STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/8/19 through 5/9/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 05/08/19 through 05/09/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 22 certified bed, facility was 17 at the time of the survey. The survey sample consisted of 13 resident reviews.	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation	F 607	1. Medical records were reviewed for	6/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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F 607

Continued From page 1

and clinical record review the facility staff failed to implement abuse policy for 2 Residents (Resident #5 and Resident #6) in a survey sample of 13 Residents.

1. For Resident #5 the facility staff failed to implement their abuse policy by not investigating and reporting of allegations of abuse or neglect and injuries of unknown source.

2. For Resident #6, the facility staff failed to implement their abuse policy as evidenced by not investigating and reporting abuse or neglect; not protecting during the investigation; and not reporting injuries of unknown source.

The findings include:

1. For Resident #5 the facility staff failed to implement their abuse policy by not investigating and reporting of allegations of abuse or neglect and injuries of unknown source.

Resident #5 is a 96 year old woman admitted to the facility on 4/30/14 with diagnoses of but not limited to Alzheimer's disease, CVA, Unspecified Osteoarthritis, Muscle weakness, Spinal stenosis, Insomnia, and anemia.

The Resident's most recent (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 3/15/19 coded as a Significant change assessment, section C the Resident as having a (Brief Interview of Mental Status) BIMS score of 10 indicating moderate cognitive impairment.

Under G 0100 ADL Assistance the Resident is coded as:

F 607

Resident #5 and #6. Residents # 5 and # 6 were assessed by the nursing team for any potential injuries. Resident #6 was found to be free of injuries of unknown source. Resident # 5 was noted to have bruises of unknown origin and a report was forwarded to OLC on 5/9/19. Follow up report was sent to OLC on 5/15/19. Abuse Policies and Procedures were reviewed, and no changes were made at this time, as current policy and procedure meets the regulations and standards of care.

2. All residents in the facility have the potential to be affected by failure to investigate abuse allegations and injuries of unknown source in accordance with the abuse policies and procedures. The Administrator and Director of Nursing have completed an audit to include 100% of all accidents/injuries since 5-9-19 to screen for potential injuries of unknown source and/or abuse allegations. All reports as required have been forwarded to OLC.

3. All team members will be re-educated on the identification and definition of injuries of unknown source. The investigation procedures have been revised with new guidance for team members related to the completion of investigations. Facility will re-educate all team members on the abuse policy and procedure to include investigations and IMMEDIATE reporting to the Administrator/designee with emphasis placed on all injuries of unknown source.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 2 A. Bed mobility - 3 = Extensive Assistance - 2 = 1 person physical assistance B. Transfer - 3 = Extensive Assistance - 2 = 1 person physical assistance C. Walk in room - 8 = Activity did not occur D. Walk in corridor - 8 = Activity did not occur The Resident is also coded under section G 0300 -Balance during Transition and moving: A. Moving from seated to standing position - 8 = Action did not occur B. Walking - 8 = Action did not occur C. Turning around and facing opposite direction while walking. - 8 = Action did not occur D. Moving on and off toilet - 2 = Not steady only able to stabilize with human assistance E. Surface to surface transfer - 2 = Not steady only able to stabilize with human assistance On 5/8/19 it was discovered that between 5/1/2018 and 5/8/2019 the Resident had 34 facility incidents reports completed. Of the 34 incidents: 19 were injuries of unknown source 11 were unwitnessed falls (found on floor) 3 witnessed falls (1 of which involved the use of a sit to stand lift) 1 Elopement According to the incident reports the most recent incidents include: 3/5/19 at 7:00 AM - "red /black bruise noted this AM to Left front calf measuring 15 cm X 7 cm also during the last day increased left sided weakness noted resident and staff are unsure	F 607	Abuse Policies and Procedures will be reviewed with all new team members on hire and at minimum annually with all team members. 4. All allegations of abuse/reports of injuries of unknown source will be reported immediately to OLC and internal investigations will be initiated. A 100% audit of all accidents/incidents/injuries will be completed by the Administrator, Director of Nursing, and/or designee within 72 hours to ensure that any potential reportable incidents have been reported and residents are safe and protected from harm. The Administrator and Director of Nursing will complete monthly tracking analysis on all incidents to identify patterns and/or trends related to injuries of unknown source. This audit will be ongoing to ensure compliance with abuse policy/procedures and regulatory guidelines and will be reported and reviewed quarterly through the QAPI process. 5. All corrective actions will be completed by 6/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607		F 607		

Continued From page 3
how bruise occurred but it could be related to sit to stand usage."

However, according to care plan sit to stand use was not discontinued until 3/19/19.

3/11/19 at 1:00 AM - "New bruise noted on top and outer aspect of left foot (16 cm X 9 cm) site is tender to touch she is poor historian and unable to state how injury occurred. However she has left sided weakness and sometimes drags her foot or crosses her feet in bed and wheelchair."

Additional comments and or steps taken to prevent reoccurrence:
- "Make sure L [left] foot is in leg rest."
- "In bed, place pillow between legs / feet."

3/17/19 at 2:50 PM - "8 cm X 7 cm red purple bruise noted to left forearm about 10 minutes BEFORE resident had fall resident and staff are unaware of cause."

Additional comments and or steps taken to prevent reoccurrence:
- "Verify placement of arms before lifting on Hoyer"

3/17/19 at 3:00 PM - "Unwitnessed fall appears as if resident leaned over to pick up toy cat and fell on the floor found lying on right side."

Additional comments and or steps taken to prevent reoccurrence:
- "OT to eval for placement of half tray (flip up) to put cat on."

3/26/19 at 2:20 PM - "Resident was being put to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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F 607	Continued From page 4	F 607		

bed for nap and CNA seen [sic] dried blood on resident support hose and writter [sic] went to assess and the area was dry and no active bleeding and had a bruise around skin tear."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling." 5/9/19 at 8:43am an Interview was conducted with the Social worker and when asked if she is a part of the investigation of abuse she stated that "They notify me if there is a suspicion of abuse and I would interview the resident."

When asked who was responsible for reporting suspected abuse she answered "Any employee is supposed to report any allegations of abuse and my administrator would call me."

When asked had she seen all of the incidents of injuries of unknown origin she stated "It is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 5	F 607		

concerning that I have never seen these reports"

She indicated that the facility started a new morning meeting with the new leadership and they review incidents. She indicated that the reports should have been told to the supervisor and should have come to her to interview all parties and after the Administrator receives her report of identified concerns, the Administrator would then report. She further elaborated that she has not had any abuse referrals since the new administrator started.

On 5/9/19/ at 9:30 AM an interview was conducted with the CEO and the Administrator stated, "If any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)."

According to the facility abuse policy:

"Preventing Resident Abuse"

"Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

"B. [facility name redacted] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur."

C. Resident and environmental rounds will be conducted periodically throughout the day. These

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ____ B. WING ____	05/09/2019

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F 607	Continued From page 6	F 607		

rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being supervised and the environment is free of hazards.

The facility Administrator was made aware of the issues with injuries of unknown origin and no further information was provided.

2. For Resident #6, the facility staff failed to implement their abuse policy as evidenced by not investigating and reporting abuse or neglect; not protecting during the investigation; and not reporting injuries of unknown source.

