PRINTED: 06/03/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ') MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/	09/2019
	ROVIDER OR SUPPLIER MEADE OF WILLIAMSE	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
E 000	Initial Comments An unannounced En	nergency Preparedness	E 0	00			
F 000	survey was conducted. The facility was in sur CFR Part 483.73, Rec Care Facilities. No e	ed 5/8/19 through 5/9/19. Abstantial compliance with 42 equirement for Long-Term emergency preparedness estigated during the survey.	F 0	00			
	conducted 05/08/19 Corrections are requirements. The Li	ired for compliance with 42					
F 607 SS=E	at the time of the sur consisted of 13 resid	Abuse/Neglect Policies	F 6	07			6/23/19
		licies and procedures that: it and prevent abuse, tion of residents and					
	to investigate any su	ish policies and procedures ch allegations, and e training as required at					
AROBATOPY	This REQUIREMEN by: Based on staff interv	T is not met as evidenced view, facility documentation		Medical records were revie TITLE	ewed for		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/30/2019

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.

Electronically Signed

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Under G 0100 ADL Assistance the Resident is Administrator/designee with emphasis		io indicating mod	erate cognitive impairment.				u	
		Linder G 0100 AD	Il Assistance the Pesident is			. •		
Logger as.		coded as:	L'Addiction the Addictions			placed on all injuries of unknown sour		

Facility ID: VA0399

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495402	B. WING		05/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	·
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 607	Continued From pag how bruise occurred to stand usage."	e 3 but it could be related to sit	F 60	7	
	was not discontinued 3/11/19 at 1:00 AM - and outer aspect of I is tender to touch sh unable to state how she has left sided we drags her foot or cro wheelchair." Additional comments prevent reoccurrence - "Make sure L [left] 1 - "In bed, place pillow 3/17/19 at 2:50 PM - bruise noted to left fo BEFORE resident ha unaware of cause." Additional comments prevent reoccurrence - "Verify placement of Hoyer"	"New bruise noted on top eft foot (16 cm X 9 cm) site e is poor historian and injury occurred. However eakness and sometimes sses her feet in bed and sand or steps taken to e: foot is in leg rest." "8 cm X 7 cm red purple orearm about 10 minutes and fall resident and staff are			
	Additional comments prevent reoccurrence - "OT to eval for place put cat on."	s and or steps taken to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495402	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION	
F 607	Continued From pag	ge 4	F 60	7		
	resident support hos assess and the area bleeding and had a Additional comment prevent reoccurrence - "Resident has been L [left] leg off of foot leg." 4/8/19 at 7:50 PM - bruise noted to left usimilar to bruise noted probably be from sline Additional comment prevent reoccurrence - "Resident has been bleeding as the same and the similar to bruise noted to left usimilar to bruise noted to left using the left	n noted throughout day taking rest when staff elevate left "4.5 cm X 3.5 cm brown appears to be led in March determined to leg." s and or steps taken to				
	bruise noted to left usimilar to bruise noted probably be from slii Interview was conduand when asked if sinvestigation of abusine if there is a suspinterview the resider. When asked who was suspected abuse shouposed to report a my administrator wow.	se she stated that "They notify icion of abuse and I would nt." as responsible for reporting e answered "Any employee is any allegations of abuse and				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			05/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	She indicated that the morning meeting withey review incident reports should have and should have concerned and after the report of identified to would then report. She has not had any new administrator of the stated, "If any of out think something man abuse they are to resupervisor, and the the DON (Director of According to the fact "Preventing Reside "Injury of unknown of the word of the there is not reasonable explanately physical abuse or mout." "B. [facility name reand procedures to it in situations in which mistreatment and/of property is more like the procedures to it in situations in which property is more like the procedures in more like the procedures to it in situations in which property is more like the procedures to it in situations in which property is more like the procedures to it in situations in which property is more like the procedures to it in situations in which property is more like the procedures to it in situations in which property is more like the procedure and procedures to it in situations in which property is more like the procedure and procedures to it in situations in which property is more like the procedure and procedures to it in situations in which property is more like the procedure and proc	the facility started a new th the new leadership and its. She indicated that the been told to the supervisor me to her to interview all e Administrator receives her concerns, the Administrator She further elaborated that y abuse referrals since the tarted. AM an interview was CEO and the Administrator ream has a concern, or they y be under the heading of eport it to their administrative in immediately call myself and of Nursing)." Cility abuse policy: Int Abuse " Drigin- any injury to a resident to known etiology or tion, and for which an origin in histreatment cannot be ruled dacted] will maintain protocols dentify, correct and intervene h abuse, neglect, remisappropriation of resident	F 6	07		
	_	vironmental rounds will be ally throughout the day. These				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495402	B. WING _		0	5/09/2019	
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Continued From pag	ge 6	F 6	07			
	resident needs are be the plan of care, that	monitoring are to ensure being met in accordance with tresidents are being environment is free of					
	-	rator was made aware of the of unknown origin and no vas provided.					
	implement their abus investigating and rep	the facility staff failed to se policy as evidenced by not porting abuse or neglect; not investigation; and not unknown source.					
	The resident's diagn limited to: traumatic loss of consciousnes muscle weakness, a hyperlipidemia, supr	mitted to the facility on 6/8/19. oses included but were not subdural hemorrhage without ss, UTI, multiple fx of rib, taxia, essential hypertension, aventricular tachycardia, tion and concentration deficit, unication deficit,					
	set) (an assessment (assessment referenceded as a quarterly had a BIMS (brief in score of 13, which in cognitively intact. Requiring assistance ADL's (activities of december 1)	cent MDS (minimum data tool) with an ARD nce date) of 3/15/19 was assessment. Resident #6 terview for mental status) adicated Resident #6 was esident #6 was coded as of one staff member for aily living) which included: rs, dressing, eating, toileting,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l \	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495402	B. WING _			5/09/2019
	ROVIDER OR SUPPLIER	urg		STREET ADDRESS, CITY, STATE, ZIP COI 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•	J. 60. 20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	that the resident was floor with feet facing is no indication that a resident fall. The lno "CNA was passing io the floor in a supine passident pants were below waist. Resident pants were below waist. Resident extremities without painjuries resident's activated. Resident wout assist." [sic] The Form dated 7/7/18 st alarm-family member an investigation being the resident was not the facility staff suspispouse failed to contrain the resident was not the facility staff suspispouse failed to contrain the resident was not the facility staff suspispouse failed to contrain the office of Licensum Review of nursing not entry that read: "spout at a bruise on resident examined. Noted bruise on resident pain in wrist. was made aware. Pareceived for ice to affinoted to have flailing shift. Will monitor residence in the passion of the pain in wrist. Wall monitor resident pain in wrist.	g notes dated 7/7/18 reveal found "lying supine on the the bathroom door." There anyone witnessed the ident/Accident report states and found resident lying on position near the bathroom. Unzippered and hanging the was able to move all four ain. Resident had no personal alarm was not was attempting to transfer the Fall Analysis/Investigation ated "removed bed/chair er." There is no evidence of g conducted to exclude that a victim of abuse or neglect. The bed/chair alarm. In origin was not reported to the and Certification.	F 6	07		
	day of 8/2/18 to indic	ate resident had flailing of noted in the incident note,				

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONST		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/	09/2019
	ROVIDER OR SUPPLIER	URG		3900 WIN	ADDRESS, CITY, STATE, ZIP CODE NDSOR HALL DRIVE MSBURG, VA 23188		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Tear/Abrasion Investic comments, it read "tir Suspect injury occurr assess what resident unknown." There is r investigation form that measures were taken while an investigation the injury of unknown the Office of Licensur Nursing notes revealed 22:19 that read, "Ressounding. CNA noted the floor in the bathrowheelchair behind he abrasion red in color 2.0 cm to her back." Report stated, "Resid sounding. This nurse room by CNA who star Resident was noted sounding. The real analys revealed that no staff The CNA post fall invino one was with the rell. This unwitnesses the Office of Licensur Review of nursing nor an entry dated 8/21/1 "during weekly skin a bruise on resident's ripurple and reddish put	Review of Bruise/Skin gation form under additional ning of injury unknown. ed last night. Unable to was doing since timing to indication on the t staff were interviewed, any to protect Resident #6 was being conducted, and origin was not reported to e and Certification. ed an entry on 8/7/18 at ident's personal alarm was diresident sitting upright on om in her room with the r. Resident sustained an and measuring 11.0 cm x. The Incident/Accident ent's personal alarm was a was called to resident's ated Resident is on the floor. Sitting upright on floor in her neelchair immediately behind is/investigation form interviews were conducted. The estigation form revealed that the estiga	Fé	007			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495402	B. WING _		05/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	1 33.35.23.13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 607	revealed that no staff An investigation was were taken to protect resident was a victim unknown origin was Licensure and Certification Nursing notes for Redated 10/24/18 at 17 skin assessment notiforearm. Resident doubthe bruises. Bruises #1-4 on dorsal surface #1 1.7 x 2cm Oval & Reddish purple in the #2 1 x 0.8 cm oval & Reddish purple in the #3 1/5 x 0.7 cm irrebruise #4 1.7 x 2cm purplisedark purple 0.5 cm in #5 6 x 11.5 cm blue surface Husband was notified the bruises. He does them." [sic] The brui investigation form rewere conducted. Ad "resident seen by CN eye closed and bumptoday. Bruises were may be an explanation Husband declined ge There was a typed st stated, "nurse into as fingerlike pattern note."	sion investigation form interviews were conducted. not conducted, no measures Resident #6 in the event the of abuse and the injury of not reported to the Office of cation. sident #6 revealed an entry 30 that read, "during weekly ced bruises on right enies knowing how she got on right forearm: the #5 on dorsal and ventral bruise w/Dark purple boarder. In middle bruise, reddish purple gular shaped fading red sh red bruise with a spot of a diameter bruise, lighter on ventral d at 11:45am. He has seen a not know how she got se/skin tear/ abrasion wealed no staff interviews ditional comments read as, lia reaching for walker with bing/hitting rt arm on walker preset prior to this, however on for how it occurred. In sleeves in past." [sic] atement dated 10/26/18 that issess areas to right arm. No	F 6	07	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495402	B. WING			05/	09/2019
	ROVIDER OR SUPPLIER	URG		39	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WINDSOR HALL DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	e 10	F	307			
	provided that would in conducted or any pro- taken to protect Residunknown origin was r Licensure and Certific Review of nursing no	or any other information indicate an investigation was tective measures were dent #6. This injury of not reported to the Office of cation. tes for Resident #6 revealed [18 at 14:57 that read,					
	"Resident personal a found in the bathroon resident was taken to minutes prior to and rouse her call bell for resident has been as reach and resident kr for assistance." Revianalysis/investigation	larm sound and resident was in unassisted standing and in the bathroom about 10 resident has been reminded in assistance and at this time is sisted and call bell is within hows how to push call bell ew of the fall form under the resident					
	didn't respond to the one question which the Only one staff member indicated that Reside to the fall. There is no information provided complete investigation protective measures	n was conducted or any were taken to protect ury of unknown origin was					
	a entry dated 10/26/1 "resident was found s room after resident pound additional information clinical record that wo incident of unknown of	te for Resident #6, revealed 8 at 10:15am that read, bitting on the floor in her ersonal alarm sounded." No was found in the entire buld indicate that this origin, which is an allegation gated, staff interviewed,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/	09/2019
	ROVIDER OR SUPPLIER	URG	1	3900 W	T ADDRESS, CITY, STATE, ZIP CODE /INDSOR HALL DRIVE AMSBURG, VA 23188	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	was reported to the C Certification. Resident #6's nursing read, "resident was for on her back when per Resident has a abrass with bruising." [sic]. It tear/abrasion investiguence staff member was injury of unknown origing any other information a complete investigate protective measures. Resident #6. This injurence to the Officertification. On 12/11/18 at 3:00p have "2 new bruise not a complete investigate protective measures." Resident #6. This injurence in a complete investigate protective measures. Resident #6. This injurence in a complete investigate protective measures in a complete investigate protective measures in a complete investigate protective measures in a complete investigate investigate in a complete investigate investigate in a complete investigate investi	ring the course of an res taken to prevent the injury of unknown origin office of Licensure and office of Licensure office of the bruise/skin spation form reveals that only is interviewed regarding the gin. There is no evidence or a provided that would indicate a cion was conducted or any office of Licensure and office of Licensure and office of Licensure and office of Licensure and office office of Licensure and office office of Licensure and office office of Licensure of the sion investigation form of the sion investigation form or information provided that plete investigation was tective measures were dent #6. This injury of not reported to the Office of cation.	F6	507			
		that on 12/24/18 at 5:40pm ling resident she noticed					

ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495402	B. WING		05/09/2	019
	URG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	,	5.15
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COI	(X5) MPLETION DATE
area of concern on but writers attention. On there is pink area of concern on but writers attention. On there is pink area of concern on the p	attock and brought it to this right side of the gluteal cleft lenuded skin measuring 1 x few much smaller lesions to lesion on either side of eview of the bruise/skin tear/or form reveals that Resident wable". No staff were go the injury of unknown vidence or any other that would indicate a mass conducted or any were taken to protect any of unknown origin was effice of Licensure and in the state of the st	F 60	7		
	ROVIDER OR SUPPLIER MEADE OF WILLIAMSB SUMMARY ST. (EACH DEFICIENC' REGULATORY OR LE Continued From page area of concern on but writers attention. On there is pink area of concern on there is pink area of concern on the superior to the larges gluteal cleft. " [sic] Reabrasion investigation #6, was "non-interview interviewed regarding origin. There is no exinformation provided complete investigation protective measures or Resident #6. This injunot reported to the Off Certification. Resident #6's nursing 1/2/19 at 6:41am that assessment noticed at the resident's right had raised blue bruise with resident states the parallel Review of the bruise/sinvestigation form staresident interview "un yes to every question any staff were interview unknown origin. The other information procomplete investigation protective measures or Resident #6. This injunot reported to the Off Certification. On 2/13/19 at 8am nurevealed and read "bit intervealed and read "bit interved to the Off Certification.	A95402 ROVIDER OR SUPPLIER MEADE OF WILLIAMSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 area of concern on buttock and brought it to this writers attention. On right side of the gluteal cleft there is pink area of denuded skin measuring 1 x 0.7 cm. There are a few much smaller lesions superior to the largest lesion on either side of gluteal cleft. " [sic] Review of the bruises/skin tear/ abrasion investigation form reveals that Resident #6, was "non-interviewable". No staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and Certification. Resident #6's nursing notes had an entry dated 1/2/19 at 6:41am that read, "during weekly skin assessment noticed a bruise on the dorsum of the resident's right hand. 4 x 3 cm ovoid soft raised blue bruise with a little reddish purple, resident states the pain is moderate." [sic] Review of the bruise/skin tear/abrasion investigation form states at the subheading resident interview "unreliable answers. answered yes to every question" There is no evidence that any staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and	A BUILDING 495402 ROVIDER OR SUPPLIER MEADE OF WILLIAMSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 area of concern on buttock and brought it to this writers attention. On right side of the gluteal cleft there is pink area of denuded skin measuring 1 x 0.7 cm. There are a few much smaller lesions superior to the largest lesion on either side of gluteal cleft. "[sic] Review of the bruise/skin tear/ abrasion investigation form reveals that Resident #6, was "non-interviewable". No staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and Certification. Resident #6's nursing notes had an entry dated 1/2/19 at 6:41am that read, "during weekly skin assessment noticed a bruise on the dorsum of the resident's right hand. 4 x 3 cm ovoid soft raised blue bruise with a little reddish purple, resident states the pain is moderate." [sic] Review of the bruise/skin tear/abrasion investigation form states at the subheading resident interview "unreliable answers. answered yes to every question" There is no evidence that any staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and Certification. On 2/13/19 at 8am nursing notes for Resident #6 revealed and read "bruise on right forearm	A BUILDING 495402 READE OF WILLIAMSBURG SUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY WILLIAMSBURG) SUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY WILLIAMSBURG, VA 23188 COntinued From page 12 area of concern on buttock and brought it to this writers attention. On right side of the gluteal cleft there is pink area of denuded skin measuring 1 x 0.7 cm. There are a few much smaller lesions superior to the largest lesion on either side of gluteal cleft. "[sic] Review of the brusies/skin tear/ abrasion investigation form reveals that Resident #6, was "non-interviewable". No staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6's nursing notes had an entry dated 1/2/19 at 6.4 tam that read, "during weekly skin assessment noticed a bruise on the dorsum of the residents" right hand. 4 x 3 cm ovoid soft raised blue bruise with a little reddish purple, resident interview "unreliable answers. answered yes to every question" There is no evidence that any staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and Certification. On 2/13/19 at 8am nursing notes for Resident #6 revealed and read "bruise on right forearm"	A BUILDING A95402 B. WING STREETADDRESS.CITY, STATE. 2P CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188 SUMMARY STATEMENT OF DERCIENCIES (EACH DEPICIENCY MISTS BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 12 area of concern on buttock and brought it to this writers attention. On right side of the gluteal cleft there is pink area of denuded skin measuring 1 x 0,7 cm. There are a few much smaller lesions superior to the largest lesion on either side of gluteal cleft. "[sic] Review of the bruise/skin tear/ abrasion investigation form reveals that Resident #6, was "non-interviewable". No staff were information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #65. This injury of unknown origin was not reported to the Office of Licensure and Certification. Resident #65 nursing notes had an entry dated 12/19 at 64 fam that read, "during weekly skin assessment noticed a bruise on the dorsum of the resident's right hand. 4 x 3 cm ovoid soft raised blue bruise/skin tear/ abrasion investigation form states at the subheading resident interview "unreliable answers. answered yes to every question" There is no evidence that any staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. This injury of unknown origin was not reported to the Office of Licensure and Certification. On 213/19 at 8am nursing notes for Resident #6 revealed and read "bruise on right foream"

