated 3/15/17 at MP Q's name) types up the n them"  DON, and corporate formed of the failure of EMP notes for Resident #3, 3/16/17		386 412	Resident #7 dental consul	t was	04/18/2017
F 412 SS=D	(i) By arranging for dental services as under the State plate.	e or obtain from an outside dance with §483.70(g) of this dental services to meet the dent: services (to the extent covered an); and stal services; essary or if requested, assist sintments; and r transportation to and from the eations; residents who are eligible and to apply for reimbursement of an incurred medical expense		1. Resident #7 dental consult discontinued by MD due to not being a good candidate.  2. All residents with dental combave the potential to be affected.  3. An audit on all residents' or for dental consults will conducted to ensure that were completed. Licensed nurstaff will be in-serviced on ho input consult orders so the cois not indefinite, but a one order. The order will completed once the appoint is made.  4. The DCS/designee will a orders for consult orders make sure they are entered to correctly 4xs a week for 30d then 2xs a week for 30days. results of the audits will presented to QAPI committee review and recommendations		onsults cted. orders ll be they ursing how to corder e time ll be nament audit is and entered Odays, is. The fill be tee for	04/18/2017

### DEPARTMENT OF HEALTH AND HUE I SERVICES CENTERS FOR MEDICARE & MEDICARIO SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR	MEDICARE	& MEDICAID SERVICES				<u>VIB NO. 0938-039 I</u>
STATEMENT OF DEFIC AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
		495235	B. WING			C <b>03/16/201</b> 7
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	· ·
ENVOYOF WILL	AMODUDO			1235 MT VERNON AVENUE		
ENVOY OF WILLI	AMSBURG,	LLC		WILLIAMSBURG, VA 23185		
PREFIX (EA	CH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE COMPLÉTION
record in physicial (Resider Resider Resider Resider Resider Resider facility 3 type II of monoar disturbations of the physicial Resider Resid	on observate veriew, the fan ordered on the process of the process	ge 82  ion, staff interview, and clinical acility staff failed to provide lental care for one Resident survey sample of 24  red 11/2/16 for Resident #7 to oral surgeon. As of the end of at 3:15 p.m., Resident #7 had by an oral surgeon.  e, was initially admitted to the diagnoses included aphasia, litus, hemiplegia, ular dementia with behavioral hyroidism, hyperlipidemia, depressive disorder, res, and iron deficiency  recent MDS (minimum data ssessment reference date) of das a quarterly assessment modification. Resident #7 was ort and long term memory dotal assistance with making Resident #7 was coded as to total assistance of one to to perform his activities of the served 3/14/17 at 4:08 p.m. back, awake and alert. In was open and only four did. Resident #7 was receiving	F 4	12		
	ere observe ence care.	d. Resident #/ was receiving				

Review of Resident #7's clinical record revealed a

# DEPARTMENT OF HEALTH AND HUY 'SERVICES CENTERS FOR MEDICARE & MEDICA, SERVICES

	ATION NUMBER	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURVEY COMPLETED
4	95235 B. W	ING	C <b>03</b> /1 <b>6/20</b> 17
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL PF	ID PROVIDER'S PLAN OF CORRI REFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
signed physician's order, "11/2/1 Consult." The order had been of verbal order and a thorough reviprogress notes failed to review was ordered to see an oral surgical conwithin Resident #7's clinical recombination of the staff to ensure Resident #7's physician had been contacted and gave the Resident #7 to be seen by the order was obtained, "the staff would not tolerate sitting in the decided not to pursue Resident surgeon. No evidence was appart Resident #7's physician had been would not tolerate seeing and the order was still active on their Resident #7's care and medication.  Guidance for nursing practice for physician's orders was included "Fundamentals of Nursing 7th Ephysician is responsible for direct treatment. Nurses follow physician's stey believe the orders at harm clients."  The administrator, DON, and conconsultants were informed of the staff to ensure Resident #7 was oral surgeon per physician's ordent 11:35 a.m.	btained as a ew of the nursing why Resident #7 eon.  sult was evident ord.  :35 a.m., the the staff had eath and felt he t." The physician e order for ral surgeon. After of figured he ental chair" and #7 seeing an oral earent that en informed that oral surgeon and ecapitulation of ons.  It following in, dition, p 336, The eting medical ian's orders re in error or	F 412	