Resident #6 was admitted to the facility on 6/8/19. The resident's diagnoses included but were not limited to: traumatic subdural hemorrhage without loss of consciousness, UTI, multiple fx of rib, muscle weakness, ataxia, essential hypertension, hyperlipidemia, supraventricular tachycardia, other seizures, attention and concentration deficit, and cognitive communication deficit,

Resident #6 most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/15/19 was coded as a quarterly assessment. Resident #6 had a BIMS (brief interview for mental status) score of 13, which indicated Resident #6 was cognitively intact. Resident #6 was coded as requiring assistance of one staff member for ADL's (activities of daily living) which included: bed mobility, transfers, dressing, eating, toileting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 7 personal hygiene, and bathing. Resident #6's nursing notes dated 7/7/18 reveal that the resident was found "lying supine on the floor with feet facing the bathroom door." There is no indication that anyone witnessed the resident fall. The Incident/Accident report states "CNA was passing ice and found resident lying on the floor in a supine position near the bathroom. Resident pants were unzippered and hanging below waist. Resident was able to move all four extremities without pain. Resident had no injuries. ... resident's personal alarm was not activated. Resident was attempting to transfer w/out assist." [sic] The Fall Analysis/Investigation Form dated 7/7/18 stated "removed bed/chair alarm- family member." There is no evidence of an investigation being conducted to exclude that the resident was not a victim of abuse or neglect. The facility staff suspected that Resident #6's spouse failed to connect the bed/chair alarm. This injury of unknown origin was not reported to the Office of Licensure and Certification. Review of nursing notes dated 8/2/18 reveal an entry that read: "spouse asked this nurse to look at a bruise on resident's right wrist. Wrist examined. Noted bruise on dorsum of right wrist measuring 7cm x 7 cm. No guarding, ,grimacing or moaning during palpation of area. Resident denied pain in wrist. Notified nursing supervisor was made aware. PA made aware. New order received for ice to affected area. Resident was noted to have flailing of upper extremities on prior shift. Will monitor resident as needed." [sic] Review of nursing notes dated 8/1/18 there were no entries. There were no other entries on the day of 8/2/18 to indicate resident had flailing of upper extremities as noted in the incident note,	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 8 previously mentioned. Review of Bruise/Skin Tear/Abrasion Investigation form under additional comments, it read "timing of injury unknown. Suspect injury occurred last night. Unable to assess what resident was doing since timing unknown." There is no indication on the investigation form that staff were interviewed, any measures were taken to protect Resident #6 while an investigation was being conducted, and the injury of unknown origin was not reported to the Office of Licensure and Certification. Nursing notes revealed an entry on 8/7/18 at 22:19 that read, "Resident's personal alarm was sounding. CNA noted resident sitting upright on the floor in the bathroom in her room with the wheelchair behind her. Resident sustained an abrasion red in color and measuring 11.0 cm x 2.0 cm to her back." The Incident/Accident Report stated, "Resident's personal alarm was sounding. This nurse was called to resident's room by CNA who stated Resident is on the floor. Resident was noted sitting upright on floor in her bathroom with her wheelchair immediately behind her." The Fall analysis/investigation form revealed that no staff interviews were conducted. The CNA post fall investigation form revealed that no one was with the resident when Resident #6 fell. This unwitnessed event was not reported to the Office of Licensure and Certification. Review of nursing notes for Resident #6 revealed an entry dated 8/21/18 at 23:45 which read, "during weekly skin assessment writer noticed bruise on resident's right wrist. 4cm x 2cm dark purple and reddish purple bruise. No swelling. Resident denies pain in right wrist. She does not know how she got the bruise." Under the intervention line: "none" was typed in. The	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 9 bruise/skin tear/abrasion investigation form revealed that no staff interviews were conducted. An investigation was not conducted, no measures were taken to protect Resident #6 in the event the resident was a victim of abuse and the injury of unknown origin was not reported to the Office of Licensure and Certification. Nursing notes for Resident #6 revealed an entry dated 10/24/18 at 17:30 that read, "during weekly skin assessment noticed bruises on right forearm. Resident denies knowing how she got the bruises. Bruises on right forearm: #1-4 on dorsal surface #5 on dorsal and ventral surface #1 1.7 x 2cm Oval bruise w/Dark purple boarder. Reddish purple in the middle #2 1 x 0.8 cm oval bruise, reddish purple #3 1/5 x 0.7 cm irregular shaped fading red bruise #4 1.7 x 2cm purplish red bruise with a spot of dark purple 0.5 cm in diameter #5 6 x 11.5 cm blue bruise, lighter on ventral surface Husband was notified at 11:45am. He has seen the bruises. He does not know how she got them." [sic] The bruise/skin tear/ abrasion investigation form revealed no staff interviews were conducted. Additional comments read as, "resident seen by CNA reaching for walker with eye closed and bumping/hitting rt arm on walker today. Bruises were preset prior to this, however may be an explanation for how it occurred. Husband declined geri sleeves in past." [sic] There was a typed statement dated 10/26/18 that stated, "nurse into assess areas to right arm. No fingerlike pattern noted, no pain noted on palpation." signed by the director of nursing.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ____ B. WING ____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 10	F 607		

There is no evidence or any other information provided that would indicate an 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.

Review of nursing notes for Resident #6 revealed an entry dated 10/25/18 at 14:57 that read, "Resident personal alarm sound and resident was found in the bathroom unassisted standing and resident was taken to the bathroom 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 the fall analysis/investigation form under the resident interview section it indicated that Resident #6 didn't respond to the questions asked except for one question which the resident responded no to. Only one staff member was interviewed and they indicated that Resident #6 was "cooperative" prior to the fall. 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.

Review of nursing note for Resident #6, revealed a entry dated 10/26/18 at 10:15am that read, "resident was found sitting on the floor in her room after resident personal alarm sounded." No additional information was found in the entire clinical record that would indicate that this incident of unknown origin, which is an allegation of abuse, was investigated, staff interviewed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188**

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F 607	Continued From page 11	F 607		

resident protected during the course of an investigation, measures taken to prevent reoccurrence, or that the injury of unknown origin was reported to the Office of Licensure and Certification.

Resident #6's nursing notes on 12/5/18 at 7:15am read, "resident was found in her bathroom lying on her back when personal alarm went off. Resident has a abrasion to her right index finger with bruising." [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. This injury of unknown origin was not reported to the Office of Licensure and Certification.

On 12/11/18 at 3:00pm Resident #6 was noted to have "2 new bruise noted to top of right wrist (2 x 3 cm) and top of right forearm (0.5 x 1.2 cm). Resident is a poor historian d/t dementia and cognitive communication deficit and is unable to state when bruises occurred. " [sic] Review of the bruise/skin tear/abrasion investigation form reveals that 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.

Nursing notes reveal that on 12/24/18 at 5:40pm "while CNA was toileting resident she noticed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	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 noticed during weekly skin assessment. 3 x 3.5	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 13 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 was conducted. Nursing notes for Resident #6 revealed an entry dated 4/6/19 at 8:10am that read, "new bruise right forearm noticed while toileting resident this AM right forearm, dorsal surface 3.2 x 1.8 cm bruise. Dark purple in the center and slightly raised. Red purple in the periphery. Resident denies pain. She has good ROM of right wrist and right arm. Resident has aphasia and is unable to tell me when the bruise appeared or how it happened. Husband noticed the bruise this AM. He does not know how it happened." Review of the bruise/skin tear/ abrasion investigation form reveals that Resident #6, was "non-interviewable". No staff were interviewed	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 14	F 607		

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.

Nursing note dated 4/30/19 for Resident #6 had an entry at 15:15 that read, "resident's personal alarm on back of the w/c went off and resident was found on the floor in from of the bathroom door on her back. resident was put on toilet, but did not have to use it. unable to determine why resident fell." [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.

On 5/9/19 at 8:43am an interview was conducted with Employee C, the SW (Social Worker). When asked if she was aware of the injuries of unknown origin for Resident #6, the SW stated, "I don't specifically, it was reported or identified as abuse. This is not a resident that has ever been identified to me as a referral along those lines as being abused. She is not someone that has ever come up as someone for abuse. When abuse is identified the nurse does an interview, I do an interview. Any employee is supposed to report any suspicion of abuse and my Administrator would call me. I try to visit this resident weekly and I don't' really recall seeing any bruises. "

When asked if one resident with this amount of paperwork is concerning, the SW stated, "I definitely hear your concerns. I've just never

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 15	F 607		

suspected it with her. This is concerning, I've never seen these reports. Yes, I probably should have been made aware. It should have been told to the supervisor but this should have also come to me to interview all parties. After my report, if there are concerns identified the Administrator would report the incidents. I haven't had a referral for abuse since the new Administrator started."

