| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495402 | A. BUILDING ______ B. WING ______ | 01/19/2017 |

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| WINDSORMEADE OF WILLIAMSBURG | 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare standard survey was conducted 1/17/2017 through 1/19/2017. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this 11 certified bed facility was 10 at the time of the survey. The survey sample consisted of 4 current Resident reviews (Residents 1 through 4) and 3 closed record reviews (Residents 5 through 7).<br><br>The Life Safety Code survey/report will follow. No complaints were investigated during the survey. | F 000 | | |
| F 281 SS=E | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review and clinical record review, the facility staff failed to follow the professional standards of nursing practice for 4 residents (Resident's 1, 2, 4 and 3) of 7 residents in the survey sample.<br>1. For Resident #1, the facility staff failed to document treatments as having been administered. | F 281 | 1. All residents identified during survey not to have received treatments and medications ordered on 1/8, 1/10, 1/17 and 1/18, were monitored for adverse reaction with no concerns noted.<br><br>2. Director of Nursing audited 100% of resident Medication and Treatment | 1/31/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 01/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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2. For Resident #2, the facility staff failed to document treatments as having been administered.

3. For Resident #4, the facility staff failed to document treatments as having been administered.

4. For Resident #3, the facility staff failed to document treatments as having been administered as ordered by the physician.

The Findings Included:

1. Resident #1 was admitted to the facility on 9-3-10. Diagnoses included Pneumonia, urinary tract infections, syncope, depression, high cholesterol, hypertension, stroke, heart disease, chronic kidney disease and osteo-arthritis.

Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-6-16 was coded as a 30 day full assessment, after a hospitalization. Resident #1 was coded with a BIMS (Brief Interview of Mental Status) score of 14, indicating no cognitive impairment. Resident #1 was coded as extensive to total dependence on staff for activities of daily living, and was always incontinent of bowel and bladder.

Review of Resident #1's clinical record and medication administration record (MAR) revealed no documentation that the following 3 treatments were administered per physician's orders on 1-8-17:

1. Resident to wear right hand protector on in the morning, and off at bedtime. The removal of the

F 281

Records from January 18-January 29. No issues noted.

3. Medication Administration Policy was reviewed and revised to ensure accuracy with Lippincott method. All licensed nursing staff will review and acknowledge understanding of revised policy by 2/18/17. All licensed nursing staff will be responsible for reviewing Medication and Treatment records during shift to shift report to ensure all physician orders followed.

4. Director of Nursing or designee will audit Medication and Treatment records every 48 hours x 30 days to ensure all physician orders followed. Director of Nursing or designee will be present for shift to shift report weekly x 60 days to ensure licensed nursing staff are reviewing Medication and Treatment records. Director of Nursing or designee will complete weekly resident rounds x 30 days and then monthly rounds x90 days to ensure resident treatment orders are being followed.

5. Corrective action for all items noted above will be completed by February 24, 2017 and will be on-going.

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device was not signed as completed on 1-8-17.

2. Apply splint to left hand at bedtime for positioning, remove in the morning. The application of the device was not signed as completed on 1-8-17.

3. Humidified oxygen at 2 liters per minute on at bedtime and off in the morning. The oxygen was not signed as administered on 1-8-17.

It is notable to mention, that other medications and treatments were signed as administered for 1-8-17 by the same nurse who omitted these entries. The staff member LPN (A) stated she could not recall why the treatments were not signed.

A thorough review of Resident #1's clinical record did not reveal documentation of the administration of the treatments in question, and no nursing progress note was written on this day.

The facility policy stated, That medications and treatments will be administered according to the "7 Rights". These 7 rights were; 1) Right Resident. 2) Right Medication. 3) Right Dosage. 4) Right route. 5) Right Time. 6) Right Effect. 7) Right Documentation.

The Director of Nursing (DON) cited Lippincott as the facility's nursing reference source. Guidance is given to nursing by "Lippincott", which stated "After administering a medication or treatment, record it immediately on the appropriate record form."

On 1-18-17 and 1-19-17, at the end of day debrief, the Administrator, and DON were advised

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| F 281 | Continued From page 3 | F 281 | | |

of the failure of the staff to document treatments as having been administered for Resident #1. No further information was provided.

2. Resident #2 was admitted to the facility on 3-12-14. Diagnoses included; Dementia, depression, high cholesterol, hypertension, difficulty walking, and gastro-esophageal reflux disease.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-13-16 was coded as a quarterly assessment. Resident #2 was coded as severely cognitively impaired. Resident #2 was coded as extensive dependence on staff for activities of daily living, and was occasionally incontinent of bowel and frequently incontinent of bladder.

Review of Resident #2's clinical record and medication administration record (MAR) revealed no documentation that the following treatment was administered per physician's orders on 1-8-17 and 1-17-17:

1. Apply bilateral protective arm sleeves every morning, and remove at bedtime. The removal of the devices was not signed as completed on 1-8-17 and 1-17-17.

It is notable to mention, that other medications and treatments were signed as administered for 1-8-17 and 1-17-17, by the same nurse who omitted these entries. The staff member LPN (A) stated she could not recall why the treatments were not signed.

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| F 281 | Continued From page 4 | F 281 | | |

A thorough review of Resident #2's clinical record did not reveal documentation of the administration of the treatments in question, and no nursing progress note was written on this day.