	MENT OF HEALTH			(		PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			1	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  3		LETED
		495235	B. WING		03/1	6/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				1235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC		WILLIAMSBURG, VA 23185	<del></del>	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION
PRÉFIX	(EACH DEFICIENC) 	Y MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP	RIATE	OATE
IAG				DEFICIENCY)		
			1			
E 425	Continued From pa	200 84	F 42	5		
	•	_	1 42			04/18/2017
55=E	ACCURATE PROC	EDURES, RPH		1. Resident #5 Clozapine	is	
	(a) Deponduent A:	facility must provide		available to administer as order	ered.	
	(a) Procedures. A	facility must provide vices (including procedures		Physician was notified of om	itted	j
		curate acquiring, receiving,		administration occurren		
		ministering of all drugs and		<del></del>	!	
	biologicals) to mee	t the needs of each resident.		Resident #5 Clozapine has		
	biologicale) to moe			administered since 9/1/17.	No	
	(b) Service Consult	tation. The facility must	Ī	adverse effects noted	from	
		ne services of a licensed		omission of administration.	ļ	
	pharmacist who			Resident #7 Hydrophor oint	ment	
	i L				I	
		Itation on all aspects of the		is available to administe		
		acy services in the facility;		ordered. Physician was notifi	ed of	
		NT is not met as evidenced		omitted occurrence. No ad-	verse	
	by:	andow facility documentation		effects noted from omission	n of	
		erview, facility documentation record review the facility staff		medication administration.		
		edications were available for				
		ive Residents (Residents' #5,		Resident #14 Cyanocobal	1	
		8) in a survey sample of 24		injection is available	to	
	Residents.	-,		administer as ordered. Phys	ician	
	: !			notified of omitted occurre	nces.	
		5, Clozapine (an antipsychotic	1	No adverse effects noted		
	medication) was no	ot available for administration;		omission of medic		}
	! !			*****	ation	
		7, Hydrophor ointment (a		administration.		
		nt) was not available for				
	administration on 1	12/17/16 on 3-11 shift;				
	: : 2	14, the facility staff failed to		! !		
		ition Cyanocobalamin (Vitamin				
		available for administration.		i		,
		a medication used for the				
		in B-12 deficiency, was	1		1	
		t administered and unavailable				
		on 10/23/2016, 11/23/2016 and				
	12/23/2016;			•		
	•		1			

						POWITED	
DEPAR	MENT OF HEALTH	AND HUN SERVICES			(		: 03/30/2017 APPROVED
		& MEDICAID SERVICES					. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495235	B. WING	<u>.</u>		- 1	C
		493233	D. WING			03/	/16/2017
NAME OF	PROVIDER OR SUPPLIER			I	REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY	OF WILLIAMSBURG,	LLC			35 MT VERNON AVENUE ILLIAMSBURG, VA 23185		
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ΙD	<u> </u>	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU	LD BE	COMPLÉTION
***********************	REGULATORY OR L	SC IDENTIFYING INFORMATION) ========	TAC	September 1	CROSS REFERENCED TO THE ARRIVED TO T	)PRIATE	DATE
	t		<u> </u>		DEFICIENCY)		
F 425	Continued From pa	ge 85	F.	425			
	4. Resident #17's F	entanyl patch was not		!	Resident #17 Fentanyl patc	h was	
	available for use; a	nd		Ì	discontinued with new	pain	
					management in place. Phy	sician	1
		, the facility staff failed to			• •	mitted	
		in ordered pain medication					
	(Percocet) and anti			ļ	occurrence. No adverse e		
	(Clonazepam) were	e available for administration.		i	noted from omission	of	
	The findings include	od:			medication administration.	Pain	
	The manys include	ea.		*	assessment completed on 4/3	5/17.	<u>}</u>
	1 For Resident #5	, Clozapine (an antipsychotic			Resident # 8 Percocet		
		at available for administration.					
	modication, was no	to a difficulties of the control of			<u> </u>		Ì
	Resident #5, a male	e, was admitted to the facility			administer as ordered. Phy		
		ted after a hospitalization		1	was notified of o	mitted	
	8/29/16. His diagno	oses included chronic		!	occurrences. No adverse e	effects	
	obstructive pulmon	ary disease, muscle		i	noted from omission		
	weakness, schizoa			:	medication administration.		1
		ia, anorexia nervousa,					ļ
		ion, benign prostatic		:	assessment completed on 3/		
		esophageal reflux disease,		:	2. Residents receiving order	s for	
	type ii diabetes me	llitus, and dysphagia.		:	medications from pharmac	y and	
	Resident #5's most	recent MDS (minimum data		÷	over the counter medication	s have	
		(assessment reference date)			the potential to be affected	, -	
		d as a quarterly assessment.			•	1	
•		oded as having no memory		:	3. Licensed nursing staff will		
		le to make his own daily life			educated on the policy	y for	
		nt #5 was coded as requiring		:	reordering medications fro	m the	
	no assistance with	his activities of daily living with			pharmacy. Nursing staff v	vill be	
		g and bathing. For eating and			re-educated on stat box usag		
		ded as requiring standby		:	To oddodiod off stat ook asag	,0.	
	assistance.			į			
				:			
		t #5's clinical record revealed					
		alized from 6/28/16 to 8/29/16		;			
		ne of mental stability and		ļ			
		including delusions,		:			Ì
	Handenations, and	behaviors. Upon returning to	1				1