On 05/09/19 at 09:39 AM an interview was conducted with the facility Administrator. When asked if she knew the cause of the injuries of unknown origin and multitude of bruises Resident #6 has sustained, the Administrator stated, "I can't answer , I don't know what meds she is on, she is ataxic and does a lot of failing."

The Administrator was made aware that the SW stated "they investigate prior to reporting, she talked about mandated reporting, but reporting of abuse allegations is not occurring." The Administrator stated, "if any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)." When asked what would make them think an allegation of abuse, the Administrator stated, "if it looks like a hand print, something out of ordinary, I would be questioning that right away, and depending on the placement of where things are. When an injury occurs and no one knows how it occurred. I would look, I would ask if they had a lab draw, if we don't know how it happened, if there is no reasonable expectation. When there is an injury of unknown source it should be reported no later than 24 hours, if there is hospitalization or sign injury you have a two hour time frame."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 16	F 607		

When asked why reporting is not happening the Administrator stated, "I can't answer for anything prior to Jan 5. I was not here, we did have a different DON." She was shown there were six injuries of unknown origin for Resident #6 since her tenure. The Administrator then said, "I have no problem at all reporting every bruise and every skin tear, if we look at it immediately and if we can't give an answer if we don't have an immediate answer, we will report it."

The Administrator was advised of the injury of unknown origin on 10/24/18 that appeared to be a hand print, the Administrator said "If saw hand prints and that would raise my concern and I would investigate. I would talk to all team members, would talk to spouse, and the direct care team. I would want to know if anyone saw anything, someone maybe said she went to fall and they went to grab her, etc. I would be concerned about possible abuse." When asked about next steps, The Administrator stated, "the nurse would then call the DON and myself, I have a concern here, I would send it in to you. If there is any thought that this could be abuse, it would be reported. A nurses writing the report is self reporting. This nurse is also a medical doctor, ,who didn't like being a doctor and is a nurse. She is a board certified practitioner.

Review of the facility policy titled "Preventing Resident Abuse" with a revision date of 6/1/18 has a subheading of Procedure that read: "Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 17	F 607		

Under the policy subheading, Prevention, it read "b. [facility name] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur."

Under the policy subheading, Identification, it read "a. during orientation and annually at a minimum, team members will be educated on observation and reporting important information about resident care, condition or behavior. Team members are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.
B. Team members are encouraged to identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, team members are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member.
C. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being supervised and the environment is free of hazards.
D. Administrative and facility leadership staff will supervise team members to identify inappropriate behaviors, action and response to resident needs."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 18	F 607		

Under the policy subheading, Investigation, it read, "A. designated team members will immediately review and investigate all allegations or observations of abuse. B. [facility name] will conduct analysis for trends and patterns related to incidents [i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.] C. outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee and in accordance with federal, state and local law."

Under the policy subheading, Protection, it read, "A. In the event of an allegation or observation of abuse, [facility name] will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. B. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident."

Under the policy subheading, Reporting, it read, "A. [facility name] will maintain systems to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 607	Continued From page 19 jurisdiction in long-term care facilities) in accordance with State law through established procedures. B. Each covered individual/mandated reporter shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or crime, or not later than 24 hours if the events that cause suspicion doe not result in serous bodily injury. i. The organization will report to local law enforcement agencies any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Notification to the James City County Police is to be made by contacting [phone number listed]. C. The organization will immediately report all alleged violations involving neglect, abuse, including injuries or unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee of the facility. D. The results of all investigations are to be communicated to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken." The facility Administrator and DON were made aware of the facility staff's failure to ensure Resident #6 was free from abuse during the end of day meeting on 5/9/19. No further information was provided.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 20 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to report injuries of unknown origin for two Residents (Resident #6 and Resident #5) in a survey sample of 13 Residents. 1. For Resident #6, the facility staff failed to report accidents and injuries of unknown origin, which were allegations of abuse or neglect. 2. For Resident #5 the facility staff failed to report of allegations of abuse or neglect to include lack	F 609	1. Medical records were reviewed for Resident #5 and #6. Residents # 5 and # 6 were assessed by the nursing team for any potential injuries. Resident #6 was found to be free of injuries of unknown source. Resident # 5 was noted to have bruises of unknown origin and a report was forwarded to OLC on 5/9/19. Follow up report was sent to OLC on 5/15/19. Abuse Policies and Procedures were reviewed, and no changes were made at this time, as current policy and procedure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 609

Continued From page 21

of supervision and injuries of unknown origin.

The findings included:

1. For Resident #6, the facility staff failed to report accidents and injuries of unknown origin, which were allegations of abuse or neglect.

Resident #6 was admitted to the facility on 6/8/19. The resident's diagnoses included but were not limited to: traumatic subdural hemorrhage without loss of consciousness, UTI, multiple fx of rib, muscle weakness, ataxia, essential hypertension, hyperlipidemia, supraventricular tachycardia, other seizures, attention and concentration deficit, and cognitive communication deficit,

Resident #6 most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/15/19 was coded as a quarterly assessment. Resident #6 had a BIMS (brief interview for mental status) score of 13, which indicated Resident #6 was cognitively intact. Resident #6 was coded as requiring assistance of one staff member for ADL's (activities of daily living) which included: bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.

Resident #6's nursing notes dated 7/7/18 reveal that the resident was found "lying supine on the floor with feet facing the bathroom door." There is no indication that anyone witnessed the resident fall. The Incident/Accident report states "CNA was passing ice and found resident lying on the floor in a supine position near the bathroom. Resident pants were unzippered and hanging below waist. Resident was able to move all four

F 609

meets the regulations and standards of care.

2. All residents in the facility have the potential to be affected by failure to investigate abuse allegations and injuries of unknown source in accordance with the abuse policies and procedures. The Administrator and Director of Nursing have completed an audit to include 100% of all accidents/injuries since 5-9-19 to screen for potential injuries of unknown source and/or abuse allegations. All reports as required have been forwarded to OLC.

3. All team members will be re-educated on the identification and definition of injuries of unknown source. The investigation procedures have been revised with new guidance for team members related to the completion of investigations. Facility will re-educate all team members on the abuse policy and procedure to include investigations and IMMEDIATE reporting to the Administrator/designee with emphasis placed on all injuries of unknown source. Abuse Policies and Procedures will be reviewed with all new team members on hire and at minimum annually with all team members.

4. All allegations of abuse/reports of injuries of unknown source will be reported immediately to OLC and internal investigations will be initiated. A 100% audit of all accidents/incidents/injuries will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 22 extremities without pain. Resident had no injuries. ... resident's personal alarm was not activated. Resident was attempting to transfer w/out assist." [sic] The Fall Analysis/Investigation Form dated 7/7/18 stated "removed bed/chair alarm- family member." There is no evidence of an investigation being conducted to exclude that the resident was not a victim of abuse or neglect. The facility staff suspected that Resident #6's spouse failed to connect the bed/chair alarm. This injury of unknown origin was not reported to the Office of Licensure and Certification. Review of nursing notes dated 8/2/18 reveal an entry that read: "spouse asked this nurse to look at a bruise on resident's right wrist. Wrist examined. Noted bruise on dorsum of right wrist measuring 7cm x 7 cm. No guarding, ,grimacing or moaning during palpation of area. Resident denied pain in wrist. Notified nursing supervisor was made aware. PA made aware. New order received for ice to affected area. Resident was noted to have flailing of upper extremities on prior shift. Will monitor resident as needed." [sic] Review of nursing notes dated 8/1/18 there were no entries. There were no other entries on the day of 8/2/18 to indicate resident had flailing of upper extremities as noted in the incident note, previously mentioned. Review of Bruise/Skin Tear/Abrasion Investigation form under additional comments, it read "timing of injury unknown. Suspect injury occurred last night. Unable to assess what resident was doing since timing unknown." There is no indication on the investigation form that staff were interviewed, any measures were taken to protect Resident #6 while an investigation was being conducted, and the injury of unknown origin was not reported to	F 609	be completed by the Administrator, Director of Nursing, and/or designee within 72 hours to ensure that any potential reportable incidents have been reported and residents are safe and protected from harm. The Administrator and Director of Nursing will complete monthly tracking analysis on all incidents to identify patterns and/or trends related to injuries of unknown source. This audit will be ongoing to ensure compliance with abuse policy/procedures and regulatory guidelines and will be reported and reviewed quarterly through the QAPI process. 5. All corrective actions will be completed by 6/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 23	F 609		

the Office of Licensure and Certification.