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING _		_	05/	09/2019
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STA 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 231	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
F 607	distal forearm. It is dipurple boarder, resider Resident is unable to [sic] Review of the brinvestigation form review member was interview unknown origin. The other information procomplete investigation protective measures resident #6. On 2/16/19 at 4:03am Resident #6 read, "ne (6 x 5 cm). Resident unable to state how in prone to frequent injuron things." Review of abrasion investigation interviewed regarding origin. There is no exinformation provided complete investigation. Nursing notes for Resident 4/6/19 at 8:10ar right forearm noticed. AM right forearm, do bruise. Dark purple in denies pain. She has and right arm. Residunable to tell me when how it happened. Hut this AM. He does not Review of the bruise/investigation form reviewestigation form reviewest	I bruise on dorsal surface of ark purple with a reddish ent denies pain at the site. Itell me how is occurred." ruise/skin tear/ abrasion reals that only one staff wed regarding the injury of re is no evidence or any wided that would indicate a n was conducted or any were taken to protect In a nursing note entry for ew bruise seen on right hand is a poor historian and njury occurred. Resident is ries from her hitting her arm of the bruise/skin tear/ in form reveals no staff were go the injury of unknown widence or any other that would indicate a n was conducted. Sident #6 revealed an entry m that read, "new bruise while toileting resident this real surface 3.2 x 1.8 cm in the center and slightly in the periphery. Resident segood ROM of right wrist ent has aphasia and is in the bruise appeared or sband noticed the bruise to know how it happened."	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			05/09/2019	
	ROVIDER OR SUPPLIER	BURG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Continued From pag	e 14	F 6	07			
	no evidence or any of that would indicate a conducted or any pro- taken to protect Resi unknown origin was Licensure and Certifi						
	an entry at 15:15 that alarm on back of the was found on the floodoor on her back. redid not have to use it resident fell." [sic] Fabrasion investigation staff member was intinjury of unknown or its staff was intinjury of unknown or its staff was	I/30/19 for Resident #6 had tread, "resident's personal w/c went off and resident or in from of the bathroom esident was put on toilet, but to unable to determine why Review of the bruise/skin tear/ on form reveals that only one terviewed regarding the igin. There is no evidence or in provided that would indicate tion was conducted.					
	with Employee C, the asked if she was away origin for Resident #1 specifically, it was retained to me as a referral all abused. She is not sup as someone for a identified the nurse of interview. Any employers any suspicion of abuy would call me. I try to	an interview was conducted as SW (Social Worker). When are of the injuries of unknown 6, the SW stated, "I don't ported or identified as abuse. It that has ever been identified long those lines as being someone that has ever come buse. When abuse is loes an interview, I do an oyee is supposed to report se and my Administrator to visit this resident weekly stall seeing any bruises."					
	paperwork is concer	esident with this amount of ning, the SW stated, "I concerns. I've just never					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _		,	05/09/2019
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STATE, ZIP COI 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	never seen these rephave been made awa to the supervisor but to me to interview all there are concerns id would report the incide for abuse since the normal of the conducted with the fasked if she knew the unknown origin and reference to the can't answer, I don't she is ataxic and does. The Administrator was tated "they investigated about mandate abuse allegations is a Administrator stated, concern, or they think the heading of abuse administrative supervicall myself and the D. When asked what we allegation of abuse, to looks like a hand print I would be questioning depending on the plate When an injury occurred. I would loot lab draw, if we don't I there is no reasonable is an injury of unknown reported no later than	This is concerning, I've corts. Yes, I probably should are. It should have been told this should have also come parties. After my report, if lentified the Administrator dents. I haven't had a referral ew Administrator started." AM an interview was acility Administrator. When excause of the injuries of multitude of bruises Resident ex Administrator stated, "I know what meds she is on, as a lot of failing." Is made aware that the SW ate prior to reporting, she end reporting, but reporting of not occurring." The "if any of our team has a comething may be under they are to report it to their visor, and then immediately ON (Director of Nursing)." ould make them think an the Administrator stated, "if it at, something out of ordinary, and the them things are. It is and no one knows how it k, I would ask if they had a know how it happened, if e expectation. When there we source it should be	F 6	07		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			05/09/2019	
	ROVIDER OR SUPPLIER	BURG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	Administrator stated, prior to Jan 5. I was different DON." She injuries of unknown of her tenure. The Admino problem at all repskin tear, if we look a can't give an answer immediate answer, where the Administrator was unknown origin on 10 hand print, the Administrator was unknown origin on 10 hand print was unknown origin on 10 hand print was unknown origin on 10 hand print was unknown origin or 10 hand print was unknown origin or 10 hand was unknown origin or 10 hand was unknown origin or 10 hand wa	porting is not happening the "I can't answer for anything not here, we did have a was shown there were six origin for Resident #6 since ninistrator then said, "I have orting every bruise and every at it immediately and if we if we don't have an we will report it." It is advised of the injury of 0/24/18 that appeared to be a nistrator said "If saw hand raise my concern and I	F	507			
	anything, someone nand they went to grad concerned about possabout next steps, Thourse would then cal a concern here, I wor is any thought that the reported. A nurse reporting. This nurse, who didn't like being She is a board certification. Review of the facility Resident Abuse" with has a subheading of of unknown origin- and which there is no known explanation, and for the subset of the subheading of the subset of the	naybe said she went to fall of her, etc. I would be esible abuse." When asked the Administrator stated, "the I the DON and myself, I have all send it in to you. If there is could be abuse, it would so writing the report is self to is also a medical doctor, a doctor and is a nurse.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495402	B. WING _		0	5/09/2019	
	ROVIDER OR SUPPLIER	URG	1	STREET ADDRESS, CITY, STATE, ZIP CO 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	e 17	F 6	07			
	Under the policy sublimb. [facility name] will procedures to identify situations in which about and/or misappropriation more likely to occur." Under the policy sublimber and "a. during orient minimum, team mem observation and reportance about resident care, of members are encount maintained to promot reporting of events, so fresidents, occurrer that may constitute all direction of the invest B. Team members are correct, and intervene abuse, neglect and/oresident property is minmediately following safety, team member or observation of abudirector of nursing, as leadership member. C. Resident and envicended and frequent resident needs are bethe plan of care, that supervised and the envicence and supervise team mem	meading, Prevention, it read maintain protocols and v, correct and intervene in puse, neglect, mistreatment on of resident property is meading, Identification, it ation and annually at a bers will be educated on rting important information condition or behavior. Team aged and protocols will be etimely identification and uch as suspicious bruising nees, patterns, and trends buse; and to determine the rigation. The encouraged to identify, the in situations in which is misappropriation of nore likely to occur. The ensuring the resident's is are to report any allegation se to their supervisor, dministrator or facility throughout the day. These monitoring are to ensure leing met in accordance with residents are being					

AND BLAN OF CORRECTION INTERPRETATION NUMBERS		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495402	B. WING _		05/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETIC
F 607	read, "A. designated immediately review a or observations of abconduct analysis for to incidents [i.e. falls of unknown origin, unreportable incidents, bodies, such as the las directed by the acceptant of the policy sub "A. In the event of an abuse, [facility name resident, notify the prepresentative, and presidents from further resident's plan of car interventions to minimal any injury or harm id of the resident." Under the policy sub "A. [facility name] will all eged violations exploitation or mistre unknown source and property, are reported than 2 hours after the events that cause the result in serious bodin hours if the events that obdily injury, to the and bodily injury, to the and his or her designee, (including to the Stateston or the stateston of the s	heading, Investigation, it team members will and investigate all allegations puse. B. [facility name] will trends and patterns related skin tears, bruising or injury nusual occurrences, etc.] C. outside investigative local police will be contacted iministrator or his or her ordance with federal, state of the ading, Protection, it read, allegation or observation of will immediately assess the envision and resident for otect the resident and other or harm or incident. B. The le will be revised to reflect mize recurrence and to treat entified through assessment the ading, Reporting, it read, I maintain systems to ensure involving abuse, neglect, atment, including injuries of misappropriation of resident dimmediately, but not later the allegation is made, if the entity allegation involve abuse or ly injury; or not later than 24 at cause the allegation do did do not result in serious dministrator of the facility, or	F 6	07	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED			
		495402	B. WING			05/09/2019	
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 607	procedures. B. Each reporter shall report in than 2 hours after for events that cause the bodily injury or crime, the events that cause serous bodily injury. to local law enforcem reasonable suspicion individual who is a refrom, the facility. Not County Police is to be number listed]. C. Thimmediately report all neglect, abuse, include source, mistreatment resident property, by on behalf of the provihis or her designee of all investigations a	m care facilities) in e law through established covered individual/mandated mmediately, but not later ming the suspicion, if the e suspicion result in serious or not later than 24 hours if e suspicion doe not result in i. The organization will report ent agencies any of a crime against any sident of, or is receiving care ification to the James City e made by contacting [phone e organization will alleged violations involving ding injuries or unknown and/or misappropriation of anyone furnishing services der, to the administrator or if the facility. D. The results re to be communicated to	F 60	07			
F 609 SS=E	the incident, and if the appropriate corrective. The facility Administration aware of the facility someone of day meeting on 5/5 to further information Reporting of Alleged CFR(s): 483.12(c)(1)(s) \$483.12(c) In response	n was provided. Violations	F 60	09		6/23/19	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED				
		495402	B. WING _		05/09/2019	
	ROVIDER OR SUPPLIER	URG	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		1 03/03/2013	
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F 609	Continued From page		F 6	09		
	involving abuse, neglimistreatment, including source and misapproare reported immedia hours after the allegathat cause the allegaserious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective services for jurisdiction in long	e that all alleged violations ect, exploitation or ang injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if a the allegation do not involve ault in serious bodily injury, to the facility and to other the State Survey Agency and the state survey Agenc				
	designated represent accordance with Statt Survey Agency, within incident, and if the all appropriate corrective. This REQUIREMENT by: Based on staff interview, and clinical refailed to report injuried Residents (Resident survey sample of 13. 1. For Resident #6, the accidents and injuried were allegations of all 2. For Resident #5 the	administrator or his or her sative and to other officials in se law, including to the State in 5 working days of the leged violation is verified e action must be taken. To is not met as evidenced siew, facility documentation ecord review the facility staff is of unknown origin for two #6 and Resident #5) in a Residents. The facility staff failed to report is of unknown origin, which		1. Medical records were reviewed Resident #5 and #6. Residents # 5 6 were assessed by the nursing te any potential injuries. Resident #6 found to be free of injuries of unknource. Resident # 5 was noted to bruises of unknown origin and a rewas forwarded to OLC on 5/9/19. If up report was sent to OLC on 5/15 Abuse Policies and Procedures were viewed, and no changes were must be the stime, as current policy and pro	and # am for was own have port Follow i/19. ere ade at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495402	B. WING		05/09/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2013
				3900 WINDSOR HALL DRIVE	
WINDSOR	MEADE OF WILLIAMSB	URG		WILLIAMSBURG, VA 23188	
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F 609	Continued From page	e 21	F 609	9	
	of supervision and in	juries of unknown origin.		meets the regulations and standar care.	rds of
	The findings included	:		All residents in the facility have potential to be affected by failure to the control of th	
		ne facility staff failed to report		investigate abuse allegations and	
		s of unknown origin, which		of unknown source in accordance	
	were allegations of abuse or neglect. Resident #6 was admitted to the facility on 6/8/19.			abuse policies and procedures. The	
				Administrator and Director of Nurs	_
		-		have completed an audit to includ	
	The resident's diagnoses included but were not limited to: traumatic subdural hemorrhage without			of all accidents/injuries since 5-9-screen for potential injuries of unk	
		s, UTI, multiple fx of rib,		source and/or abuse allegations.	
		axia, essential hypertension,		reports as required have been for	
		ventricular tachycardia,		to OLC.	wardod
		ion and concentration deficit,		15 525.	
	and cognitive commu			3. All team members will be re-ed	ucated
	3	,		on the identification and definition	of
	Resident #6 most rec	ent MDS (minimum data		injuries of unknown source. The	
	set) (an assessment	•		investigation procedures have been	en
	(assessment reference	ce date) of 3/15/19 was		revised with new guidance for tea	m
	coded as a quarterly	assessment. Resident #6		members related to the completio	n of
		erview for mental status)		investigations. Facility will re-educ	ate all
		dicated Resident #6 was		team members on the abuse police	
		sident #6 was coded as		procedure to include investigation	s and
		of one staff member for		IMMEDIATE reporting to the	
	`	ally living) which included:		Administrator/designee with emph	
		s, dressing, eating, toileting,		placed on all injuries of unknown	
	personal hygiene, and	d bathing.		Abuse Policies and Procedures w	
	D : 1 + 1/01 :	1 1 1 7 7 7 4 0		reviewed with all new team memb	
		notes dated 7/7/18 reveal		hire and at minimum annually with	ıaıı
		found "lying supine on the		team members.	
	floor with feet facing the bathroom door." There is no indication that anyone witnessed the				
		ident/Accident report states		4. All allegations of abuse/reports	of
		e and found resident lying on		injuries of unknown source will be	
		osition near the bathroom.		reported immediately to OLC and	
		unzippered and hanging		investigations will be initiated. A 1	
		nt was able to move all four		audit of all accidents/incidents/inju	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _		0:	5/09/2019	
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		3,00,2010	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 609	injuries resident activated. Residen w/out assist." [sic] Form dated 7/7/18 alarm- family membran investigation beithe resident was not The facility staff sus spouse failed to conthis injury of unknothe Office of Licens Review of nursing rentry that read: "spat a bruise on residexamined. Noted be measuring 7cm x 7 or moaning during lidenied pain in wrist was made aware. received for ice to a noted to have flailing shift. Will monitor review of nursing reno entries. There we day of 8/2/18 to indupper extremities a previously mentione Tear/Abrasion Investigation form to measures were tak while an investigation form to measures were tak while an investigation.	ge 22 pain. Resident had no s personal alarm was not t was attempting to transfer The Fall Analysis/Investigation stated "removed bed/chair per." There is no evidence of ng conducted to exclude that of a victim of abuse or neglect. spected that Resident #6's nnect the bed/chair alarm. own origin was not reported to ure and Certification. Thotas dated 8/2/18 reveal an ouse asked this nurse to look ent's right wrist. Wrist oruise on dorsum of right wrist cm. No guarding, ,grimacing palpation of area. Resident solution. Notified nursing supervisor PA made aware. New order affected area. Resident was ag of upper extremities on prior esident as needed." [sic] notes dated 8/1/18 there were were no other entries on the icate resident had flailing of s noted in the incident note, ed. Review of Bruise/Skin stigation form under additional timing of injury unknown. urred last night. Unable to nt was doing since timing s no indication on the hat staff were interviewed, any en to protect Resident #6 on was being conducted, and on origin was not reported to	F6	be completed by the Admir Director of Nursing, and/or within 72 hours to ensure the potential reportable incider reported and residents are protected from harm. The and Director of Nursing will monthly tracking analysis of to identify patterns and/or injuries of unknown source be ongoing to ensure compabuse policy/procedures a guidelines and will be reporteviewed quarterly through process. 5. All corrective actions will by 6/23/19.	designee that any that and that and that and that and that and that any that and that any that and that any tha		

