STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 08/09/2021 through 08/11/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey (VA00052718 - Substantiated, VA00052668 - Substantiated, VA00052292 - Substantiated). The census in this 130 certified bed facility was 88 at the time of the survey. The survey sample consisted of 5 Resident reviews.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of	F 563		9/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/01/2021

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

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F 563	Continued From page 1 residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff limited visitation in June 2021 to Tuesdays, Thursdays, and Saturdays resulting in preventing immediate access to Residents by family and others 24 hours a day/7 days a week. The findings included: On 08/09/2021 at 11:45 A.M., this surveyor observed a sign on the front entrance of the facility that documented the following excerpt: "Attention All Visitors: Due to the risk of COVID-19, visitation is currently prohibited unless end of life medical issues are present in your loved one." On 08/09/2021 at approximately 12:00 P.M., an interview with Employee D, Regional Director of Clinical Services, was conducted. Employee D confirmed there were no COVID-19 positive Residents in the facility. On 08/09/2021 at 3:00 P.M., an interview with Certified Nursing Assistant A (CNA A) was conducted. When asked about the process for Residents receiving visitors, CNA A stated that family has to call and schedule an appointment. When asked how far in advance family need to	F 563	1.Visitation is conducted per regulation as of July 26, 2021. 2. All residents have the potential to be affected. 3. 100% of facility staff including agency staff, will be educated on visitation guidelines by the Executive Director/designee. 4. The Executive Director/designee will conduct audits weekly for four weeks to ensure that visits occur as scheduled and per the CDC guidance. Any variances will be reported to the Quality Assurance Performance Improvement Committee for review.	

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call, CNA A stated he did not know.

On 08/09/2021 at 3:30 P.M., an interview with Registered Nurse A (RN A) was conducted. When asked about the process for Residents receiving visitors, RN A stated that visiting has to be scheduled through social services. RN A also stated that visiting days are Tuesdays, Thursdays, and Saturdays. When asked about compassionate visits, RN A stated that compassionate visits had to be authorized by "someone in administration." RN A added that the [compassionate] visit would have to be scheduled and that the visitor would have to be screened [for COVID-19] and check their vaccination status.

On 08/09/2021 at 4:00 P.M., an interview with Employee E, the social worker, was conducted. When asked about the process for Residents receiving visitors, Employee E stated that until just recently, there were only compassionate visits allowed. Employee E stated that before the outbreak, visitors could come any time between 8:00 A.M. and 8:00 P.M. Employee E then stated prior to July 19th [2021], visitors had to schedule an appointment to come in on Tuesdays, Thursdays, and Saturdays between 10:00 A.M. and 4:00 P.M. and between 12:00 P.M.- 1:00 P.M. on weekends. Employee E stated that visitors met in the dining room and could stay 30 minutes. When asked for clarification of dates for the changes in visiting hours, Employee E stated he was unsure of dates.

On 08/10/2021 at approximately 10:45 A.M., the Regional Director of Clinical Services provided a written clarification of visiting hour changes from June 2021 through current as requested. It

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documented the following:
"1st Week of June Visitation was open Tuesday, Thursday and Saturday for the month with compassion visit allowed.
1st week of July open visitation.
July 19th, 2021 Potential exposure, open visitation stopped, compassion visits allowed.
August 8, 2021-curent [sic] Open visitation and compassion visits allowed.
Please note for any visit open or compassion - Visitors must be able to passing [sic] the visitor screening tool to gain entry into the building."

On 08/10/2021 at approximately 10:45 A.M., a copy of their visitation policy was requested and the Regional Director of Clinical Services provided a copy of their policy entitled, "COVID-19 Pandemic Plan." Under the header, "Visitation" in Section 4 entitled, "Indoor Visitation", an excerpt documented, "Indoor visitation should be accommodated for all residents at all times ..."

On 08/10/2021 at 2:50 P.M., a follow-up interview with Employee E was conducted. When asked who authorizes compassionate visits for Residents, Employee E stated he would "run it by nursing" to determine if a Resident should have compassionate visits. When asked about the process for compassionate visits, Employee E stated he would like [visitors] to call ahead of time. Employee E added that the [visitors] could call the front desk and the front desk [receptionist] could transfer the call to social services to schedule the visit.