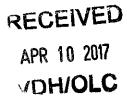
	MENT OF HEALTH	AND HUM SERVICES  & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495235	B. WING		03/	C 1 <b>6/2017</b>
	PROVIDER OR SUPPLIER OF WILLIAMSBURG,	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185		
(X4) ID PREFIX	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 425	physician order was 150 mg (milligram) daily)." An accompthe eMAR (electror record). "5, 9, or Hindicating Clozaril 1 on 8/29 at 5 p.m. th doses).  www.drugs.com ind "Clozapine is an anworks by changing brain.  Clozapine is used to reduce the ris with schizophrenia.  Clozapine is availa pharmacy under a registered in the prefrequent blood test.  Documentation revelogation had not his discharge to the June, 2016. Resid medication while his psychiatric facility, 8/29/16.  When interviewed, stated 3/16/17 at 1 available as the medication as the medi	d with his readmission is, "8/29/16 Clozaril (Clozapine) PO (by mouth) BID (twice panying entry was placed on hic medication administration were entered into the area 150 mg was not administered by a mouth of particular of par	F 4	4. The DCS/designee will medication administration residents with documentation and or counter medications available as a week for 30 days. The residents will be presequently as a week for 30 days. The resident will be presequently as a week for reversion of the second secon	on for MAR wer the ailability then 2xs results of ented to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N46M11

Facility ID: VA0274

If continuation sheet Page 87 of 103



### DEPARTMENT OF HEALTH AND HU( I SERVICES CENTERS FOR MEDICARE & MEDICARE) SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CENTE	V2 LOK MEDICAKE	E & MEDICAID SEKVICES				<u> </u>	<u> </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(CO)	TE SURVEY MPLETED
		495235	B. WING	,—			C 3 <b>/16/201</b> 7
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENIVOY (	OF WILLIAMSBURG, I	116	1	1:	235 MT VERNON AVENUE		
ENVO	JF WILLIAMSDUKU,	LLC	J	V	VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION OATE
F 425	Continued From pa	аge 87	F	425			:
	consultants were in staff to ensure Cloz administration to Re 3/16/17 at 11:35 a.m.  2. For Resident #7, protective ointment administration 12/1.  Resident #7, a male facility 3/2/01. His of type II diabetes mel monoarthritis, vascu disturbances, hypot osteoporosis, major	7, Hydrophor ointment (a t) was not available for 7/16 on 3-11 shift. le, was initially admitted to the diagnoses included aphasia,					
	set) with an ARD (at 12/17/16 was coded with a subsequent recoded as having she deficits and required daily life decisions. requiring extensive	t recent MDS (minimum data assessment reference date) of a as a quarterly assessment modification. Resident #7 was nort and long term memory at total assistance with making Resident #7 was coded as to total assistance of one two erform his activities of daily	3				
	"Hydrophor" was no order 1/12/17 on 3- protective ointment after incontinent epi eTAR (electronic tre	t #7's clinical record revealed of administered per physician's -11 shift. Hydrophor was a to be applied every shift and bisodes. An entry was on the eatment administration record) nent was not administered and					

referred the reader to the nursing progress notes.

### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CENTE	12 FOR MEDICARE	A MEDICAID SERVICES				<u> </u>	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		E CONSTRUCTION	СОМ	E SURVEY
		495235	B. WING			1	C <b>16/20</b> 1 <b>7</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
ENIVOY (	DE WILLIAMODUDO			12	235 MT VERNON AVENUE		
ENVOT	OF WILLIAMSBURG,	LLC		W	ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	Continued From pa	ae 88	F4	125			
•	<del>-</del>	progress notes, was an entry	' 7	rZJ			
		progress notes, was an entry lent was not available.					
	When interviewed	3/16/17 at 11:35 a.m., the DON					
		) stated she was unsure why	İ				
		ot available as it was a "stock"	<u> </u>				 
	information was pro	end of the survey, no further ovided.					
	The administrator	DON, and corporate					
		dvised of the failure of the staff					i i
		phor ointment to Resident #7	! !				
	on 1/12/17 3-11 shi 3/16/17 at 11:35 a.r	ft, per physician's order, n.	i i i i				
	3. For Resident # 1	4, the facility staff failed to	!				
		ion Cyanocobalamin (Vitamin					
	B 12) injection was	available for administration.					
		medication used for the					
		n B-12 deficiency, was					:
		administered and unavailable n 10/23/2016, 11/23/2016 and					!
	12/23/2016.	11 10/25/2010, 11/25/2010 and					
	. ,						
		originally admitted to the facility	!				ļ
		eadmitted on 12/2/2015 with					
		ut not limited to, Diabetes,	:				İ
		othyroidism, Gastroesophageal ronic Kidney Disease, Major	-				
		er, Carcinoma in Situ,					
		n of Ovary, Endometrial					
		oolism and Thrombosis of					:
	Deep Veins.						!
	The most recent Mi	nimum Data Set (MDS) was a					
		nimum Data Set (MDS) was a ent with an Assessment					
		RD) of 1/14/17. The MDS	! !				· :
		4 with a BIMS (Brief Interview	1				

for Mental Status) of 15/15 indicating no cognitive

### DEPARTMENT OF HEALTH AND HUT I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CEIVIE	13 FOR MEDICARE	A MEDICAID SERVICES				INB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COM	E SURVEY IPLETED
		495235	B. WING		<u> </u>		C 1 <b>6/2017</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	235 MT VERNON AVENUE		
ENVOY	OF WILLIAMSBURG,	LLC		W	/ILLIAMSBURG, VA 23185		
// / / ID	CHMMADY CTA	TEMENT OF DEFICIENCIES	<u>_</u>		<del></del>		<del> </del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x I	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 425	Continued From pa	ae 80	· 	) DE			1
1 720	· ·	_	F 4	<b>Z</b> 5			İ
		nt # 14 was coded as					
		extensive assistance of one					
	•	vities of Daily Living; required					
		ng; and always continent of ly incontinent of bladder.					
	On 3/15/17 at 9 a m	n., Resident #14's clinical					
		d. The review revealed a	į				
		ated 9/30/2016 which read:					
		/itamin B-12) 1000 mcg/ml					
		per milliliter) inject one milliliter					
	subcutaneously on						:
	The order was trans	scribed on the October 2016					
		tration Record (MAR), on					
		to be administered at 6 A.M.					Ē
		n month. Review of the					
	October 2016 MAR	revealed the number "5" and					
		or 10/23/16. On the bottom of					
	the page of the MAI						
		odes" section was listed					
	"5=Hold/See Nurse	Notes."					
	Review of the Interd	disciplinary Notes revealed					
		0/23/2016 at 6:28 AM of					
		stration Note: Placed on hold	:				
		pharmacy. STAT refill	i				!
		d to received today." (sic)	1				
		linary Note was 10/23/2016 at					:
	6:30 AM Nursing No		İ				
		om pharmacy so that resident					
	can receive injection	n today as scheduled."					
	Review of the Nove	mber 2016 MAR, on Page 2,					
		er "9" and the nurse's initials					
	for 11/23/16. On the	e bottom of the page of the	1				İ
		art Codes/Follow Up Codes"	:				

section was listed "9=Other/See Nurse Notes."

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							0
		495235	B. WING			03/	16/2017
	PROVIDER OR SUPPLIER DF WILLIAMSBURG, I		_	12	TREET ADDRESS, CITY, STATE, ZIP CODE 235 MT VERNON AVENUE /ILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 90	F∠	125			
	revealed the number for 12/23/16. On the MAR under the "Chasection was listed". Review of the Interedocumentation on 1 "Medication Administration and faxed	e medication.  PM, an interview was Director of Nursing (DON) ald investigate to determine if wed the medication as ordered the Director of Nursing stated a that medications should be stration as ordered by the ector of Nursing stated the e pharmacy immediately to in that is not available at the					
	conducted with the I	a.m. an interview was Director of Nursing who stated e documentation in the					