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F 609	22:19 that read, "Ressounding. CNA note the floor in the bathrowheelchair behind he abrasion red in color 2.0 cm to her back." Report stated, "Resident was noted sounding. This nurse room by CNA who states and the color of the	re and Certification. ed an entry on 8/7/18 at sident's personal alarm was d resident sitting upright on from in her room with the er. Resident sustained an and measuring 11.0 cm x. The Incident/Accident dent's personal alarm was er was called to resident's ated Resident is on the floor. Sitting upright on floor in her neelchair immediately behind sis/investigation form from the fine that the extreme that the	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		495402	B. WING			05/09/2019	
	NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG			STREET ADDRESS, CITY, STATE, ZIP COI 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•	, 0500.2010	
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F 609	the bruises. Bruises #1-4 on dorsal surface surface #1 1.7 x 2cm Oval Reddish purple in the #2 1 x 0.8 cm oval #3 1/5 x 0.7 cm irre bruise #4 1.7 x 2cm purpli dark purple 0.5 cm ir #5 6 x 11.5 cm blue surface Husband was notified the bruises. He does them." [sic] The brui investigation form rewere conducted. Ad "resident seen by CN eye closed and bump today. Bruises were may be an explanation Husband declined get There was a typed si stated, "nurse into as fingerlike pattern not palpation." signed by There is no evidence provided that would i conducted or any protaken to protect Resi unknown origin was Licensure and Certific Review of nursing not an entry dated 10/25	ceed bruises on right enies knowing how she got on right forearm: ce #5 on dorsal and ventral cruise w/Dark purple boarder. e middle oruise, reddish purple gular shaped fading red ch red bruise with a spot of a diameter c bruise, lighter on ventral ch at 11:45am. He has seen c not know how she got se/skin tear/ abrasion vealed no staff interviews ditional comments read as, lA reaching for walker with bing/hitting rt arm on walker preset prior to this, however on for how it occurred. ceri sleeves in past." [sic] catement dated 10/26/18 that casess areas to right arm. No ced, no pain noted on of the director of nursing. or any other information indicate an investigation was objective measures were dent #6. This injury of not reported to the Office of	F 60	09			

OL: TILL	O T OIT MEDIOTALE G	MEDIO/ (ID OLI (VIOLO				<u> </u>	7. 0000 000 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495402	B. WING			05/	09/2019
	ROVIDER OR SUPPLIER	URG		3	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WINDSOR HALL DRIVE VILLIAMSBURG, VA 23188		
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F 609	resident was taken to minutes prior to and resident has been as reach and resident kr for assistance." Revianalysis/investigation interview section it indidn't respond to the one question which the Only one staff membrindicated that Reside to the fall. There is n information provided complete investigation protective measures Resident #6. This injunot reported to the Or Certification.	n unassisted standing and the bathroom about 10 resident has been reminded a assistance and at this time sisted and call bell is within hows how to push call bell ew of the fall form under the resident dicated that Resident #6 questions asked except for the resident responded no toter was interviewed and they int #6 was "cooperative" prior to evidence or any other that would indicate a in was conducted or any were taken to protect arry of unknown origin was effice of Licensure and	F	609			
	a entry dated 10/26/1 "resident was found s room after resident pound additional information clinical record that we incident of unknown of abuse, was investived to the control of the co	origin, which is an allegation gated, staff interviewed, ring the course of an					

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	NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	1 00/00/2010	
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F 609	tear/abrasion investione staff member winjury of unknown of any other information a complete investig protective measure Resident #6. This in not reported to the Certification. On 12/11/18 at 3:00 have "2 new bruise 3 cm) and top of rig Resident is a poor It cognitive communic state when bruises bruise/skin tear/abrareveals that no staff the injury of unknown evidence or any of the would indicate a conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete the conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification. On the complete conducted or any pataken to protect Resunknown origin was Licensure and Certification.	Review of the bruise/skin tigation form reveals that only was interviewed regarding the rigin. There is no evidence or on provided that would indicate ation was conducted or any is were taken to protect adjury of unknown origin was office of Licensure and of the protect of th	F 60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING			05/	09/2019
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F 609	protective measures Resident #6. This injunot reported to the Ore Certification. Resident #6's nursing 1/2/19 at 6:41am that assessment noticed at the resident's right har aised blue bruise wit resident states the paraised blue bruise wit resident states the paraised of the bruise/investigation form states to every question any staff were intervieunknown origin. The other information procomplete investigation protective measures	that would indicate a n was conducted or any were taken to protect ary of unknown origin was ffice of Licensure and g notes had an entry dated a read, "during weekly skin a bruise on the dorsum of and. 4 x 3 cm ovoid soft th a little reddish purple, ain is moderate." [sic] skin tear/abrasion ttes at the subheading areliable answers. answered " There is no evidence that ewed regarding the injury of the is no evidence or any wided that would indicate a n was conducted or any were taken to protect ury of unknown origin was	F	609	DEFICIENCY)		
	dated 4/6/19 at 8:10a right forearm noticed AM right forearm, do bruise. Dark purple ir raised. Red purple ir denies pain. She has and right arm. Resid unable to tell me whe how it happened. Hu this AM. He does no Review of the bruise/	m that read, "new bruise while toileting resident this rsal surface 3.2 x 1.8 cm in the center and slightly in the periphery. Resident is good ROM of right wrist ent has aphasia and is ent the bruise appeared or in the bruise appeared that the bruise appeared in					

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PREFIX (EACH DEFICIENCY I	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATI	(X5) COMPLETION DATE	
regarding the injury of the no evidence or any oth that would indicate a conducted or any protestaken to protect Resides unknown origin was no Licensure and Certification. On 5/9/19 at 8:43am and with Employee C, the Stasked if she was award origin for Resident #6, specifically, it was report This is not a resident that to me as a referral along abused. She is not sort up as someone for abused interview. Any employed any suspicion of abused would call me. I try to wand I don't' really recall. When asked if one resident with her. The resident is concerning the definitely hear your consuspected it with her. The resident would report the incident for abuse since the new On 05/09/19 at 09:39 Amonths.	o staff were interviewed unknown origin. There is er information provided omplete investigation was ective measures were ent #6. This injury of at reported to the Office of ation. In interview was conducted SW (Social Worker). When e of the injuries of unknown the SW stated, "I don't orted or identified as abuse. In the second that has ever been identified and those lines as being meone that has ever come are is supposed to report and my Administrator visit this resident weekly a seeing any bruises." Indent with this amount of any, the SW stated, "I have seeing any bruises." Indent with this amount of any, the SW stated, "I have seeing any bruises." Indent with this amount of any, the SW stated, "I have seeing any bruises. This is concerning, I've arts. Yes, I probably should as a should have also come arties. After my report, if antified the Administrator ints. I haven't had a referral and Administrator started."	F6	509			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/09/2019
	NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG			STREET ADDRESS, CITY, STATE, ZIP COL 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188)E	
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F 609	#6 has sustained, the can't answer, I don't she is ataxic and doe The Administrator wa stated "they investigated about mandate abuse allegations is radministrator stated, concern, or they think the heading of abuse administrative supervical myself and the DWhen asked what wo allegation of abuse, tooks like a hand print I would be questionin depending on the plate When an injury occur occurred. I would look lab draw, if we don't with the is no reasonable is an injury of unknown reported no later than hospitalization or signitime frame." When asked why repart Administrator stated, prior to Jan 5. I was different DON." She injuries of unknown on her tenure. The Administrator stall reports.	nultitude of bruises Resident Administrator stated, "I know what meds she is on, s a lot of failing." s made aware that the SW te prior to reporting, she ed reporting, but reporting of not occurring." The "if any of our team has a s something may be under they are to report it to their risor, and then immediately ON (Director of Nursing)." ould make them think an he Administrator stated, "if it t, something out of ordinary, g that right away, and cement of where things are. s and no one knows how it k, I would ask if they had a know how it happened, if e expectation. When there yn source it should be n 24 hours, if there is n injury you have a two hour orting is not happening the "I can't answer for anything not here, we did have a was shown there were six rigin for Resident #6 since inistrator then said, "I have orting every bruise and every t it immediately and if we if we don't have an	F 6	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER MEADE OF WILLIAMSB	URG		STREET ADDRESS, CITY, STATE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 2318			
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F 609	unknown origin on 10 hand print, the Admin prints and that would would investigate. It was members, would talk care team. I would vanything, someone mand they went to grade concerned about possibout next steps, The nurse would then call a concern here, I would be reported. A nurse reporting. This nurse who didn't like being She is a board certification. This nurse with has a subheading of unknown originary which there is no known explanation, and for was abuse or mistreatmen. Under the policy subhing ituations in which abuse and/or misappropriation more likely to occur." Under the policy subhing ituations in which abuse or mistreatmen. Under the policy subhing ituations in which abuse or mistreatmen. Under the policy subhing ituations in which abuse or mistreatmen will procedures to identify situations in which abund/or misappropriation more likely to occur."	s advised of the injury of 1/24/18 that appeared to be a istrator said "If saw hand raise my concern and I would talk to all team to spouse, and the direct want to know if anyone saw taybe said she went to fall to her, etc. I would be sible abuse." When asked the Administrator stated, "the the DON and myself, I have ald send it in to you. If there is could be abuse, it would to writing the report is self is also a medical doctor, a doctor and is a nurse.	F	609			