On 08/10/2021 at 3:45 P.M., an interview with the front desk receptionist, Employee G, was conducted. When asked about the process for

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F 563	Continued From page 4 Residents receiving visitors in June 2021, Employee G stated that when visitors would call to schedule a visit, she would transfer them to Social Services to schedule it. When asked how far in advance visitors would have to schedule the visit, Employee G stated that Employee E told her that visitors would need to call 24 hours in advance to schedule a visit. When asked about the current process for Residents receiving visitors, Employee G stated that now visitors can come anytime. Employee G added that "even if they don't call in advance", visitors can come in any time. On 08/10/2021 at 4:15 P.M., a follow-up interview with Employee E was conducted. When asked why visitation was only allowed three days a week in June 2021, Employee E stated it was because that's the way the previous administrator wanted it. When asked how far in advance the visitors had to call to schedule a visit, Employee E indicated they would like enough time to get the Resident ready [for the visit]. When asked if it had to be at least 24 hours in advance, Employee E stated, "No." On 08/11/2021 at 2:40 P.M., the administrator and Director of Nursing were notified of concerns with limiting visitation to three days a week in June 2021. The administrator stated that "We have now fixed it according to the regulation." The administrator added that he took the signs down on the front door and will educate staff on the visitation policy. By the end of survey, the administrator stated they had no further documentation or information to submit.	F 563		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		9/22/21

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§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, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to implement their abuse policy for 1 Resident (Resident #3) in a sample size of 5 Residents. Specifically, the facility staff failed to screen new hires according to their policy as well as report and investigate an allegation of abuse on 05/31/2021.

The findings included:

Resident #3, an 81-year old male, was admitted to the facility on 12/15/2020. Diagnoses included but were not limited to dementia and diabetes mellitus type 2.

Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 05/18/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "3" out of possible "15" indicative of severe cognitive impairment. Functional status for transfers, dressing, and

1. The facility reported incident for Resident #3 was completed and submitted on 8/11/21 to Virginia Office of Licensure and Certification, Adult Protective Services and the Ombudsman. CNA B no longer works at the facility. CNA C will have references completed.

2. All residents and staff have the potential to be affected by the alleged deficiency.

100% of employee files to include agency will be audited by the Executive Director/designee to validate that there is a sworn statement and completed reference checks in employee files. Grievances will be monitored by the Executive Director for potential abuse and reported as indicated.

Residents with a BIMS of 8 or greater will be interviewed regarding abuse/neglect to ensure there are no instances of

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personal hygiene were coded as requiring extensive assistance from staff.

On 08/09/2021, the facility staff provided a copy of their facility-reported incidents (FRI) for February 2021 through August 2021. There was no facility-reported incident involving Resident #3 for an allegation of abuse that occurred on 05/31/2021.

On 08/09/2021 at approximately 2:00P.M., Resident #3 was observed in his room seated in his wheelchair. When asked if the staff treated him well, Resident #3 stated, "As well as can be expected." When asked if he felt safe, Resident #3 stated, "Yes."

On 08/09/2021 at 3:00 P.M., an interview with Certified Nursing Assistant A (CNA A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, CNA A stated he would report it to the nurse.

On 08/09/2021 at 3:30 P.M., an interview with Registered Nurse A (RN A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, RN A stated that she would immediately tell the administrator. RN A added that staff are supposed to report any allegations of abuse.

On 08/10/2021 at 9:00 A.M., Resident #3's progress notes were reviewed. A nursing progress note dated 05/31/2021 at 9:48 P.M. documented, "Note Text: This writer was informed by 3-11 nurse on [unit name], that this evening when resident was visiting with his daughter, he begin crying and resident stated "I did not like

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unreported abuse/neglect. Residents with BIMS of less than 8 will have skin evaluations completed to ensure no evidence of abuse/neglect and their Responsible Party will be interviewed as well regarding abuse/neglect.