The facility policy stated; That medications and treatments will be administered according to the "7 Rights". These 7 rights were; 1) Right Resident. 2) Right Medication. 3) Right Dosage. 4) Right route. 5) Right Time. 6) Right Effect. 7) Right Documentation.

The Director of Nursing (DON) cited Lippincott as the facility's nursing reference source. Guidance is given to nursing by "Lippincott", which stated "After administering a medication or treatment, record it immediately on the appropriate record form."

On 1-18-17, and 1-19-17, at the end of day debrief, the Administrator, and DON were advised of the failure of the staff to document treatments as having been administered for Resident #1. No further information was provided.

3. Resident #4 was admitted to the facility on 4-30-14. Diagnoses included; Alzheimer's Dementia, difficulty walking, Spinal stenosis, gastro-intestinal bleeding, chronic iron deficiency anemia, Vitamin B-12, and Vitamin D anemias.

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-15-16 was coded as a full significant change assessment. Resident #4 was coded with a BIMS (brief interview for mental status) score of 5, indicating severe cognitive impairment. Resident #4 was coded as limited to extensive

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dependence on staff for activities of daily living, and was frequently incontinent of bowel and occasionally incontinent of bladder.

Review of Resident #4's clinical record and medication administration record (MAR) revealed that (Ted hose) compression stockings were not applied as ordered per the physician's orders on 1-10-17 and 1-18-17:

1. Apply Knee high ted hose apply every morning, and remove at bedtime, for edema. The application of the devices was signed as not completed on 1-10-17 and 1-18-17.

It is notable to mention, that nursing progress notes for 1-10-17 stated that the compression stockings were unavailable, and on 1-18-17, the nursing progress notes stated the reason for omission was that the stockings were "wet".

The facility policy stated; That medications and treatments will be administered according to the "7 Rights". These 7 rights were; 1) Right Resident. 2) Right Medication. 3) Right Dosage. 4) Right route. 5) Right Time. 6) Right Effect. 7) Right Documentation.

The Director of Nursing (DON) cited Lippincott as the facility's nursing reference source. Guidance is given to nursing by "Lippincott", which stated "Medications and treatments must be administered per physician's orders.

On 1-18-17, and 1-19-17, at the end of day debrief, the Administrator, and DON were advised of the failure of the staff to provide the compression stockings as ordered by the physician for Resident #4. No further information

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| F 281 | Continued From page 6 was provided. | F 281 | | |

4. For Resident # 3, the facility staff failed to ensure treatments were documented as having been administered as ordered by the physician.

Resident #3, an 82 year old female, was admitted to the facility 5/1/2014. Her diagnoses included but were not limited to: Dementia with Behavioral Disturbance, Osteoarthritis of Knee, Hypertension, Atrial Fibrillation, Hypothyroidism, Hyperparathyroidism, and Glaucoma.

The most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/16/2016 was coded as a quarterly assessment. Resident # 3 was coded as having severe cognitive impairment. She was also coded as requiring extensive assistance of one to two staff members for her activities of daily living. Resident # 3 was coded as frequently incontinent of bowel and always incontinent of bladder.

Review of Resident # 3's clinical record was conducted on 1/17/2017 at 3:30 PM and 1/18/2017.

Review of the January 2017 Physicians Orders revealed orders for "Apply Bilateral Heel Protectors for pressure redistribution and protection. Apply at hour of sleep and remove in the morning and Apply Protective arm sleeves every morning and remove every night at bedtime."

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| F 281 | Continued From page 7 | F 281 | | |

Review of the 2017 Treatment Administration Record (TAR) revealed missing documentation of administration of treatments on 1/8/17 at 9 PM and 1/17/17 at 9 PM:

"Apply Bilateral Heel Protectors for pressure redistribution and protection. Apply at hour of sleep and remove in the morning: no documentation that heel protectors were applied on 1/8/17 at 9 PM and 1/17/17 at 9 PM.

"Apply Protective arm sleeves every morning and remove every night at bedtime.": No documentation that the sleeves were removed 1/8/17 at 9 PM and 1/17/17 at 9 PM.

Review of the Nursing Progress Notes revealed no entries regarding missing documentation of administration of treatments on 1/8/17 and 1/17/17.

During the end of day debriefing on 1/18/2017 at 5:00 PM, the Administrator and Director of Nursing were informed of the missing documentation of treatments on 1/8/17 and 1/17/17. An interview was conducted with the Director of Nursing who stated the expectation was that all medication and treatments should be documented at the time of administration.

The Director of Nursing cited Lippincott as the facility's professional nursing guidance.

Review of the Facility Policy on Medication Administration and Documentation revised 6/1/16 under Procedures revealed:
II. Standard Operating Procedures:
A. Medication will be administered through verifying the "7 RIGHTS"

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| F 281 | Continued From page 8<br>1. Right Resident<br>2. Right Medication<br>3. Right Dosage<br>4. Right Route<br>5. Right Time<br>6. Right Effect<br>7. Right Documentation."<br><br>Guidance for nursing standards for the administration of medication and treatments is provided by "Lippincott", which stated "After administering a medication or treatment, record it immediately on the appropriate record form."<br><br>During the end of day debriefing on 1/19/2017, the facility Administrator and Director of Nursing were informed of the failure of the staff to document treatments of having been administered on 1/8/17 and 1/17/17.<br><br>Valid physician's orders were evident for the treatments not documented as administered. No further information was provided. | F 281 | | |