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F 609	maintained to pro reporting of event of residents, occu that may constitut direction of the into B. Team members correct, and intervabuse, neglect an resident property Immediately follow safety, team memor observation of director of nursing leadership members. C. Resident and econducted periodic rounds and frequeresident needs and the plan of care, the	ouraged and protocols will be mote timely identification and s, such as suspicious bruising rrences, patterns, and trends e abuse; and to determine the vestigation. Is are encouraged to identify, vene in situations in which d/or misappropriation of is more likely to occur. ving ensuring the resident's obers are to report any allegation abuse to their supervisor, g, administrator or facility	F	609			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 609	Continued From paç	ge 32	F 6	609			
	"A. In the event of a abuse, [facility name resident, notify the prepresentative, and resident's plan of ca interventions to minimany injury or harm it of the resident." Under the policy sut "A. [facility name] will alleged violations exploitation or mistru unknown source and property, are reported than 2 hours after the events that cause the result in serious body hours if the events that cause the result in serious body injury, to the abodily injury, to the abodily injury, to the accordance with Staprocedures. B. Each reporter shall report than 2 hours after for events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury or crimed the events that cause the bodily injury.	te law through established a covered individual/mandated immediately, but not later rming the suspicion, if the e suspicion result in serious e, or not later than 24 hours if e suspicion doe not result in i. The organization will report					

i ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	BURG	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS)	D BE COMPLETION	
F 609	County Police is to number listed]. C. T immediately report neglect, abuse, incl source, mistreatme resident property, b on behalf of the prohis or her designee of all investigations the State Survey Agthe incident, and if appropriate correction.	otification to the James City be made by contacting [phone The organization will all alleged violations involving uding injuries or unknown Int and/or misappropriation of y anyone furnishing services vider, to the administrator or of the facility. D. The results are to be communicated to gency, within 5 working days of the alleged violation is verified ve action must be taken." trator and DON were made staff's failure to ensure the from abuse during the end 5/9/19.	F 609			
	of allegations of about of supervision and Resident #5 is a 96 the facility on 4/30/limited to Alzheimer Osteoarthritis, Musc Insomnia, and aner The Resident's mos MDS with an (Asse of 3/15/19 coded as	the facility staff failed to report use or neglect to include lack injuries of unknown origin year old woman admitted to 14 with diagnoses of but not its disease, CVA, Unspecified cle weakness, Spinal stenosis, mia. St recent (Minimum Data Set) ssment Reference Date) ARD is a Significant change in C the Resident as having a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			05/	09/2019		
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS 3900 WINDSOR I WILLIAMSBUR					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 609	Under G 0100 ADL / coded as: A. Bed mobility - 3 = person physical assis. B. Transfer - 3 = Ext person physical assis. C. Walk in room - 8 D. Walk in corridor - The Resident is also-Balance during Trans. A. Moving from seat Action did not occur. B. Walking - 8 = Actic. Turning around a while walking 8 = Actic. Turning around a while walking 8 = D. Moving on and of able to stabilize with E. Surface to surface only able to stabilize With E. Surface to surface only able to stabilize incidents: 19 were injuries of until the stability incidents and the stability incidents and the stability incidents: 19 were injuries of until the stability incidents: 19 were injuries of until the stability incidents: 19 were injuries of until the stand lift) 1 Elopement	ental Status) BIMS score of ate cognitive impairment. Assistance the Resident is Extensive Assistance - 2 = 1 istance lensive Assistance - 2 = 1 istance = Activity did not occur 8 = Activity did not occur 0 coded under section G 0300 insition and moving: ed to standing position - 8 = 1 ion did not occur ind facing opposite direction Action did not occur if toilet - 2 = Not steady only human assistance e transfer - 2 = Not steady with human assistance covered that between 19 the Resident had 34 orts completed. Of the 34	F	509					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	(X3) DATE SURVEY COMPLETED		
		495402	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	BURG	3	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WINDSOR HALL DRIVE VILLIAMSBURG, VA 23188	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 609	Continued From pa	ge 35	F 609			
	AM to Left front calf also during the last weakness noted res	"red /black bruise noted this if measuring 15 cm X 7 cm day increased left sided sident and staff are unsure d but it could be related to sit				
	However, according was not discontinue	g to care plan sit to stand use ed until 3/19/19.				
	and outer aspect of is tender to touch si unable to state how she has left sided w	- "New bruise noted on top left foot (16 cm X 9 cm) site he is poor historian and injury occurred. However yeakness and sometimes osses her feet in bed and				
	prevent reoccurrence - "Make sure L [left]					
	bruise noted to left	- "8 cm X 7 cm red purple forearm about 10 minutes nad fall resident and staff are				
	prevent reoccurrent	ts and or steps taken to ce: of arms before lifting on				
	as if resident leaned	- "Unwitnessed fall appears d over to pick up toy cat and nd lying on right side."				
	Additional commen	ts and or steps taken to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			0	5/09/2019	
	ROVIDER OR SUPPLIER	BURG		3900 W	ADDRESS, CITY, STATE, ZIP CODE INDSOR HALL DRIVE AMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 609	put cat on." 3/26/19 at 2:20 PM bed for nap and CNA resident support hos assess and the area bleeding and had a backlional comments prevent reoccurrence - "Resident has been L [left] leg off of foot leg." 4/8/19 at 7:50 PM - "bruise noted to left u similar to bruise noted probably be from slin Additional comments prevent reoccurrence - "Resident has been L [left] leg off of foot leg." 4/8/19 at 7:50 PM - "bruise noted to left u similar to bruise noted to left u similar to bruise noted probably be from slin Interview was condu and when asked if shinvestigation of abus me if there is a suspiinterview the residen When asked who was	e: ement of half tray (flip up) to - "Resident was being put to a seen [sic] dried blood on e and writter [sic] went to was dry and no active oruise around skin tear." - and or steps taken to e: - noted throughout day taking rest when staff elevate left - 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e: - noted throughout day taking rest when staff elevate left - 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e: - noted throughout day taking rest when staff elevate left - 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 1.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 2.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 3.5 cm brown pper forearm appears to be d in March determined to e 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 4.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 5.9/19 at 8:43 am an extend with the Social worker e 6.5 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 6.7 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 7.7 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 8.7 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 9.7 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 9.7 cm X 3.5 cm brown pper forearm appears to be d in March determined to e 9.7 cm X 3.5 cm brown pper forearm appears and a to be e 9.7 cm X 3.5 cm brown pper forearm appears and a to be e 9.7 cm X 3.5 cm brown pper forearm appears and a to be e 9.7 cm X 3.5 cm brown pper forearm appears and a to be e 9.7 cm X 3.5 cm brown pper forearm ap	F	609				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495402	B. WING _		90	5/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	Continued From pag	e 37	F 6	09		
	supposed to report a my administrator wo	ny allegations of abuse and uld call me."				
	injuries of unknown	e seen all of the incidents of origin she stated "It is ve never seen these reports"				
	morning meeting wit they review incidents reports should have and should have cor parties and after the report of identified co would then report. S	the facility started a new the new leadership and so. She indicated that the been told to the supervisor me to her to interview all Administrator receives her concerns, the Administrator She further elaborated that abuse referrals since the arted.				
	stated, "If any of our think something may abuse they are to re	CEO and the Administrator team has a concern, or they be under the heading of port it to their administrative immediately call myself and				
	According to the faci	lity abuse policy:				
	"Preventing Residen	t Abuse"				
	for which there is no reasonable explanat	rigin- any injury to a resident known etiology or ion, and for which an origin in streatment cannot be ruled				
		lacted] will maintain protocols lentify, correct and intervene abuse, neglect,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495402	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 609	C. Resident and environducted periodicall rounds and frequent resident needs are bethe plan of care, that supervised and the enhazards.	ronmental rounds will be y throughout the day. These monitoring are to ensure eing met in accordance with residents are being nvironment is free of	F 60	09		
F 610 SS=E	Investigate/Prevent/CCFR(s): 483.12(c)(2)- §483.12(c) In responsing neglect, exploitation, must: §483.12(c)(2) Have eviolations are thorough substitutions in professional substitutions in professional substitutions are thorough substitutions are thorough substitutions in professional substitutions are thorough substitutions are thorough substitutions are thorough substitutions in professional substitutions are thorough substitutions.	correct Alleged Violation (4) se to allegations of abuse, or mistreatment, the facility vidence that all alleged shly investigated. It further potential abuse, or mistreatment while the gress. Ithe results of all administrator or his or her ative and to other officials in the law, including to the State of 5 working days of the eged violation is verified a action must be taken. It is not met as evidenced	F 61		6/23/19	
		iew, facility documentation, cord review the facility staff		Medical records were reviewed for Resident #5 and #6. Residents # 5 and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495402	B. WING _		05/09/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•
				3900 WINDSOR HALL DRIVE	
WINDSOR	MEADE OF WILLIAN	ISBURG		WILLIAMSBURG, VA 23188	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 610	Continued From p	age 39	F 6	10	
	abuse and neglec in a survey sample 1. For Resident #5 investigate allegat include lack of sur unknown origin. 2. For Resident #6 protect the resident	e and protect Residents from t for 2 Residents (# 5 and # 6) e of 13 Residents. the facility staff failed to ions of abuse or neglect to pervision and injuries of the facility staff failed to nt, conduct an investigation for njuries of unknown origin.		6 were assessed by the nurany potential injuries. Resid found to be free of injuries of source. Resident # 5 was not bruises of unknown origin at was forwarded to OLC on 5, up report was sent to OLC of Abuse Policies and Procedureviewed, and no changes withis time, as current policy a meets the regulations and scare.	ent #6 was of unknown bted to have and a report /9/19. Follow on 5/15/19. ures were were made at and procedure
	investigate allegat include lack of sup unknown origin. Resident #5 is a 9 the facility on 4/30 limited to Alzheime	5 the facility staff failed to ions of abuse or neglect to pervision and injuries of 6 year old woman admitted to 1/14 with diagnoses of but not per's disease, CVA, Unspecified scle weakness, Spinal stenosis,		2. All residents in the facil potential to be affected by fa investigate abuse allegation of unknown source in accordabuse policies and procedur Administrator and Director of have completed an audit to of all accidents/injuries since screen for potential injuries source and/or abuse allegat reports as required have be to OLC.	ailure to s and injuries dance with the res. The of Nursing include 100% e 5-9-19 to of unknown ions. All
	The Resident's model MDS with an (Ass of 3/15/19 coded a assessment, section (Brief Interview of 10 indicating model) Under G 0100 AD coded as:	ost recent (Minimum Data Set) essment Reference Date) ARD as a Significant change on C the Resident as having a Mental Status) BIMS score of erate cognitive impairment. L Assistance the Resident is B = Extensive Assistance - 2 = 1		3. All team members will be on the identification and def injuries of unknown source. investigation procedures had revised with new guidance for members related to the company investigations. Facility will reteam members on the abuse procedure to include investigations. Include investigations in the Administrator/designee with placed on all injuries of unknown Abuse Policies and Procedure to include investigations.	inition of The ve been or team upletion of e-educate all e policy and gations and e emphasis nown source.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495402	B. WING	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER MEADE OF WILLIAMSB	URG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	Ĭ		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		SHOULD BE	(X5) COMPLETION DATE	
F 610	B. Transfer - 3 = Exter person physical assis C. Walk in room - 8 = D. Walk in corridor - 8 The Resident is also on Balance during Transfer A. Moving from seate Action did not occur. B. Walking - 8 = Action C. Turning around an while walking - 8 = Action C. Turning aro	nsive Assistance - 2 = 1 tance Activity did not occur 3 = Activity did not occur coded under section G 0300 sition and moving: d to standing position - 8 = an did not occur d facing opposite direction ction did not occur toilet - 2 = Not steady only numan assistance transfer - 2 = Not steady with human assistance overed that between 9 the Resident had 34 ts completed. Of the 34 known source falls (found on floor) f which involved the use of a ent reports the most recent ed /black bruise noted this neasuring 15 cm X 7 cm	F 6	reviewed with all new team me hire and at minimum annually team members. 4. All allegations of abuse/repinjuries of unknown source will reported immediately to OLC investigations will be initiated. audit of all accidents/incidents be completed by the Administration Director of Nursing, and/or dewithin 72 hours to ensure that potential reportable incidents reported and residents are sarprotected from harm. The Adand Director of Nursing will comonthly tracking analysis on a to identify patterns and/or treninjuries of unknown source. The ongoing to ensure complianabuse policy/procedures and guidelines and will be reported reviewed quarterly through the process. 5. All corrective actions will be by 6/23/19.	orts of Il be and internal A 100% s/injuries will rator, signee any have been fe and ministrator emplete all incidents ds related to his audit will nce with regulatory d and e QAPI		
	AM to Left front calf malso during the last daweakness noted residues						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495402	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 610	was not discontinue 3/11/19 at 1:00 AM and outer aspect of is tender to touch s unable to state how she has left sided w drags her foot or or wheelchair." Additional commen prevent reoccurrene - "Make sure L [left] - "In bed, place pillo 3/17/19 at 2:50 PM bruise noted to left BEFORE resident h unaware of cause." Additional commen prevent reoccurrene - "Verify placement Hoyer" 3/17/19 at 3:00 PM as if resident leaner fell on the floor four Additional commen prevent reoccurrene - "OT to eval for pla put cat on." 3/26/19 at 2:20 PM bed for nap and CN	g to care plan sit to stand use ad until 3/19/19. - "New bruise noted on top left foot (16 cm X 9 cm) site he is poor historian and rinjury occurred. However reakness and sometimes posses her feet in bed and to stand or steps taken to be: If oot is in leg rest." If we between legs / feet." - "8 cm X 7 cm red purple forearm about 10 minutes had fall resident and staff are stand or steps taken to be: If of arms before lifting on - "Unwitnessed fall appears dover to pick up toy cat and and lying on right side." Its and or steps taken to	F 61			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05	/09/2019
	ROVIDER OR SUPPLIER	BURG		3900	EET ADDRESS, CITY, STATE, ZIP CODE I WINDSOR HALL DRIVE LIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Additional comments prevent reoccurrence - "Resident has been L [left] leg off of foot leg." 4/8/19 at 7:50 PM - "bruise noted to left u similar to bruise note probably be from slin. Additional comments prevent reoccurrence - "Resident has been L [left] leg off of foot leg." 4/8/19 at 7:50 PM - "bruise noted to left u similar to bruise noted to left u similar to bruise noted probably be from slin linterview was conduand when asked if shinvestigation of abus me if there is a suspiniterview the residen. When asked who was suspected abuse she supposed to report a my administrator work.	and or steps taken to as and or steps taken to as and or steps taken to as a noted throughout day taking rest when staff elevate left. 4.5 cm X 3.5 cm brown pper forearm appears to be ad in March determined to ag." 5 and or steps taken to as and or steps taken to as an anoted throughout day taking rest when staff elevate left. 4.5 cm X 3.5 cm brown pper forearm appears to be ad in March determined to ag." 5/9/19 at 8:43am an acted with the Social worker he is a part of the e she stated that "They notify cion of abuse and I would t." 1 as responsible for reporting answered "Any employee is ny allegations of abuse and	F	510			
	She indicated that th	e facility started a new					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/09/2019
	ROVIDER OR SUPPLIER	BURG	1	STREET ADDRESS, CITY, STATE, ZIP C 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 610	they review incident reports should have and should have coparties and after the report of identified owould then report. she has not had any new administrator so the conducted with the stated, "If any of outhink something materials abuse they are to resupervisor, and the the DON (Director of According to the factor "Preventing Reside "Injury of unknown for which there is not reasonable explanately physical abuse or mout." "B. [facility name reand procedures to it in situations in which mistreatment and/oproperty is more like the conducted periodical rounds and frequent resident needs are	th the new leadership and the second to the supervisor of the supe	F	510		