Nursing notes revealed an entry on 8/7/18 at 22:19 that read, "Resident's personal alarm was sounding. CNA noted resident sitting upright on the floor in the bathroom in her room with the wheelchair behind her. Resident sustained an abrasion red in color and measuring 11.0 cm x 2.0 cm to her back." The Incident/Accident Report stated, "Resident's personal alarm was sounding. This nurse was called to resident's room by CNA who stated Resident is on the floor. Resident was noted sitting upright on floor in her bathroom with her wheelchair immediately behind her." The Fall analysis/investigation form revealed that no staff interviews were conducted. The CNA post fall investigation form revealed that no one was with the resident when Resident #6 fell. This unwitnessed event was not reported to the Office of Licensure and Certification.

Review of nursing notes for Resident #6 revealed an entry dated 8/21/18 at 23:45 which read, "during weekly skin assessment writer noticed bruise on resident's right wrist. 4cm x 2cm dark purple and reddish purple bruise. No swelling. Resident denies pain in right wrist. She does not know how she got the bruise." Under the intervention line: "none" was typed in. The bruise/skin tear/abrasion investigation form revealed that no staff interviews were conducted. An investigation was not conducted, no measures were taken to protect Resident #6 in the event the resident was a victim of abuse and the injury of unknown origin was not reported to the Office of Licensure and Certification.

Nursing notes for Resident #6 revealed an entry dated 10/24/18 at 17:30 that read, "during weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 24 skin assessment noticed bruises on right forearm. Resident denies knowing how she got the bruises. Bruises on right forearm: #1-4 on dorsal surface #5 on dorsal and ventral surface #1 1.7 x 2cm Oval bruise w/Dark purple boarder. Reddish purple in the middle #2 1 x 0.8 cm oval bruise, reddish purple #3 1/5 x 0.7 cm irregular shaped fading red bruise #4 1.7 x 2cm purplish red bruise with a spot of dark purple 0.5 cm in diameter #5 6 x 11.5 cm blue bruise, lighter on ventral surface Husband was notified at 11:45am. He has seen the bruises. He does not know how she got them." [sic] The bruise/skin tear/ abrasion investigation form revealed no staff interviews were conducted. Additional comments read as, "resident seen by CNA reaching for walker with eye closed and bumping/hitting rt arm on walker today. Bruises were preset prior to this, however may be an explanation for how it occurred. Husband declined geri sleeves in past." [sic] There was a typed statement dated 10/26/18 that stated, "nurse into assess areas to right arm. No fingerlike pattern noted, no pain noted on palpation." signed by the director of nursing. There is no evidence or any other information provided that would indicate an 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. Review of nursing notes for Resident #6 revealed an entry dated 10/25/18 at 14:57 that read, "Resident personal alarm sound and resident was	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25	F 609		

found in the bathroom unassisted standing and resident was taken to the bathroom 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 the fall analysis/investigation form under the resident interview section it indicated that Resident #6 didn't respond to the questions asked except for one question which the resident responded no to. Only one staff member was interviewed and they indicated that Resident #6 was "cooperative" prior to the fall. 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.

Review of nursing note for Resident #6, revealed a entry dated 10/26/18 at 10:15am that read, "resident was found sitting on the floor in her room after resident personal alarm sounded." No additional information was found in the entire clinical record that would indicate that this incident of unknown origin, which is an allegation of abuse, was investigated, staff interviewed, resident protected during the course of an investigation, measures taken to prevent reoccurrence, or that the injury of unknown origin was reported to the Office of Licensure and Certification.

Resident #6's nursing notes on 12/5/18 at 7:15am read, "resident was found in her bathroom lying on her back when personal alarm went off. Resident has a abrasion to her right index finger

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 26	F 609		

with bruising." [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. This injury of unknown origin was not reported to the Office of Licensure and Certification.

On 12/11/18 at 3:00pm Resident #6 was noted to have "2 new bruise noted to top of right wrist (2 x 3 cm) and top of right forearm (0.5 x 1.2 cm). Resident is a poor historian d/t dementia and cognitive communication deficit and is unable to state when bruises occurred. " [sic] Review of the bruise/skin tear/abrasion investigation form reveals that 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.

Nursing notes reveal that on 12/24/18 at 5:40pm "while CNA was toileting resident she noticed 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 27 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. Nursing notes for Resident #6 revealed an entry dated 4/6/19 at 8:10am that read, "new bruise right forearm noticed while toileting resident this AM right forearm, dorsal surface 3.2 x 1.8 cm bruise. Dark purple in the center and slightly raised. Red purple in the periphery. Resident denies pain. She has good ROM of right wrist and right arm. Resident has aphasia and is unable to tell me when the bruise appeared or how it happened. Husband noticed the bruise this AM. He does not know how it happened." Review of the bruise/skin tear/ abrasion investigation form reveals that Resident #6, was	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 28	F 609		

"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.

On 5/9/19 at 8:43am an interview was conducted with Employee C, the SW (Social Worker). When asked if she was aware of the injuries of unknown origin for Resident #6, the SW stated, "I don't specifically, it was reported or identified as abuse. This is not a resident that has ever been identified to me as a referral along those lines as being abused. She is not someone that has ever come up as someone for abuse. When abuse is identified the nurse does an interview, I do an interview. Any employee is supposed to report any suspicion of abuse and my Administrator would call me. I try to visit this resident weekly and I don't' really recall seeing any bruises. "

When asked if one resident with this amount of paperwork is concerning, the SW stated, "I definitely hear your concerns. I've just never suspected it with her. This is concerning, I've never seen these reports. Yes, I probably should have been made aware. It should have been told to the supervisor but this should have also come to me to interview all parties. After my report, if there are concerns identified the Administrator would report the incidents. I haven't had a referral for abuse since the new Administrator started."

On 05/09/19 at 09:39 AM an interview was conducted with the facility Administrator. When asked if she knew the cause of the injuries of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29	F 609		

unknown origin and multitude of bruises Resident #6 has sustained, the Administrator stated, "I can't answer , I don't know what meds she is on, she is ataxic and does a lot of failing."

The Administrator was made aware that the SW stated "they investigate prior to reporting, she talked about mandated reporting, but reporting of abuse allegations is not occurring." The Administrator stated, "if any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)." When asked what would make them think an allegation of abuse, the Administrator stated, "if it looks like a hand print, something out of ordinary, I would be questioning that right away, and depending on the placement of where things are. When an injury occurs and no one knows how it occurred. I would look, I would ask if they had a lab draw, if we don't know how it happened, if there is no reasonable expectation. When there is an injury of unknown source it should be reported no later than 24 hours, if there is hospitalization or sign injury you have a two hour time frame."

When asked why reporting is not happening the Administrator stated, "I can't answer for anything prior to Jan 5. I was not here, we did have a different DON." She was shown there were six injuries of unknown origin for Resident #6 since her tenure. The Administrator then said, "I have no problem at all reporting every bruise and every skin tear, if we look at it immediately and if we can't give an answer if we don't have an immediate answer, we will report it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30	F 609		

The Administrator was advised of the injury of unknown origin on 10/24/18 that appeared to be a hand print, the Administrator said "If saw hand prints and that would raise my concern and I would investigate. I would talk to all team members, would talk to spouse, and the direct care team. I would want to know if anyone saw anything, someone maybe said she went to fall and they went to grab her, etc. I would be concerned about possible abuse." When asked about next steps, The Administrator stated, "the nurse would then call the DON and myself, I have a concern here, I would send it in to you. If there is any thought that this could be abuse, it would be reported. A nurses writing the report is self reporting. This nurse is also a medical doctor, ,who didn't like being a doctor and is a nurse. She is a board certified practitioner.