### DEPARTMENT OF HEALTH AND HUM I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	(0) 01(11122-01)	A MILDICAID SLIVICES	·		<u> </u>	SIVID INC	<u>7. 0936-039 F</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING				C
	<u> </u>	+30200	D			03	/16/2017
	PROVIDER OR SUPPLIER  DF WILLIAMSBURG,	LLC		123	REET ADDRESS, CITY, STATE, ZIP CODE  35 MT VERNON AVENUE  LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 425	that the medication pharmacy but was a 10/23/2016. The Do routine deliveries to deliveries. The DOI Pharmacy Shipmer which documented Injection 1000 mcg/10/23/2016 at 8:54/10/24/2016 at 12:33 the medication was Director of Nursing that medications shordered by the physical During the end of document of the physical short of the	Pharmacy and determined was delivered by the not administered on ON stated the Pharmacy made to times per day and STAT of presented a copy of the state of Summary for 10/23/016 Cyanocobalamin B-12 of mI vial was picked up on PM and delivered on AM. The DON again stated not administered. The stated the expectation was could be administered as sician.  The process of the findings of the findings.	F4	125			
	Resident #17, a fen facility 8/19/14. Her fracture, Alzheimer' depression.  Resident #17's mos set) with an ARD (a 11/16/16 was coded	Fentanyl patch was not  nale, was admitted to the r diagnoses included pelvic s dementia, anxiety and  et recent MDS (minimum data ssessment reference date) of d as a quarterly assessment. having short and long term					

#### PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HU 1 SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495235 B. WING 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE **ENVOY OF WILLIAMSBURG, LLC** WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 425 Continued From page 92 F 425 memory deficits and required total assistance with making daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #17 was coded as having pain almost constantly with a pain level of "10" out of 10. On 3/16/17 at 9:05 AM, Resident #17 was observed in the bed. She stated, "I hurt so bad." The medication nurse was notified of resident's complaints of pain. Review of the clinical record, to include MAR's (medication administration record) for February and March of 2017 was conducted. The resident had a physician's order dated 3/18/16 for Fentanyl patch every 72 hours. Fentanyl is an opioid, schedule II narcotic used to treat chronic pain. Dates and times the medication was not given as it was not available are below: 2/5/17 at 1:00 PM: coded as a "9" or see nurses notes. Nurses notes dated 2/5/17 included: Resident's medication is on afternoon run from the pharmacy." Her pain score was left blank and no documentation was evident the patch had been applied. Tylenol 650 mg (milligrams) was given at 6:00 PM with a pain score of "8". At 7:00 PM, the nurses note read, "prn (as needed) pain

given on 2/7/17 at 9:50 AM.

medication was ineffective." Pain scale was still "8". At 8:38 PM, Norco 5/325 mg one tablet was given with relief and a pain scale of "2" an hour later. The Fentanyl patch was documented as

3/5/17 at 7:58 PM: "no patch available old patch left on." Pain level was scored as a "10". No patch was documented as given until 3/8/17 at

	TMENT OF HEALTH RS FOR MEDICARE	AND HUI N SERVICES			(		FORM	03/30/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DAT	E SURVEY PLETED
		495235	B. WING					C 16/2017
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG, I	LLC		123	REET ADDRESS, CITY, STATE, 35 MT VERNON AVENUE LLIAMSBURG, VA 2318			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· !	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 425	3/6/17 at 9:23 PM, vidocumented as "7" was given.  On 3/16/17 at 12:07 conducted with the She described the pharmacy. physician for a scrip Review of the policy included the following negative physical ar consequences, included threatening functions.	medication was given until which the pain level was and Norco 7.5/325 mg pill 7 PM, an interview was DON (director of nursing). procedure for obtaining available. She stated, "We We may need to call the ot (prescription)."  y on Pain Management ng: "Unrelieved pain has nd psychological uding the potential for nal ability."	F 4	25				
	ensure the physician (Percocet) and antia (Clonazepam) were Resident #8 was ad 4/20/15 with the diag	the facility staff failed to n ordered pain medication anxiety medication available for administration. Imitted to the facility on gnoses of, but not limited to, eoarthritis, lower back pain						
	The most recent Mi	nimum Data Set (MDS) was a						

quarterly assessment with an Assessment Reference Date (ARD) of 12/16/16. The MDS coded Resident #8 with no cognitive impairment; required set up to no assistance with activities of daily living; was continent of bowel and bladder;

#### PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HU! **N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 495235 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE **ENVOY OF WILLIAMSBURG, LLC** WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 425 Continued From page 94 F 425 and had occasional pain with an average pain scale of 4 (out of 10). On 3/14/17 at 2:25 p.m., Resident #8 was observed in her room sitting in a lounge chair with 2 visitors exiting the room. She was alert and talkative. A Resident interview was conducted and when asked about physician visits, she stated she has seen her doctor and "He ordered me pain medication but I don't think I've had my medicine for anxiety ordered yet" Resident #8 did not complain of pain nor show signs of anxiety. On 3/15/17 at 8:50 a.m. Resident #8's clinical record was reviewed. The review revealed pain assessments were completed each shift for the months of February and March 2017. Physician orders were reviewed and revealed the following medications for pain management: Oxycodone-Acetaminophen (Percocet) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 8 hours for Pain. Voltaren Gel 1 % (Diclofenac Sodium) Apply 4 gram transdermally as needed for Pain apply to elbows and knees as needed 4 x daily. Mapap Tablet 325 mg (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for Pain.