AND DLAN OF CORRECTION INTEREST INCIDENTIFICATION NUMBERS		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495402	B. WING		05/09/2019
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 610	supervised and the enhazards. The facility Administra	nvironment is free of ator was made aware of the unknown origin and no	F 61		
	protect the resident, of accidents and/or injuring accidents and/or injuring accidents and/or injuring accidents and/or injuring accidents and accident's diagnoral limited to: traumatic soloss of consciousness muscle weakness, atchyperlipidemia, supraother seizures, attent and cognitive community accident #6 most reciset) (an assessment reference coded as a quarterly had a BIMS (brief intescore of 13, which incognitively intact. Rerequiring assistance of ADL's (activities of data.)	ent MDS (minimum data sool) with an ARD se date) of 3/15/19 was assessment. Resident #6 erview for mental status) dicated Resident #6 was sident #6 was coded as of one staff member for illy living) which included: s, dressing, eating, toileting,			
	Resident #6's nursing	notes dated 7/7/18 reveal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495402	B. WING _	B. WING		05/09/2019	
	IDER OR SUPPLIER	SBURG		STREET ADDRESS, CITY, STATE, ZIP 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		0/03/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
the flocis record the Robert R	cor with feet facing no indication that is ident fall. The consider that was passing a floor in a suping elow waist. Resident pants we consider the consider that is identified to consider the consideration of the consid	age 45 as found "lying supine on the gethe bathroom door." There at anyone witnessed the incident/Accident report states ice and found resident lying on the position near the bathroom. The entition is position near the bathroom. The entition is personal alarm was not entity as attempting to transfer. The Fall Analysis/Investigation stated "removed bed/chair iber." There is no evidence of sing conducted to exclude that not a victim of abuse or neglect. Ispected that Resident #6's innect the bed/chair alarm. Inotes dated 8/2/18 reveal an inouse asked this nurse to look ident's right wrist. Wrist ibruise on dorsum of right wrist if cm. No guarding, "grimacing palpation of area. Resident was ingo of upper extremities on prior resident as needed." [sic] inotes dated 8/1/18 there were were no other entries on the dicate resident had flailing of as noted in the incident note, need. Review of Bruise/Skin estigation form under additional "timing of injury unknown.	F6	310			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05/	09/2019
	ROVIDER OR SUPPLIER	BURG	•	390	REET ADDRESS, CITY, STATE, ZIP CODE 00 WINDSOR HALL DRIVE ILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	measures were take while an investigation. Nursing notes reveal 22:19 that read, "Resounding. CNA note the floor in the bathrowheelchair behind he abrasion red in color 2.0 cm to her back." Report stated, "Resice sounding. This nurs room by CNA who stand the color with her wher." The Fall analyst revealed that no staff the CNA post fall into one was with the fell. Review of nursing note an entry dated 8/21/"during weekly skin a bruise on resident's in purple and reddish procession.		F	510			
	revealed that no staf An investigation was were taken to protec resident was a victim Nursing notes for Re	sion investigation form f interviews were conducted. not conducted, no measures t Resident #6 in the event the n of abuse. sident #6 revealed an entry :30 that read, "during weekly					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495402	B. WING _		,	05/09/2019
	OVIDER OR SUPPLIER	BURG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	the bruises. Bruises #1-4 on dorsal surface #1 1.7 x 2cm Oval I Reddish purple in the #2 1 x 0.8 cm oval I #3 1/5 x 0.7 cm irre bruise #4 1.7 x 2cm purpli dark purple 0.5 cm irre #5 6 x 11.5 cm blue surface Husband was notified the bruises. He does them." [sic] The brui investigation form revere conducted. Ad "resident seen by CN eye closed and bump today. Bruises were may be an explanation Husband declined get There was a typed stated, "nurse into as fingerlike pattern not palpation." signed by There is no evidence provided that would i conducted or any protaken to protect Resi Review of nursing no an entry dated 10/25 "Resident personal a	detection bruises on right enies knowing how she got on right forearm: the #5 on dorsal and ventral coruise w/Dark purple boarder. The middle bruise, reddish purple gular shaped fading red she has bruise with a spot of a diameter to bruise, lighter on ventral coruise, lighter on ve	F 6	10		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		495402	B. WING		0	5/09/2019	
	ROVIDER OR SUPPLIER	BURG	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 610	to use her call bell for resident has been as reach and resident k for assistance." Rev analysis/investigation interview section it in didn't respond to the one question which to Only one staff membindicated that Reside to the fall. There is r information provided complete investigation protective measures Resident #6. Review of nursing not a entry dated 10/26/2" "resident was found room after resident padditional information clinical record that w incident of unknown of abuse, was invest the resident protecte investigation. Resident #6's nursing read, "resident was fon her back when per Resident has a abras with bruising." [sic]. tear/abrasion investion one staff member was injury of unknown or any other information a complete investigation.	resident has been reminded or assistance and at this time or sisted and call bell is within nows how to push call bell	F 6	10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		495402	B. WING	····		5/09/2019	
	ROVIDER OR SUPPLIER	eurg	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 610	have "2 new bruise n 3 cm) and top of right Resident is a poor his cognitive communical state when bruises or bruise/skin tear/abrass reveals that no staff of the injury of unknown evidence or any other would indicate a commoducted or any protaken to protect Resimilar of concern on bouriters attention. On there is pink area of 0.7 cm. There are a superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the injury of unknown the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the larges gluteal cleft. " [sic] Rabrasion investigation with the superior to the	om Resident #6 was noted to oted to top of right wrist (2 x throrarm (0.5 x 1.2 cm). Storian d/t dementia and tition deficit and is unable to occurred. " [sic] Review of the sion investigation form were interviewed regarding in origin. There is no information provided that splete investigation was oftective measures were dent #6. That on 12/24/18 at 5:40pm ting resident she noticed auttock and brought it to this right side of the gluteal cleft denuded skin measuring 1 x few much smaller lesions of the teview of the bruise/skin tear/in form reveals that Resident wable". No staff were gone the injury of unknown vidence or any other that would indicate a sin was conducted or any were taken to protect. In ontes had an entry dated a pruise on the dorsum of and. 4 x 3 cm ovoid soft the a little reddish purple,	F 61				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495402 B. WING		05/09/2019	
WINDSORMEADE OF WILLIAMSBURG	REET ADDRESS, CITY, STATE, ZIP CODE 00 WINDSOR HALL DRIVE ILLIAMSBURG, VA 23188		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 610 Continued From page 50 F 610			
Review of the bruise/skin tear/abrasion investigation form states at the subheading resident interview "unreliable answers. answered yes to every question" There is no evidence that any staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. On 2/13/19 at 8am nursing notes for Resident #6 revealed and read "bruise on right forearm noticed during weekly skin assessment. 3 x 3.5 cm irregularly shaped bruise on dorsal surface of distal forearm. It is dark purple with a reddish purple boarder, resident denies pain at the site. Resident is unable to tell me how is occurred." [sic] Review of the bruise/skin tear/ abrasion investigation form reveals that only one staff member was interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted or any protective measures were taken to protect Resident #6. On 2/16/19 at 4:03am a nursing note entry for Resident #6 read, "new bruise seen on right hand (6 x 5 cm). Resident is a poor historian and unable to state how injury occurred. Resident is prone to frequent injuries from her hitting her arm on things." Review of the bruise/skin tear/ abrasion investigation form reveals no staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation form reveals no staff were interviewed regarding the injury of unknown origin. There is no evidence or any other information provided that would indicate a complete investigation was conducted.			