Review of the facility policy titled "Preventing Resident Abuse" with a revision date of 6/1/18 has a subheading of Procedure that read: "Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

Under the policy subheading, Prevention, it read "b. [facility name] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur."

Under the policy subheading, Identification, it read "a. during orientation and annually at a minimum, team members will be educated on observation and reporting important information about resident care, condition or behavior. Team

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 31	F 609		

members are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.
B. Team members are encouraged to identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, team members are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member.
C. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being supervised and the environment is free of hazards.
D. Administrative and facility leadership staff will supervise team members to identify inappropriate behaviors, action and response to resident needs."

Under the policy subheading, Investigation, it read, "A. designated team members will immediately review and investigate all allegations or observations of abuse. B. [facility name] will conduct analysis for trends and patterns related to incidents [i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.] C. outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee and in accordance with federal, state and local law."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 32	F 609		

Continued From page 32

Under the policy subheading, Protection, it read, "A. In the event of an allegation or observation of abuse, [facility name] will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. B. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident."

Under the policy subheading, Reporting, it read, "A. [facility name] will maintain systems to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. B. Each covered individual/mandated reporter shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or crime, or not later than 24 hours if the events that cause suspicion doe not result in serous bodily injury. i. The organization will report to local law enforcement agencies any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 33	F 609		

from, the facility. Notification to the James City County Police is to be made by contacting [phone number listed]. C. The organization will immediately report all alleged violations involving neglect, abuse, including injuries or unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee of the facility. D. The results of all investigations are to be communicated to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken."

The facility Administrator and DON were made aware of the facility staff's failure to ensure Resident #6 was free from abuse during the end of day meeting on 5/9/19.

No further information was provided.

2. For Resident #5 the facility staff failed to report of allegations of abuse or neglect to include lack of supervision and injuries of unknown origin

Resident #5 is a 96 year old woman admitted to the facility on 4/30/14 with diagnoses of but not limited to Alzheimer's disease, CVA, Unspecified Osteoarthritis, Muscle weakness, Spinal stenosis, Insomnia, and anemia.

The Resident's most recent (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 3/15/19 coded as a Significant change assessment, section C the Resident as having a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 34	F 609		

(Brief Interview of Mental Status) BIMS score of 10 indicating moderate cognitive impairment.

Under G 0100 ADL Assistance the Resident is coded as:

A. Bed mobility - 3 = Extensive Assistance - 2 = 1 person physical assistance
B. Transfer - 3 = Extensive Assistance - 2 = 1 person physical assistance
C. Walk in room - 8 = Activity did not occur
D. Walk in corridor - 8 = Activity did not occur

The Resident is also coded under section G 0300 -Balance during Transition and moving:

A. Moving from seated to standing position - 8 = Action did not occur
B. Walking - 8 = Action did not occur
C. Turning around and facing opposite direction while walking. - 8 = Action did not occur
D. Moving on and off toilet - 2 = Not steady only able to stabilize with human assistance
E. Surface to surface transfer - 2 = Not steady only able to stabilize with human assistance

On 5/8/19 it was discovered that between 5/1/2018 and 5/8/2019 the Resident had 34 facility incidents reports completed. Of the 34 incidents:

19 were injuries of unknown source
11 were unwitnessed falls (found on floor)
3 witnessed falls (1 of which involved the use of a sit to stand lift)
1 Elopement

According to the incident reports the most recent incidents include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 35	F 609		

3/5/19 at 7:00 AM - "red /black bruise noted this AM to Left front calf measuring 15 cm X 7 cm also during the last day increased left sided weakness noted resident and staff are unsure how bruise occurred but it could be related to sit to stand usage."

However, according to care plan sit to stand use was not discontinued until 3/19/19.

3/11/19 at 1:00 AM - "New bruise noted on top and outer aspect of left foot (16 cm X 9 cm) site is tender to touch she is poor historian and unable to state how injury occurred. However she has left sided weakness and sometimes drags her foot or crosses her feet in bed and wheelchair."

Additional comments and or steps taken to prevent reoccurrence:
- "Make sure L [left] foot is in leg rest."
- "In bed, place pillow between legs / feet."

3/17/19 at 2:50 PM - "8 cm X 7 cm red purple bruise noted to left forearm about 10 minutes BEFORE resident had fall resident and staff are unaware of cause."

Additional comments and or steps taken to prevent reoccurrence:
- "Verify placement of arms before lifting on Hoyer"

3/17/19 at 3:00 PM - "Unwitnessed fall appears as if resident leaned over to pick up toy cat and fell on the floor found lying on right side."

Additional comments and or steps taken to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 36	F 609		

prevent reoccurrence:
- "OT to eval for placement of half tray (flip up) to put cat on."

3/26/19 at 2:20 PM - "Resident was being put to bed for nap and CNA seen [sic] dried blood on resident support hose and writter [sic] went to assess and the area was dry and no active bleeding and had a bruise around skin tear."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling." 5/9/19 at 8:43am an Interview was conducted with the Social worker and when asked if she is a part of the investigation of abuse she stated that "They notify me if there is a suspicion of abuse and I would interview the resident."

When asked who was responsible for reporting suspected abuse she answered "Any employee is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 37	F 609		

supposed to report any allegations of abuse and my administrator would call me."

When asked had she seen all of the incidents of injuries of unknown origin she stated "It is concerning that I have never seen these reports"

She indicated that the facility started a new morning meeting with the new leadership and they review incidents. She indicated that the reports should have been told to the supervisor and should have come to her to interview all parties and after the Administrator receives her report of identified concerns, the Administrator would then report. She further elaborated that she has not had any abuse referrals since the new administrator started.

On 5/9/19/ at 9:30 AM an interview was conducted with the CEO and the Administrator stated, "If any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)."

According to the facility abuse policy:

"Preventing Resident Abuse"

"Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

"B. [facility name redacted] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect,

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 38 mistreatment and/or misappropriation of resident property is more likely to occur." C. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being supervised and the environment is free of hazards. The facility Administrator was made aware and no further information was provided.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, clinical and clinical record review the facility staff	F 610	1. Medical records were reviewed for Resident #5 and #6. Residents # 5 and #	6/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 610

Continued From page 39

failed to investigate and protect Residents from abuse and neglect for 2 Residents (# 5 and # 6) in a survey sample of 13 Residents.

1. For Resident #5 the facility staff failed to investigate allegations of abuse or neglect to include lack of supervision and injuries of unknown origin.

2. For Resident #6, the facility staff failed to protect the resident, conduct an investigation for accidents and/or injuries of unknown origin.

The findings include

1. For Resident #5 the facility staff failed to investigate allegations of abuse or neglect to include lack of supervision and injuries of unknown origin.

Resident #5 is a 96 year old woman admitted to the facility on 4/30/14 with diagnoses of but not limited to Alzheimer's disease, CVA, Unspecified Osteoarthritis, Muscle weakness, Spinal stenosis, Insomnia, and anemia.

The Resident's most recent (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 3/15/19 coded as a Significant change assessment, section C the Resident as having a (Brief Interview of Mental Status) BIMS score of 10 indicating moderate cognitive impairment.

Under G 0100 ADL Assistance the Resident is coded as:

A. Bed mobility - 3 = Extensive Assistance - 2 = 1 person physical assistance

F 610

6 were assessed by the nursing team for any potential injuries. Resident #6 was found to be free of injuries of unknown source. Resident # 5 was noted to have bruises of unknown origin and a report was forwarded to OLC on 5/9/19. Follow up report was sent to OLC on 5/15/19. Abuse Policies and Procedures were reviewed, and no changes were made at this time, as current policy and procedure meets the regulations and standards of care.

2. All residents in the facility have the potential to be affected by failure to investigate abuse allegations and injuries of unknown source in accordance with the abuse policies and procedures. The Administrator and Director of Nursing have completed an audit to include 100% of all accidents/injuries since 5-9-19 to screen for potential injuries of unknown source and/or abuse allegations. All reports as required have been forwarded to OLC.