3. Human Resources Coordinator will be educated by the Executive Director/designee on proper documentation needed for employee files prior to hire date. 100% of facility staff to include agency will be educated by Executive Director/designee on proper reporting of abuse and also completing grievance forms with customer service concerns.

4. Executive Director/designee will audit all new hire files to include agency weekly for 2 months to ensure all necessary documents are present in employee files. Executive Director/designee will review all grievances weekly for two months and ongoing to ensure that residents are free from abuse. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.

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who got me up this morning", "I felt disrespected and they did not put the cap back on my urinal and did not wash me well". Supervisor on duty was notified. Will continue to monitor and follow current plan of care." A nursing progress note dated 06/01/2021 at 12:25 P.M. documented, "Note Text: Late Entry for 5-31-21at 2200 [10:00 P.M.] Resident RP [responsible party] called to the facility at 2200, and voiced her concerns about her conversation she had with her father earlier that day. Resident was in bed and this writer took cell phone to resident room and called RP so they could talk. Resident stated to RP that he was okay now. RP did thank this writer afterwards." A nursing progress note dated 06/01/2021 at 2:30 P.M. documented, "Note Text: Per daughter (after her private conversation with her father), resident states, "he does not want to be disrespected and he stops [sic] it before it goes far yesterday.""

On 08/10/2021 at 9:15 A.M., the administrator was interviewed. When asked about the process if a Resident reports staff was disrespectful toward them, the administrator indicated the process is to interview the Resident and see if it rises to the level of abuse, then it would be reported and an investigation would be initiated. This surveyor and the administrator then observed the progress notes from 05/31/2021 through 06/01/2021 in Resident #3's electronic health record. When asked about the expectation related to this situation, the administrator stated that this would've prompted a further investigation. The administrator also stated he would look into it.

On 08/10/2021 at 9:40 A.M., the administrator returned to the conference room and provided a

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copy of a grievance form dated 06/01/2021. The administrator stated he is an interim administrator that just started working at this facility but he would've reported the incident as an allegation of abuse and would have conducted an investigation if he was working here at the time. The administrator also stated that he would now have an ad hoc QAPI [quality assurance performance improvement] meeting and educate the staff.

On 08/10/2021 at approximately 9:45 A.M., the grievance form dated 06/01/2021 provided by the administrator was reviewed. Under the header "Describe Concern in Detail", it was documented, "Resident stated he didn't like the staff that got him up and they didn't put the cap on his urinal." Under the header "Documentation of Investigation" it was documented, "Followup with resident and inservice with staff, followup phone call with daughter [name]." Under the header "Plan to resolve complaint/grievance", it was documented, "Customer service inservice with staff, in-person visit for resident with daughter, and quarterly care plan meeting completed." Under the header, "Compaint/Grievance resolved?", it was documented, "Yes, R/P [responsible party] was able to visit with resident no further concerns noted, will continue to monitor resident."

On 08/11/2021 at 9:00 A.M., this surveyor requested from the administrator a copy of the FRI associated with the incident on 05/31/2021 as well as the name of the staff member. At 10:45 A.M., the administrator stated that a FRI was sent today and an investigation was underway. The administrator stated the CNA [CNA B] assigned to Resident #3 on 05/31/2021 and signed off on ADL's [activities of daily living] was no longer

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working at the facility. The administrator also provided the names of the CNA's assigned to care for Resident #3 (CNA C, new employee; and CNA D) on the night shift into the morning of 05/31/2021.

On 08/11/2021 at 11:55 A.M., Employee H of Human Resources and this surveyor reviewed the employee files for CNA B, CNA C, and CNA D.