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
		495402	B. WING _			5/09/2019	
	ROVIDER OR SUPPLIER	ISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		-		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	dated 4/6/19 at 8: right forearm notic AM right forearm bruise. Dark purpraised. Red purpl denies pain. She and right arm. Reunable to tell me whow it happened. this AM. He does Review of the bru investigation form "non-interviewable regarding the injurno evidence or an that would indicate conducted or any taken to protect R Nursing note date an entry at 15:15 alarm on back of twas found on the door on her back. did not have to us resident fell." [sic abrasion investigating staff member was injury of unknown any other informa a complete invest On 5/9/19 at 8:43 with Employee C, asked if she was a origin for Residen specifically, it was	Resident #6 revealed an entry 10am that read, "new bruise sed while toileting resident this a dorsal surface 3.2 x 1.8 cm le in the center and slightly e in the periphery. Resident has good ROM of right wrist esident has aphasia and is when the bruise appeared or Husband noticed the bruise not know how it happened." ise/skin tear/ abrasion reveals that Resident #6, was e.". No staff were interviewed by of unknown origin. There is y other information provided a complete investigation was protective measures were	F6				

	OF DEFICIENCIES CORRECTION			, ,	(X3) DATE SURVEY COMPLETED	
		495402	B. WING		05/0	09/2019
	ROVIDER OR SUPPLIER	BURG	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	abused. She is not up as someone for a identified the nurse interview. Any emplany suspicion of abuwould call me. I try and I don't' really red. When asked if one repaperwork is concerdefinitely hear your suspected it with he never seen these rehave been made away to the supervisor but to me to interview all there are concerns in would report the incipation of the supervisor to moducted with the feasked if she knew the unknown origin and #6 has sustained, the can't answer, I don's she is ataxic and do. The Administrator we stated "they investig	long those lines as being someone that has ever come abuse. When abuse is does an interview, I do an oyee is supposed to report use and my Administrator to visit this resident weekly call seeing any bruises. " esident with this amount of ming, the SW stated, "I concerns. I've just never r. This is concerning, I've ports. Yes, I probably should trare. It should have been told at this should have also come I parties. After my report, if dentified the Administrator dents. I haven't had a referral new Administrator started." 9 AM an interview was accility Administrator. When he cause of the injuries of multitude of bruises Resident the Administrator stated, "I taknow what meds she is on, es a lot of failing." as made aware that the SW attention and the sum and the	F 6	10		
	abuse allegations is Administrator stated concern, or they thir the heading of abus administrative super call myself and the I	ted reporting, but reporting of not occurring." The , "if any of our team has a lak something may be under e they are to report it to their visor, and then immediately DON (Director of Nursing)."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495402	B. WING			05/09/2019
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS, CITY, STATE, ZIP COD 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	•	3500372013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 610	looks like a hand prin I would be questionin depending on the plat When an injury occur occurred. I would loo lab draw, if we don't I there is no reasonablis an injury of unknow reported no later than hospitalization or sign time frame." When asked why repadministrator stated, prior to Jan 5. I was different DON." She injuries of unknown of her tenure. The Admin o problem at all reposkin tear, if we look a can't give an answer immediate answer, where the different prints and that would would investigate. I would investigate. I would investigate. I would would investigate would investigate would investigate. I would would investigate would investigate. I would would investigate would inv	the Administrator stated, "if it tot, something out of ordinary, and the tright away, and cement of where things are. It is and no one knows how it tok, I would ask if they had a know how it happened, if the expectation. When there we source it should be a 24 hours, if there is an injury you have a two hour torting is not happening the "I can't answer for anything not here, we did have a was shown there were six origin for Resident #6 since sinistrator then said, "I have corting every bruise and every to it immediately and if we if we don't have an the will report it."	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING _			05	/09/2019
	ROVIDER OR SUPPLIER	URG		STREET ADDRESS 3900 WINDSOR H WILLIAMSBURG			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD R-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	reporting. This nurse ,who didn't like being She is a board certific Review of the facility Resident Abuse" with has a subheading of of unknown origin- ar which there is no known explanation, and for wabuse or mistreatmen. Under the policy sublemost being the facility name will procedures to identify situations in which about and/or misappropriation more likely to occur." Under the policy sublemost likely to occur."	e is also a medical doctor, a doctor and is a nurse. ed practitioner. policy titled "Preventing a revision date of 6/1/18 Procedure that read: "Injury by injury to a resident for two etiology or reasonable which an origin in physical and cannot be ruled out." meading, Prevention, it read maintain protocols and by, correct and intervene in two energies, neglect, mistreatment ion of resident property is meading, Identification, it ation and annually at a bers will be educated on writing important information condition or behavior. Team aged and protocols will be the timely identification and uch as suspicious bruising	F6	10	SELIGITION		
	that may constitute at direction of the invest B. Team members ar correct, and intervend abuse, neglect and/o resident property is n Immediately following safety, team member or observation of abu	e encouraged to identify, e in situations in which r misappropriation of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495402	B. WING			05/	09/2019
	ROVIDER OR SUPPLIER MEADE OF WILLIAMSE	URG	·	39	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WINDSOR HALL DRIVE VILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 55	F	610			
	C. Resident and enviconducted periodical rounds and frequent resident needs are bethe plan of care, that supervised and the enazards. D. Administrative and supervise team membehaviors, action and needs." Under the policy subfread, "A. designated immediately review a or observations of abconduct analysis for to incidents [i.e. falls, of unknown origin, unreportable incidents, bodies, such as the leas directed by the addesignee and in account and local law." Under the policy subfraction in the event of an abuse, [facility name resident, notify the prepresentative, and president's plan of car interventions to minimany injury or harm ide of the resident."	ronmental rounds will be by throughout the day. These monitoring are to ensure leing met in accordance with residents are being invironment is free of a facility leadership staff will bers to identify inappropriate a response to resident in team members will ind investigate all allegations use. B. [facility name] will interest and patterns related skin tears, bruising or injury insual occurrences, etc.] C. outside investigative local police will be contacted ministrator or his or her ordance with federal, state in eading, Protection, it read, allegation or observation of will immediately assess the hysician and resident into the resident and other or harm or incident. B. The lead will be revised to reflect inize recurrence and to treat entified through assessment.					
	"A. [facility name] will	neading, Reporting, it read, maintain systems to ensure involving abuse, neglect,					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ONID NO. 0930-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495402	B. WING		05/09/2019
	ROVIDER OR SUPPLIER	BURG		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE COMPLETION
F 610	unknown source and property, are reported than 2 hours after the events that cause the result in serious bodi hours if the events the not involve abuse and bodily injury, to the adhis or her designee, a (including to the State protective services wight jurisdiction in long-ted accordance with State procedures. B. Each reporter shall report if than 2 hours after for events that cause the bodily injury or crime the events that cause the bodily injury or crime the events that cause serous bodily injury. To local law enforcem reasonable suspicion individual who is a refrom, the facility. Not County Police is to be number listed]. C. Thimmediately report all neglect, abuse, inclusiource, mistreatment resident property, by on behalf of the provints or her designee of all investigations at the State Survey Age the incident, and if the appropriate corrective and the state survey and the property of the incident, and if the appropriate corrective and the state survey an	atment, including injuries of misappropriation of resident d immediately, but not later e allegation is made, if the e allegation involve abuse or ly injury; or not later than 24 hat cause the allegation do d do not result in serious dministrator of the facility, or and to other officials e Survey Agency and adult there state law provides for rm care facilities) in the law through established covered individual/mandated mmediately, but not later rming the suspicion, if the e suspicion result in serious, or not later than 24 hours if e suspicion doe not result in i. The organization will report ment agencies any of a crime against any esident of, or is receiving care tification to the James City e made by contacting [phone	F 610		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMP	SURVEY
		495402	B. WING_			05/	09/2019
	ROVIDER OR SUPPLIER	URG	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 57	F	510			
	Resident #6 was free of day meeting on 5/9						
F 656 SS=D	No further information Develop/Implement (CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F	656			6/23/19