3. All team members will be re-educated on the identification and definition of injuries of unknown source. The investigation procedures have been revised with new guidance for team members related to the completion of investigations. Facility will re-educate all team members on the abuse policy and procedure to include investigations and IMMEDIATE reporting to the Administrator/designee with emphasis placed on all injuries of unknown source. Abuse Policies and Procedures will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40	F 610		

B. Transfer - 3 = Extensive Assistance - 2 = 1 person physical assistance
C. Walk in room - 8 = Activity did not occur
D. Walk in corridor - 8 = Activity did not occur

The Resident is also coded under section G 0300 -Balance during Transition and moving:

A. Moving from seated to standing position - 8 = Action did not occur
B. Walking - 8 = Action did not occur
C. Turning around and facing opposite direction while walking. - 8 = Action did not occur
D. Moving on and off toilet - 2 = Not steady only able to stabilize with human assistance
E. Surface to surface transfer - 2 = Not steady only able to stabilize with human assistance

On 5/8/19 it was discovered that between 5/1/2018 and 5/8/2019 the Resident had 34 facility incidents reports completed. Of the 34 incidents:

19 were injuries of unknown source
11 were unwitnessed falls (found on floor)
3 witnessed falls (1 of which involved the use of a sit to stand lift)
1 Elopement

According to the incident reports the most recent incidents include:

3/5/19 at 7:00 AM - "red /black bruise noted this AM to Left front calf measuring 15 cm X 7 cm also during the last day increased left sided weakness noted resident and staff are unsure how bruise occurred but it could be related to sit to stand usage."

reviewed with all new team members on hire and at minimum annually with all team members.

4. All allegations of abuse/reports of injuries of unknown source will be reported immediately to OLC and internal investigations will be initiated. A 100% audit of all accidents/incidents/injuries will be completed by the Administrator, Director of Nursing, and/or designee within 72 hours to ensure that any potential reportable incidents have been reported and residents are safe and protected from harm. The Administrator and Director of Nursing will complete monthly tracking analysis on all incidents to identify patterns and/or trends related to injuries of unknown source. This audit will be ongoing to ensure compliance with abuse policy/procedures and regulatory guidelines and will be reported and reviewed quarterly through the QAPI process.

5. All corrective actions will be completed by 6/23/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 41	F 610		

However, according to care plan sit to stand use was not discontinued until 3/19/19.

3/11/19 at 1:00 AM - "New bruise noted on top and outer aspect of left foot (16 cm X 9 cm) site is tender to touch she is poor historian and unable to state how injury occurred. However she has left sided weakness and sometimes drags her foot or crosses her feet in bed and wheelchair."

Additional comments and or steps taken to prevent reoccurrence:
- "Make sure L [left] foot is in leg rest."
- "In bed, place pillow between legs / feet."

3/17/19 at 2:50 PM - "8 cm X 7 cm red purple bruise noted to left forearm about 10 minutes BEFORE resident had fall resident and staff are unaware of cause."

Additional comments and or steps taken to prevent reoccurrence:
- "Verify placement of arms before lifting on Hoyer"

3/17/19 at 3:00 PM - "Unwitnessed fall appears as if resident leaned over to pick up toy cat and fell on the floor found lying on right side."

Additional comments and or steps taken to prevent reoccurrence:
- "OT to eval for placement of half tray (flip up) to put cat on."

3/26/19 at 2:20 PM - "Resident was being put to bed for nap and CNA seen [sic] dried blood on resident support hose and writter [sic] went to assess and the area was dry and no active

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 42	F 610		

bleeding and had a bruise around skin tear."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling."

Additional comments and or steps taken to prevent reoccurrence:
- "Resident has been noted throughout day taking L [left] leg off of foot rest when staff elevate left leg."

4/8/19 at 7:50 PM - "4.5 cm X 3.5 cm brown bruise noted to left upper forearm appears to be similar to bruise noted in March determined to probably be from sling." 5/9/19 at 8:43am an Interview was conducted with the Social worker and when asked if she is a part of the investigation of abuse she stated that "They notify me if there is a suspicion of abuse and I would interview the resident."

When asked who was responsible for reporting suspected abuse she answered "Any employee is supposed to report any allegations of abuse and my administrator would call me."

When asked had she seen all of the incidents of injuries of unknown origin she stated "It is concerning that I have never seen these reports"

She indicated that the facility started a new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 43	F 610		

morning meeting with the new leadership and they review incidents. She indicated that the reports should have been told to the supervisor and should have come to her to interview all parties and after the Administrator receives her report of identified concerns, the Administrator would then report. She further elaborated that she has not had any abuse referrals since the new administrator started.

On 5/9/19/ at 9:30 AM an interview was conducted with the CEO and the Administrator stated, "If any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)."

According to the facility abuse policy:

"Preventing Resident Abuse"

"Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

"B. [facility name redacted] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur."

C. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 44	F 610		

supervised and the environment is free of hazards.

The facility Administrator was made aware of the issues with injuries of unknown origin and no further information was provided.

2. For Resident #6, the facility staff failed to protect the resident, conduct an investigation for accidents and/or injuries of unknown origin.

Resident #6 was admitted to the facility on 6/8/19. The resident's diagnoses included but were not limited to: traumatic subdural hemorrhage without loss of consciousness, UTI, multiple fx of rib, muscle weakness, ataxia, essential hypertension, hyperlipidemia, supraventricular tachycardia, other seizures, attention and concentration deficit, and cognitive communication deficit,

Resident #6 most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/15/19 was coded as a quarterly assessment. Resident #6 had a BIMS (brief interview for mental status) score of 13, which indicated Resident #6 was cognitively intact. Resident #6 was coded as requiring assistance of one staff member for ADL's (activities of daily living) which included: bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.

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	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 45	F 610		

that the resident was found "lying supine on the floor with feet facing the bathroom door." There is no indication that anyone witnessed the resident fall. The Incident/Accident report states "CNA was passing ice and found resident lying on the floor in a supine position near the bathroom. Resident pants were unzippered and hanging below waist. Resident was able to move all four extremities without pain. Resident had no injuries. ... resident's personal alarm was not activated. Resident was attempting to transfer w/out assist." [sic] The Fall Analysis/Investigation Form dated 7/7/18 stated "removed bed/chair alarm- family member." There is no evidence of an investigation being conducted to exclude that the resident was not a victim of abuse or neglect. The facility staff suspected that Resident #6's spouse failed to connect the bed/chair alarm.

Review of nursing notes dated 8/2/18 reveal an entry that read: "spouse asked this nurse to look at a bruise on resident's right wrist. Wrist examined. Noted bruise on dorsum of right wrist measuring 7cm x 7 cm. No guarding, ,grimacing or moaning during palpation of area. Resident denied pain in wrist. Notified nursing supervisor was made aware. PA made aware. New order received for ice to affected area. Resident was noted to have flailing of upper extremities on prior shift. Will monitor resident as needed." [sic] Review of nursing notes dated 8/1/18 there were no entries. There were no other entries on the day of 8/2/18 to indicate resident had flailing of upper extremities as noted in the incident note, previously mentioned. Review of Bruise/Skin Tear/Abrasion Investigation form under additional comments, it read "timing of injury unknown. Suspect injury occurred last night. Unable to assess what resident was doing since timing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 46 unknown." There is no indication on the investigation form that staff were interviewed, any measures were taken to protect Resident #6 while an investigation was being conducted. Nursing notes revealed an entry on 8/7/18 at 22:19 that read, "Resident's personal alarm was sounding. CNA noted resident sitting upright on the floor in the bathroom in her room with the wheelchair behind her. Resident sustained an abrasion red in color and measuring 11.0 cm x 2.0 cm to her back." The Incident/Accident Report stated, "Resident's personal alarm was sounding. This nurse was called to resident's room by CNA who stated Resident is on the floor. Resident was noted sitting upright on floor in her bathroom with her wheelchair immediately behind her." The Fall analysis/investigation form revealed that no staff interviews were conducted. The CNA post fall investigation form revealed that no one was with the resident when Resident #6 fell. Review of nursing notes for Resident #6 revealed an entry dated 8/21/18 at 23:45 which read, "during weekly skin assessment writer noticed bruise on resident's right wrist. 4cm x 2cm dark purple and reddish purple bruise. No swelling. Resident denies pain in right wrist. She does not know how she got the bruise." Under the intervention line: "none" was typed in. The bruise/skin tear/abrasion investigation form revealed that no staff interviews were conducted. An investigation was not conducted, no measures were taken to protect Resident #6 in the event the resident was a victim of abuse. Nursing notes for Resident #6 revealed an entry dated 10/24/18 at 17:30 that read, "during weekly	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 47	F 610		