Resident #8's Medication Administration Record (MAR) for the months of February and March 2017 were reviewed. The review revealed the

Percocet was administered as ordered throughout the month of February and the as needed (PRN) Mapap was administered on 3

Review of March 2017's MAR revealed the

occasions (2/11, 2/24 & 2/25/17).

#### PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HU! **YI SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAND SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495235 B. WING 03/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1235 MT VERNON AVENUE ENVOY OF WILLIAMSBURG, LLC WILLIAMSBURG, VA 23185 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE OATE TAG DEFICIENCY) F 425 Continued From page 95 F 425 following: The Percocet was administered as ordered 3/1-3/11 at 6 a.m., 2 p.m. and 10 p.m. From 3/12/17 at 10 p.m. through 3/14/17 at 10 p.m. the medication was documented as "9=Other/See Nurse Notes." Review of the Progress Notes for the corresponding dates had documentation that read "Not available awaiting pharmacy to deliver." There was no documentation that the pharmacy or physician were called. Resident #8 received PRN Mapap for complaints of back pain or headache on 3/9/17 at 11 p.m., 3/11 at 9:06 p.m., 3/12 at 9:28 p.m., 3/13 at 4:38 p.m. and 3/14/17 at 6:11 a.m. The PRN pain medication was documented as effective. Further review of the physician's orders revealed the medication Clonazepam 0.5 mg Give 1 tablet by mouth every 12 hours for for(sic) anxiety was ordered on 10/5/16. The MAR for February 2017 revealed the Clonazepam was scheduled for administration at 9 a.m. and 9 p.m. and was initialed by the nurses as administered. The MAR for March 2017 revealed the Clonazepam was not administered as ordered on 3/8, 3/9, 3/10, 3/12, 3/13 and 3/14/17 at 9 p.m. and 3/10, 3/11, 3/12, 3/13 and 3/14 at 9 a.m. Documentation on

the MAR read either "5=Hold/See Nurse Notes" or "9=Other/See Nurse Notes." The nurses notes included "med not in house," "med put on hold by md until available," and on 3/14/17 at 10:24 p.m. "not available needs new script. Patient aware"

On 3/15/17 at 2:45 p.m. an interview was conducted with Licensed Practical Nurse-B (LPN-B). LPN-B showed surveyor upon request the blisterpack (medication package) containing

### DEPARTMENT OF HEALTH AND HUT IN SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

OLITIL	TO LOIL MEDIONIL	- G MEDIOPAD SERVICES				IND MO	<u>, 0936-039 i</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
		495235	B. WING	i		1	C
11414E OF I		700200				03/	/16/2017
	PROVIDER OR SUPPLIER  OF WILLIAMSBURG,	LLC		123	REET ADDRESS, CITY, STATE, ZIP CODE 85 MT VERNON AVENUE LLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 425	Continued From pa	ige 96	F.	, 425			
		ocet. The processing date on					
		17 for 9 tablets. There were 2	i i				
		n package which would have					
		e doses given on 3/15/17 at 6					
		PN-B explained that Resident					
		edication every 8 hours and	1				1
		o dose today. When asked	:				
		to obtain the medication if it	•				
		n the medication cart she ot is still good, (we) fill out					
		of they would give us a code to					
		t box." She stated "If no active					
		vait for the doctor to call it into					
		then write a hard (paper)					4
		ed if she was unable to get a					
		doctor, LPN-B stated they					
		cal director (Employee-Q) or	!				
		cian. When asked to see the	į				
		PN-B brought surveyor into	!				
		m and locked in a cabinet was	1				į
		ol box" with a code lock	1				
		plained the pharmacy needed	i				!
	to give the code to	open the combination lock.	i				
		surveyor the Clonazepam 0.5					i l
	•	ch had a processing date of					•
		ets. There was one tablet	1				
		ack. LPN-B stated she gave	1				
		the packet this morning.					
		reordering the Clonazepam	:				
		LPN-B stated "The last day I	i .				
		the Clonazepam (3/9/17).					İ
		mentation that the pharmacy	!				
	was notified or that additional information	the pharmacy requested on.	!				
	Review of the stat t	oox medication list included					
	but was not limited	to:					
	Oxycodone/APAP (	Percocet) 5MG/325MG TAB					

### DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

OFILE	TO FOIL MEDICAILE	G MEDIONID SERVICES				ON CIVIL	<u>. 0936-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	COM	E SURVEY IPLETED
		495235	B. WING	j		i	C <b>16/2017</b>
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,	
ENVOY (	OF WILLIAMSBURG, I	LLC			235 MT VERNON AVENUE VILLIAMSBURG, VA 23185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	quantity of 2, and Oxycodone 5MG TA Clonazepam was not medication in the standard conducted with the p.m. (LPN-A). When the Percocet from the due, LPN-A stated they stated it was an blisterpack)." And "I LPN-A stated he "To once it arrived and to Tylenol."  On 3/15/17 at 4:55 (Employee-B) and the informed of the Percadministered due to available.  On 3/16/17 at 9:10 acconducted with the (Employee-B). When expectations were in unavailable, Employee the nurses (from the doctor) if it stated she would "Expect the nurses (from the doctor) if it stated she would "Expect the murses (from the doctor) if it stated she would "Expect the nurses (from the doctor) if it	ty of 5, 7.5/325 MG TAB ORAL with a AB ORAL with a quantity of 5.  ot listed as an available rat box.  p.m. an interview was nurse on duty 3/14/17 at 10 on asked why he didn't obtain the stat box at the time it was 'I called the pharmacy and liready sent out (the new of the the sent of the the sent of the the sent of the medication not being the Administrator were cocet and Clonazepam not of the medication not being the medications were see-B stated she would to get a new script if needed it was running out." She expect the nurses to document doctor) and pharmacy, get the partified and they have been	F	, 125			
	educated on the pro	ocess.					

DEPARTMENT OF HEALT			(	FORM APPROVED
CENTERS FOR MEDICAR STATEMENT OF OFFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	MB NO. 0938-0391 (X3) OATE SURVEY
ANO PLAN OF CORRECTION	IOENTIFICATION NUMBER:	• •		COMPLETEO
	495235	B. WING		C 03/16/2017
NAME OF PROVIOER OR SUPPLIE	3		STREET AOORESS, CITY, STATE, ZIP COOE	
ENVOY OF WILLIAMSBURG	, LLC		1235 MT VERNON AVENUE NILLIAMSBURG, VA 23185	
PRETIX FACH DEFICIENT	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC:10ENTIFYING:1NF0RMATION)	IO PREFIX	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLETION
F 441 Continued From providing services arrangement basic conducted accordaccepted national implementation is  (2) Written standafor the program, valued to:  (i) A system of suppossible communication is facility;  (ii) When and to valued From providing services arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordaccepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced arrangement basic conducted accordance accepted national implementation is serviced accepted national implementation is serviced accepted national implementation is serviced accepted national implementation is serviced accepted national implementation is serviced accepted national implementation is serviced accepted national implementation is serviced national implementation in the serviced national implementation is serviced national implementation in the serviced	page 98  (e)(f) INFECTION CONTROL, AD, LINENS  ention and control program.  establish an infection prevention am (IPCP) that must include, at ollowing elements:  reventing, identifying, reporting, controlling infections and seases for all residents, staff, s, and other individuals and upon the facility assessment ling to §483.70(e) and following a standards (facility assessment and Phase 2);  ards, policies, and procedures which must include, but are not reveillance designed to identify nicable diseases or infections pread to other persons in the	F 441 F 441	OEFICIENCY)	ok on event out a vaste, s are azard per and be interested blood azard onitor nazard
reported; (iii) Standard and to be followed to	sease or infections should be transmission-based precautions prevent spread of infections;		biohazard waste dis properly 4xs a week for 30 then 2xs a week for 30 days results of the audits with presented to QAPI committe	s. The
	w isolation should be used for a g but not limited to:		review and recommendation 5. 04/18/17	

# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICA, J SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO 0938-0391

CEIVIE	42 FOR MEDICARE	A MEDICY'D SEKAICES				NAIR IAC	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495235			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING				C 03/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	25.400   14.400   10.0			12	235 MT VERNON AVENUE		
ENVOY OF WILLIAMSBURG, LLC			WILLIAMSBURG, VA 23185				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION OATE
F 441	Continued From pa	ae 99	F 4	.41			
		uration of the isolation,	' -	7			
	depending upon the infectious agent or organism involved, and						
	(B) A requirement that the isolation should be the						
	least restrictive possible for the resident under the circumstances.						
	(u) The alrest me	and under which the facility.					
	(v) The circumstances under which the facility must prohibit employees with a communicable						
	disease or infected skin lesions from direct						
	contact with residents or their food, if direct						
	contact will transmi						
		ne procedures to be followed direct resident contact.	 				
		cording incidents identified PCP and the corrective e facility.					
	(a) Linana Darsan	nol must boundle etems					
		nel must handle, store, port linens so as to prevent the					
	spread of infection.	out linens so as to prevent the					
		The facility will conduct an		•	,		1
		IPCP and update their					<b>†</b>
	program, as necessary. This REQUIREMENT is not met as evidenced						
	by: Resed on observat	ion staff interview facility					
	Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an effective						
		gram related to biohazardous					
	waste and blood bo						
•	The biohazard close	et was open and available to					
		e wandering unsupervised in					
		oset contained scattered on					