For CNA B, Employee H stated that CNA B was an agency CNA so the employee file looks different than facility staff files. When asked for CNA B's hire date, Employee H looked through the file and stated she didn't know the date of hire. The criminal background check results dated 04/27/2021 documented "No identifiable records." The license lookup was dated 03/16/2021. When asked about references, Employee H stated there were no references on file. When asked about the sworn statement, Employee H stated there was no sworn statement. When asked about the process for obtaining sworn statements, Employee H stated that she doesn't get sworn statements on agency staff and that she was not aware she had to do that. When asked about her termination date, Employee H stated that CNA B did not have a termination date; she was agency staff and could work at the facility up through 09/06/2021 unless she was flagged as DNR [do not return]. Employee H confirmed CNA B was not considered a DNR. Employee H then accessed electronic time cards for CNA B from May 2021 through August 2021. This surveyor and Employee H observed that CNA B worked 2 shifts at the facility in that date range (05/24/2021 and 05/31/2021). CNA B's date of hire was requested.

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For CNA C, there was a criminal background check, a sworn statement, and license verification prior to the date of hire on 03/16/2021. Employee H stated there were no references. When asked why there were no references on file, Employee H stated that CNA C did not want to provide references. Employee H stated that she notified the previous administrator about it and the previous administrator told her to "bring her onboard" anyway.

For CNA D, there was a criminal background check, a sworn statement, references, and license verification.

On 08/11/2021 at approximately 12:20 P.M., the administrator and the Director of Nursing (DON) were notified of findings of employee file reviews. When asked about the process for utilizing agency staff, the administrator stated that the only staff authorized to call the agency for staffing were the administrator and the Director of Nursing. He also stated the process of investigating an allegation of abuse with agency staff includes notifying the nursing agency.

The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Exploitation & Misappropriation." An excerpt in Section 1 entitled, "Screening" under the header, "Procedure" documented, "Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but not limited to ....sworn disclosure statement prior to hire ....The center will ensure that all prospective consultants, contractors, volunteers, caregivers, and students are

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pre-screened as required by law."

Under the header "Procedure" in Section 4 entitled, "Identification" it was documented, "All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing. Patterns or trends will be identified that might be constitute abuse. The information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in [sic] the absence of the Executive Director, the Director of Nursing will serve as Abuse Coordinator."

Under the header "Procedure" in Section 5 entitled, "Investigation", an excerpt documented, "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation."

Under the header "Procedure" in Section 7 entitled, "Reporting/Response", an excerpt documented, "Once an allegation of abuse is reported, the Executive Director, as the Abuse Coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred."

On 08/11/2021 at 2:40 P.M., the administrator and DON were notified of findings. The administrator stated that the ad hoc meeting was completed and they are actively working on the investigation. The administrator also stated that skin sweeps were performed on all residents with a BIMS [Brief Interview for Mental Status] of 8 or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 08/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 below [indicative of moderate/severe cognitive impairment] and interviews conducted with Residents with BIMS above 8 [moderate/minimal/no cognitive impairment]. The administrator stated that none of the findings warranted sending facility-reported incidents. By the end of survey, the administrator stated there was no further information or documentation to submit.	F 607		
F 609 SS=D	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: §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	F 609		9/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609

Continued From page 13

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, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to report within 24 hours an allegation of abuse that occurred on 05/31/2021 for 1 Resident (Resident #3) in a sample size of 5 Residents.

The findings included:

Resident #3, an 81-year old male, was admitted to the facility on 12/15/2020. Diagnoses included but were not limited to dementia and diabetes mellitus type 2.

Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 05/18/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "3" out of possible "15" indicative of severe cognitive impairment. Functional status for transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

On 08/09/2021, the facility staff provided a copy of their facility-reported incidents (FRI) for February 2021 through August 2021. There was no facility-reported incident involving Resident #3 for an allegation of abuse that occurred on 05/31/2021.

On 08/09/2021 at approximately 2:00P.M., Resident #3 was observed in his room seated in his wheelchair. When asked if the staff treated him well, Resident #3 stated, "As well as can be

F 609

1. The facility reported incident for Resident #3 was completed and submitted on 8/11/21-to Virginia Office of Licensure and Certification, Adult Protective Services and the Ombudsman.

2. All residents have the potential to be affected by the alleged deficiency

Residents with a BIMS of 8 or greater will be interviewed regarding abuse/neglect to ensure there are no instances of unreported abuse/neglect. Residents with BIMS of less than 8 will have skin evaluations completed to ensure no evidence of abuse/neglect and their Responsible Party will be interviewed as well regarding abuse/neglect.