skin assessment noticed bruises on right forearm. Resident denies knowing how she got the bruises. Bruises on right forearm:
#1-4 on dorsal surface #5 on dorsal and ventral surface
#1 1.7 x 2cm Oval bruise w/Dark purple boarder. Reddish purple in the middle
#2 1 x 0.8 cm oval bruise, reddish purple
#3 1/5 x 0.7 cm irregular shaped fading red bruise
#4 1.7 x 2cm purplish red bruise with a spot of dark purple 0.5 cm in diameter
#5 6 x 11.5 cm blue bruise, lighter on ventral surface

Husband was notified at 11:45am. He has seen the bruises. He does not know how she got them." [sic] The bruise/skin tear/ abrasion investigation form revealed no staff interviews were conducted. Additional comments read as, "resident seen by CNA reaching for walker with eye closed and bumping/hitting rt arm on walker today. Bruises were preset prior to this, however may be an explanation for how it occurred. Husband declined geri sleeves in past." [sic] There was a typed statement dated 10/26/18 that stated, "nurse into assess areas to right arm. No fingerlike pattern noted, no pain noted on palpation." signed by the director of nursing. There is no evidence or any other information provided that would indicate an investigation was conducted or any protective measures were taken to protect Resident #6.

Review of nursing notes for Resident #6 revealed an entry dated 10/25/18 at 14:57 that read, "Resident personal alarm sound and resident was found in the bathroom unassisted standing and resident was taken to the bathroom about 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 48 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 the fall analysis/investigation form under the resident interview section it indicated that Resident #6 didn't respond to the questions asked except for one question which the resident responded no to. Only one staff member was interviewed and they indicated that Resident #6 was "cooperative" prior to the fall. 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. Review of nursing note for Resident #6, revealed a entry dated 10/26/18 at 10:15am that read, "resident was found sitting on the floor in her room after resident personal alarm sounded." No additional information was found in the entire clinical record that would indicate that this incident of unknown origin, which is an allegation of abuse, was investigated, staff interviewed, or the resident protected during the course of an investigation. Resident #6's nursing notes on 12/5/18 at 7:15am read, "resident was found in her bathroom lying on her back when personal alarm went off. Resident has a abrasion to her right index finger with bruising." [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	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 49	F 610		

Resident #6.

On 12/11/18 at 3:00pm Resident #6 was noted to have "2 new bruise noted to top of right wrist (2 x 3 cm) and top of right forearm (0.5 x 1.2 cm). Resident is a poor historian d/t dementia and cognitive communication deficit and is unable to state when bruises occurred. " [sic] Review of the bruise/skin tear/abrasion investigation form reveals that 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.

Nursing notes reveal that on 12/24/18 at 5:40pm "while CNA was toileting resident she noticed 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.

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]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 50 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 was conducted.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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F 610	Continued From page 51	F 610		

Nursing notes for Resident #6 revealed an entry dated 4/6/19 at 8:10am that read, "new bruise right forearm noticed while toileting resident this AM right forearm, dorsal surface 3.2 x 1.8 cm bruise. Dark purple in the center and slightly raised. Red purple in the periphery. Resident denies pain. She has good ROM of right wrist and right arm. Resident has aphasia and is unable to tell me when the bruise appeared or how it happened. Husband noticed the bruise this AM. He does not know how it happened." 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.

Nursing note dated 4/30/19 for Resident #6 had an entry at 15:15 that read, "resident's personal alarm on back of the w/c went off and resident was found on the floor in from of the bathroom door on her back. resident was put on toilet, but did not have to use it. unable to determine why resident fell." [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.

On 5/9/19 at 8:43am an interview was conducted with Employee C, the SW (Social Worker). When asked if she was aware of the injuries of unknown origin for Resident #6, the SW stated, "I don't specifically, it was reported or identified as abuse. This is not a resident that has ever been identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 610		F 610		

Continued From page 52
to me as a referral along those lines as being abused. She is not someone that has ever come up as someone for abuse. When abuse is identified the nurse does an interview, I do an interview. Any employee is supposed to report any suspicion of abuse and my Administrator would call me. I try to visit this resident weekly and I don't' really recall seeing any bruises. "

When asked if one resident with this amount of paperwork is concerning, the SW stated, "I definitely hear your concerns. I've just never suspected it with her. This is concerning, I've never seen these reports. Yes, I probably should have been made aware. It should have been told to the supervisor but this should have also come to me to interview all parties. After my report, if there are concerns identified the Administrator would report the incidents. I haven't had a referral for abuse since the new Administrator started."

On 05/09/19 at 09:39 AM an interview was conducted with the facility Administrator. When asked if she knew the cause of the injuries of unknown origin and multitude of bruises Resident #6 has sustained, the Administrator stated, "I can't answer , I don't know what meds she is on, she is ataxic and does a lot of failing."

The Administrator was made aware that the SW stated "they investigate prior to reporting, she talked about mandated reporting, but reporting of abuse allegations is not occurring." The Administrator stated, "if any of our team has a concern, or they think something may be under the heading of abuse they are to report it to their administrative supervisor, and then immediately call myself and the DON (Director of Nursing)." When asked what would make them think an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188**

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F 610	Continued From page 53	F 610		

allegation of abuse, the Administrator stated, "if it looks like a hand print, something out of ordinary, I would be questioning that right away, and depending on the placement of where things are. When an injury occurs and no one knows how it occurred. I would look, I would ask if they had a lab draw, if we don't know how it happened, if there is no reasonable expectation. When there is an injury of unknown source it should be reported no later than 24 hours, if there is hospitalization or sign injury you have a two hour time frame."

When asked why reporting is not happening the Administrator stated, "I can't answer for anything prior to Jan 5. I was not here, we did have a different DON." She was shown there were six injuries of unknown origin for Resident #6 since her tenure. The Administrator then said, "I have no problem at all reporting every bruise and every skin tear, if we look at it immediately and if we can't give an answer if we don't have an immediate answer, we will report it."

The Administrator was advised of the injury of unknown origin on 10/24/18 that appeared to be a hand print, the Administrator said "If saw hand prints and that would raise my concern and I would investigate. I would talk to all team members, would talk to spouse, and the direct care team. I would want to know if anyone saw anything, someone maybe said she went to fall and they went to grab her, etc. I would be concerned about possible abuse." When asked about next steps, The Administrator stated, "the nurse would then call the DON and myself, I have a concern here, I would send it in to you. If there is any thought that this could be abuse, it would be reported. A nurses writing the report is self

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 610	Continued From page 54	F 610		

reporting. This nurse is also a medical doctor, ,who didn't like being a doctor and is a nurse. She is a board certified practitioner.

Review of the facility policy titled "Preventing Resident Abuse" with a revision date of 6/1/18 has a subheading of Procedure that read: "Injury of unknown origin- any injury to a resident for which there is no known etiology or reasonable explanation, and for which an origin in physical abuse or mistreatment cannot be ruled out."

Under the policy subheading, Prevention, it read "b. [facility name] will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur."