	implement a compred care plan for each resident rights set for §483.10(c)(3), that in objectives and timefromedical, nursing, and needs that are identificassessment. The cordescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, including treatment under §483 (iii) Any specialized serenabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv)In consultation wit resident's represental	cility must develop and mensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's id mental and psychosocial fied in the comprehensive inprehensive care plan must in graph of the comprehensive in the sident's highest practicable in psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required in the right to refuse its exercise of rights in the right to refuse its entire indicate its ent's medical record.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495402	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	BURG	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	1 00/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 656	(B) The resident's prefuture discharge. Fa whether the resident community was assel local contact agencia entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observative documentation reviet the facility staff failed comprehensive, resione Resident (Residual 13 residents.) For Resident #1, the a comprehensive ca areas on the MDS (It cognitive loss/dements behavioral symptom) The findings include Resident #1, an 85 yield the facility on 2/4/19 not limited to respiral muscle weakness, and Resident #1's most it (assessment reference coded as an admission stay. Resident #1 wield in the resid	reference and potential for cilities must document It's desire to return to the ressed and any referrals to restaurch the the comprehensive care in the comprehensive care in the comprehensive care with the thin paragraph (c) of this. This not met as evidenced and clinical record review, and restaurch to develop and replan to address triggered winimum Data Set) to include, intia, Urinary incontinence and set. The reference and potential for the restaurch to refer and any referrals to refer and the restaurch to the referrals to refer and the restaurch to refer and the referrals to refe	F 656	1. Resident #1 was identified as affer for failure to address triggered areas identified on the MDS assessment or comprehensive care plan. Resident # has since discharged and corrections could not be made to his individual caplan. 2. All residents residing in the facility the potential to be affected by not had a complete resident-centered comprehensive care plan. 3. All members of the Interdisciplinary Team will be re-educated on the CAA process of the comprehensive MDS assessment and how to address the triggered areas on the comprehensive care plan with appropriate intervention for that resident. 4. The Administrator or designee will perform an audit of 100% of the curreresidents to ensure all areas identified the CAA's have been appropriately comprehensive assessments will be completed for one month. Monthly ongoing audits will be conducted and	h his t1 s are have ving y t e ons ent d on are	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495402	B. WING		05/09/2019		
	ROVIDER OR SUPPLIER	URG	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 656	On 5/8/19, upon furth coded MDS documer Assessment (CAA) S triggered Care Areas Loss/Dementia, Computational/Rehabilitatincontinence and Index Symptoms, Falls, Nut Ulcer, and Psychotropy On 5/8/19 at approximate refused to be interview #1's current care plan revisions/completions Worksheets were required the Director of Nursin On 5/9/19, Resident #1 The care plan did not three of the triggered Section V on the MDS urinary Incontinence, despite that the CAA addressed in the care On 5/9/19 at approximinterviewed with regal and the MDS facility a would expect to find in the part of the residen reviewed Resident #1	er review of the facility at, Section V- Care Area aummary, revealed 9 including: Cognitive munication, ADL tion Potential, Urinary welling Catheter, Behavioral ritional Status, Pressure pic Drug Use. mately 1:30 pm, Resident #1 uietly in a low bed in his nowledge a knock at his red to be sleeping. On ely 9:00 am, Resident including all and Care Area Assessment uested and received from g (DON, Employee B). #1's careplan was reviewed. contain any information for Care Areas (AA) from S: Cognitive Loss/Dementia, and Behavioral Symptoms, stated these items were eplan. mately 12:3, the DON was red to Resident #1's careplan assessment. She stated, "I dentified areas of concern to t's care plan." After she 's care plan, she stated, "I ehaviors and dementia are they should be."	F 656	the QAPI process. 5. The corrective actions will be completed by 6/23/2019.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495402	B. WING		05/09/2019	
NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 657 SS=E	§483.21(b) Compreh §483.21(b)(2) A completion of the comprehensive a (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their resident reprotent practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii) Reviewed and reviteam after each assection comprehensive and cassessments. This REQUIREMENT by: Based on staff interview, and clinical refailed to review and resident, (Resident 13 Residents.	ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined de development of the e staff or professionals in ined by the resident's needs are resident. sized by the interdisciplinary ssment, including both the quarterly review T is not met as evidenced riew, facility documentation ecord review the facility staff evise the careplan for one #6) in a survey sample of	F 65	1. Resident #6 was identified as affect with four occurrences of her care plant being updated following accidents and injuries. All areas have since resolved the care plant has been updated to residents current condition and potent risks.	not I and	
	review and revise the			2. All residents residing in the facility h	ave	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495402	B. WING _				05/09/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
				39	900 WINDSOR HALL DRIVE			
WINDSOF	RMEADE OF WILLIAM	SBURG		W	/ILLIAMSBURG, VA 23188			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From pa	age 61	F	357				
	accidents and/or in prevent reoccurant	njuries of unknown origin to ce.			the potential to be affected by not havi an updated resident-centered comprehensive care plan following	ng		
	The findings includ			changes in condition to include accidents/injuries.				
	Resident #6 was a			3. All nursing staff will be educated on				
	The resident's diag			reporting and documentation of chang				
	limited to: traumation			in condition and licensed nurses will be				
	loss of consciousne muscle weakness,			educated on making revisions to the captain. The 24 hour report will be review				
				by the nursing administration team for	eu			
	hyperlipidemia, supraventricular tachycardia, other seizures, attention and concentration deficit,				identification of changes. The DON or			
	and cognitive com				designee will verify that new intervention	ons		
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			have been added to the care plan. Any			
	Resident #6 most r	recent MDS (minimum data			intervention added to a residents care			
		nt tool) with an ARD			plan will be dated in the text box as the	∍y		
	(assessment refere	ence date) of 3/15/19 was			are entered. Once the intervention is n	0		
	coded as a quarter	ly assessment. Resident #6			longer appropriate it will be resolved.			
		interview for mental status)			4. The Administrator or designee will			
		indicated Resident #6 was			perform an audit to include 100% of al			
		Resident #6 was coded as			accidents/injuries since 5/9/19 to ensu			
		e of one staff member for			all interventions have been care plann			
		daily living) which included:			and are resident centered. This will be			
	1	fers, dressing, eating, toileting,			followed by a 100% audit for one mont			
	personal hygiene,	and bathing.			Monthly ongoing audits will be conduc			
	4 Davieus of David	lant #Clanaumainan water			and reported quarterly through the QA	ΡI		
		lent #6's nursing notes			process.	اء ما		
		5/18, the resident had a			5. The corrective action will be comple	ieu		
	scratch on the top	orner ngirt nanu.			by 6/23/2019.			
		nt #6's careplan revealed that n place or initiated following the						
		/5/18. There were no						
		ntions put in place following this						
		origin and nothing was done to						
	2. Resident #6's nu	ursing notes had an entry dated						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495402	B. WING		05/09/2019
NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188	·
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F 657	that resident was particle pushed w/c back from skin tear to the back bleeding noted to be crescent shape skin. Resident #6's carept or revision following re-occurrence. 3. Nursing notes for entry dated 10/24/18 weekly skin assess for earm. Resident of the bruises. Bruises #1-4 on dorsal surface #1 1.7 x 2cm Oval Reddish purple in th #2 1 x 0.8 cm oval #3 1/5 x 0.7 cm irrestruise #4 1.7 x 2cm purpl dark purple 0.5 cm in #5 6 x 11.5 cm blue surface Review of Resident any mention of this in prevent re-occurrence. 4. Review of nursing revealed an entry daread, "Resident persons resident was found in the skin teach i	at read, "CNA informed writer riticipating in an activity and m table and staff noticed a of right hand. Slight lock of right hand and 1.0 tear noted." [sic] an did not reveal any review this incident to prevent Resident #6 revealed an at 17:30 that read, "during ment noticed bruises on right lenies knowing how she got to on right forearm: ce #5 on dorsal and ventral bruise w/Dark purple boarder. The middle bruise, reddish purple egular shaped fading red ish red bruise with a spot of an diameter er bruise, lighter on ventral the foreast and the reveal of the foreast and the reveal of the diameter er bruise, lighter on ventral the foreast and the reveal of the reveal	F 65	57	

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 63 about 10 minutes prior to and resident has been reminded to use her call bell for assistance and at this time resident has been assisted and call bell is within reach and resident knows how to push call bell for assistance." Review of Resident #6's careplan reveals that this incident was not addressed in the careplan and no interventions were put in place to prevent re-occurrence. Review of the facility policy, titled "Care Planning" with a revision date of 6/1/18, read "The comprehensive care plan will: a. Incorporate identified problem areas; b. incorporate risk factors associated with identified problems; c. build on the resident's strengths; d. be culturally competent and trauma-informed as applicable; e. reflect treatment goals, timetables and objectives in measurable outcomes; f. identify the professional services that are responsible for each element of care; g. aide in preventing or		F 65	57	
	status and/or function resident safety; i. en of the resident by for program; and j. reflestandards of practice conditions." The facility Administration and the facility and the facility states.				