the floor, and sitting on top of red biohazardous

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495235	B. WING			1	C <b>16/2017</b>
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WILLIAMSBURG, LLC				123	REET ADDRESS, CITY, STATE, ZIP CODE 15 MT VERNON AVENUE LLIAMSBURG, VA 23185	001	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION OATE
F 441	waste, and used shinfection control and population.  The findings include On 3-14-17 during p.m., with the Direct biohazard closet was unlocked. Nursing end of the hallway a nursing station, not closet, nor able to challway. Multiple rehallway unsupervision include Resident #6 confused, agitated, aimlessly into room her rolling walker in use it at times. Resurvey sample. Up expose it's contents	multiple forms of biohazardous larp articles that would be an d injury hazard to the resident	F	.41	DEFICIENCY		
	Blood borne pathog needles, (4) overflo filled with used neemedications, etc. At the floor and in the and visibly soiled glamedication vials, (3 isolation waste and plastic), Intravenous vacutainers with nefilled with blood, use testing lancets, use						

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: VA0274

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CEIVIE	KS FUR MEDICARE	A MEDICHID SERVICES			<u>OMR M</u>	<u>J. 0938-039</u> 1
AND PLAN OF CORRECTION IDENTIFICATI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495235	B. WING_		03/16/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
ENVOV (	OF WILLIAMSBUIDS	110		1235 MT VERNON AVENUE		
	OF WILLIAMSBURG,			WILLIAMSBURG, VA 23185		
[X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOLD TO THE AP CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 441	contained some me soiled wet hand tow containers had red containment of the closet had a strong which could be dete the room.  The DON immediat stated that this room. The lock on the doc button electronic loc could not be locked employee came to the 4 sharps contain box them and remobuilding in a storage incineration, and the fourth sharps contain the other items. The however, could not stood there alone to #6 remained as did wandering. At 2:45 director came to the inoperable door locand I will have to rebroken. When asked been inoperable, state 2:45 p.m. a second the area to obtain a	able insulin which still edication in them, and a visibly wel. None of the waste bag liners in them for closed biohardous materials. The stoul human waste odor, ected in the hallway outside of tely called for staff to help, and m should always be locked. Or was a numbered punch ck, and it was inoperable, and d. A maintenance department the room and removed 3 of the stated that he would ove them to the outside of the e area to be picked up for the DON went with him. The siner was left in the room, with the room door was closed, be locked, and the surveyor to observe the room. Resident of the eroom and inspected the sk, and stated this is broken, the place it, no one told me it was the ed how long the door lock had the maintenance director left onew door handle and lock. At tenance director returned and	F 44			
		on 3-15-17 at 9:00 a.m., the				

found to be open/unlocked again. All of the items

### DEPARTMENT OF HEALTH AND HUMAN I SERVICES CENTERS FOR MEDICARE & MEDICAND SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON: AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
<b>495235</b> B. WING	B. WING		
	ADDRESS, CITY, STATE, ZIP CODE	03/16/2017	
ENVOY OF WILLIAMSBURG, LLC	T VERNON AVENUE AMSBURG, VA 23185		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
found the previous day were found still in the closet, except for the 3 sharps containers which were removed on the first observation, however, the fourth sharps container which was full to overflowing still remained in the closet also. The Corporate Registered Nurse (RN) Consultant observed the surveyor check the door, and immediately came to the room, and checked the door which had been unlocked from the inside by staff, and was left open, and unlocked. Resident #6 and other residents were again in the hallway wandering. The maintenance director was again called to the area, and changed the lock again, to one that could not be left unlocked, and could only be accessed with a key.  The Corporate RN Employee G, stated that the staff would be counseled and educated immediately on the hazards associated with blood borne pathogens in the biohazard closet, and to emphasize the importance of it always remaining locked.  Review of the facility infection control program policies revealed that The Centers for Disease Control (CDC) standards would be followed.  CDC standards require that all contaminated biohazardous waste, and blood borne pathogens must be contained in an inaccessible area to prevent the spread of infection.  The facility Administration was made aware of the issue on 3-15-17, and 3-16-17 at the end of day debriefings, and no further information was available to be provided by the facility.			

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