Under the policy subheading, Identification, it read "a. during orientation and annually at a minimum, team members will be educated on observation and reporting important information about resident care, condition or behavior. Team members are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.
B. Team members are encouraged to identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. Immediately following ensuring the resident's safety, team members are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

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F 610	Continued From page 55 C. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with the plan of care, that residents are being supervised and the environment is free of hazards. D. Administrative and facility leadership staff will supervise team members to identify inappropriate behaviors, action and response to resident needs." Under the policy subheading, Investigation, it read, "A. designated team members will immediately review and investigate all allegations or observations of abuse. B. [facility name] will conduct analysis for trends and patterns related to incidents [i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.] C. outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee and in accordance with federal, state and local law." Under the policy subheading, Protection, it read, "A. In the event of an allegation or observation of abuse, [facility name] will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. B. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident." Under the policy subheading, Reporting, it read, "A. [facility name] will maintain systems to ensure all alleged violations involving abuse, neglect,	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 56 exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. B. Each covered individual/mandated reporter shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or crime, or not later than 24 hours if the events that cause suspicion doe not result in serous bodily injury. i. The organization will report to local law enforcement agencies any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Notification to the James City County Police is to be made by contacting [phone number listed]. C. The organization will immediately report all alleged violations involving neglect, abuse, including injuries or unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee of the facility. D. The results of all investigations are to be communicated to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken." The facility Administrator and DON were made	F 610		

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	495402	A. BUILDING ______ B. WING ______	05/09/2019

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F 610	Continued From page 57 aware of the facility staff's failure to ensure Resident #6 was free from abuse during the end of day meeting on 5/9/19. No further information was provided.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		6/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING _______ B. WING _______	05/09/2019

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F 656	Continued From page 58 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to develop a comprehensive, resident-centered careplan for one Resident (Resident #1) in a survey sample of 13 residents. For Resident #1, the facility staff failed to develop a comprehensive care plan to address triggered areas on the MDS (Minimum Data Set) to include, cognitive loss/dementia, Urinary incontinence and behavioral symptoms. The findings include: Resident #1, an 85 year old male was admitted to the facility on 2/4/19 with diagnoses to include but not limited to respiratory failure, heart failure, muscle weakness, and dementia. Resident #1's most recent MDS with an ARD (assessment reference date) of 2/11/19 was coded as an admission from an acute hospital stay. Resident #1 was coded with a Brief Interview of Mental Status score of 14 out of possible 15, indicating no cognitive impairment.	F 656	1. Resident #1 was identified as affected for failure to address triggered areas identified on the MDS assessment on his comprehensive care plan. Resident #1 has since discharged and corrections could not be made to his individual care plan. 2. All residents residing in the facility have the potential to be affected by not having 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 interventions for that resident. 4. The Administrator or designee will perform an audit of 100% of the current residents to ensure all areas identified on the CAA’s have been appropriately care planned. An audit of 100% of all new comprehensive assessments will be completed for one month. Monthly ongoing audits will be conducted and reviewed and reported quarterly through	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	**3900 WINDSOR HALL DRIVE** **WILLIAMSBURG, VA 23188**

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F 656	Continued From page 59 On 5/8/19, upon further review of the facility coded MDS document, Section V- Care Area Assessment (CAA) Summary, revealed 9 triggered Care Areas including: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. On 5/8/19 at approximately 1:30 pm, Resident #1 was observed lying quietly in a low bed in his room. He did not acknowledge a knock at his doorway as he appeared to be sleeping. On 5/9/19 at approximately 9:00 am, Resident #1 refused to be interviewed. A copy of Resident #1's current care plan including all revisions/completions and Care Area Assessment Worksheets were requested and received from the Director of Nursing (DON, Employee B). On 5/9/19, Resident #1's careplan was reviewed. The care plan did not contain any information for three of the triggered Care Areas (AA) from Section V on the MDS: Cognitive Loss/Dementia, urinary Incontinence, and Behavioral Symptoms, despite that the CAA stated these items were addressed in the careplan. On 5/9/19 at approximately 12:3, the DON was interviewed with regard to Resident #1's careplan and the MDS facility assessment. She stated, "I would expect to find identified areas of concern to be part of the resident's care plan." After she reviewed Resident #1's care plan, she stated, "I don't know why his behaviors and dementia are not on the care plan, they should be." No further information was received.	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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to review and revise the careplan for one Resident, (Resident #6) in a survey sample of 13 Residents. 1. For Resident #6, the facility staff failed to review and revise the careplan following 4	F 657	1. Resident #6 was identified as affected with four occurrences of her care plan not being updated following accidents and injuries. All areas have since resolved and the care plan has been updated to residents current condition and potential risks. 2. All residents residing in the facility have	6/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 657 Continued From page 61

accidents and/or injuries of unknown origin to prevent reoccurance.

The findings included:

Resident #6 was admitted to the facility on 6/8/18. The resident's diagnoses included but were not limited to: traumatic subdural hemorrhage without loss of consciousness, UTI, multiple fx of rib, muscle weakness, ataxia, essential hypertension, hyperlipidemia, supraventricular tachycardia, other seizures, attention and concentration deficit, and cognitive communication deficit,

Resident #6 most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/15/19 was coded as a quarterly assessment. Resident #6 had a BIMS (brief interview for mental status) score of 13, which indicated Resident #6 was cognitively intact. Resident #6 was coded as requiring assistance of one staff member for ADL's (activities of daily living) which included: bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.

1. Review of Resident #6's nursing notes revealed that on 7/5/18, the resident had a scratch on the top of her right hand.

Review of Resident #6's careplan revealed that no careplan was in place or initiated following the scratch noted on 7/5/18. There were no preventive interventions put in place following this injury of unknown origin and nothing was done to prevent reoccurrence.

2. Resident #6's nursing notes had an entry dated

F 657

the potential to be affected by not having an updated resident-centered comprehensive care plan following changes in condition to include accidents/injuries.
3. All nursing staff will be educated on reporting and documentation of changes in condition and licensed nurses will be educated on making revisions to the care plan. The 24 hour report will be reviewed by the nursing administration team for identification of changes. The DON or designee will verify that new interventions have been added to the care plan. Any intervention added to a residents care plan will be dated in the text box as they are entered. Once the intervention is no longer appropriate it will be resolved.
4. The Administrator or designee will perform an audit to include 100% of all accidents/injuries since 5/9/19 to ensure all interventions have been care planned and are resident centered. This will be followed by a 100% audit for one month. Monthly ongoing audits will be conducted and reported quarterly through the QAPI process.
5. The corrective action will be completed by 6/23/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 62 10/16/18 at 14:40 that read, "CNA informed writer that resident was participating in an activity and pushed w/c back from table and staff noticed a skin tear to the back of right hand. Slight bleeding noted to back of right hand and 1.0 crescent shape skin tear noted." [sic] Resident #6's careplan did not reveal any review or revision following this incident to prevent re-occurrence. 3. Nursing notes for Resident #6 revealed an entry dated 10/24/18 at 17:30 that read, "during weekly skin assessment noticed bruises on right forearm. Resident denies knowing how she got the bruises. Bruises on right forearm: #1-4 on dorsal surface #5 on dorsal and ventral surface #1 1.7 x 2cm Oval bruise w/Dark purple boarder. Reddish purple in the middle #2 1 x 0.8 cm oval bruise, reddish purple #3 1/5 x 0.7 cm irregular shaped fading red bruise #4 1.7 x 2cm purplish red bruise with a spot of dark purple 0.5 cm in diameter #5 6 x 11.5 cm blue bruise, lighter on ventral surface Review of Resident #6's careplan did not reveal any mention of this injury, nor any intervention to prevent re-occurrence. 4. Review of nursing notes for Resident #6 revealed an entry dated 10/25/18 at 14:57 that read, "Resident personal alarm sound and resident was found in the bathroom unassisted standing and resident was taken to the bathroom	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495402	A. BUILDING ______ B. WING ______	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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F 657	Continued From page 63	F 657		

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 reducing declines in the resident's functional status and/or functional levels; h. promote resident safety; i. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and j. reflect currently recognized standards of practice for problem areas and conditions."

The facility Administrator and DON were made aware of the facility staff's failure to review and revise the careplan for Resident #6, during the end of day meeting on 5/9/19.

No further information was provided.