Grievances will be monitored for potential abuse by the Executive Director and reported as indicated.

3. 100% of facility staff to include agency will be educated by Executive Director/designee on proper reporting of abuse and also completing grievance forms with customer service concerns.

4. Executive Director/designee will review all grievances weekly for two months and ongoing to ensure that residents are free from abuse. Additionally the Executive Director/designee will interview 5 residents with a BIMS of greater than 8

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F 609	Continued From page 14 expected." When asked if he felt safe, Resident #3 stated, "Yes." On 08/09/2021 at 3:00 P.M., an interview with Certified Nursing Assistant A (CNA A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, CNA A stated he would report it to the nurse. On 08/09/2021 at 3:30 P.M., an interview with Registered Nurse A (RN A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, RN A stated that she would immediately tell the administrator. RN A added that staff are supposed to report any allegations of abuse. On 08/10/2021 at 9:00 A.M., Resident #3's progress notes were reviewed. A nursing progress note dated 05/31/2021 at 9:48 P.M. documented, "Note Text: This writer was informed by 3-11 nurse on [unit name], that this evening when resident was visiting with his daughter, he begin crying and resident stated "I did not like who got me up this morning", "I felt disrespected and they did not put the cap back on my urinal and did not wash me well". Supervisor on duty was notified. Will continue to monitor and follow current plan of care." A nursing progress note dated 06/01/2021 at 12:25 P.M. documented, "Note Text: Late Entry for 5-31-21at 2200 [10:00 P.M.] Resident RP [responsible party] called to the facility at 2200, and voiced her concerns about her conversation she had with her father earlier that day. Resident was in bed and this writer took cell phone to resident room and called RP so they could talk. Resident stated to RP that he was okay now. RP did thank this writer	F 609	weekly for 4 weeks to ensure no unreported abuse/neglect concerns are present. The wound nurse will complete skin evaluations for 5 residents with BIMS of less than 8 weekly for 4 weeks to ensure no signs of abuse/neglect are present. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.	

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F 609	Continued From page 15	F 609		

afterwards." A nursing progress note dated 06/01/2021 at 2:30 P.M. documented, "Note Text: Per daughter (after her private conversation with her father), resident states, "he does not want to be disrespected and he stops [sic] it before it goes far yesterday.""

On 08/10/2021 at 9:15 A.M., the administrator was interviewed. When asked about the process if a Resident reports staff was disrespectful toward them, the administrator indicated the process is to interview the Resident and see if it rises to the level of abuse, then it would be reported and an investigation would be initiated. This surveyor and the administrator then observed the progress notes from 05/31/2021 through 06/01/2021 in Resident #3's electronic health record. When asked about the expectation related to this situation, the administrator stated that this would've prompted a further investigation. The administrator also stated he would look into it.

On 08/10/2021 at 9:40 A.M., the administrator returned to the conference room and provided a copy of a grievance form dated 06/01/2021. The administrator stated he is an interim administrator that just started working at this facility but he would've reported the incident as an allegation of abuse and would have conducted an investigation if he was working here at the time. The administrator also stated that he would now have an ad hoc QAPI [quality assurance performance improvement] meeting and educate the staff.

On 08/11/2021 at 9:00 A.M., this surveyor requested from the administrator a copy of the FRI associated with the incident on 05/31/2021. At 10:45 A.M., the administrator stated that a FRI

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F 609	Continued From page 16 was sent today and an investigation was underway. The administrator provided a copy of the FRI and as well as fax transmittal receipts to Adult Protective Services, the Ombudsman, and the state agency. The administrator stated the police were also notified. The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Exploitation & Misappropriation." Under the header "Procedure" in Section 7 entitled, "Reporting/Response", an excerpt documented, "Once an allegation of abuse is reported, the Executive Director, as the Abuse Coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred." On 08/11/2021 at 2:40 P.M., the administrator and DON were notified of findings. By the end of survey, the administrator stated there was no further information or documentation to submit.	F 609		
F 610 SS=D	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.	F 610		9/22/21

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F 610	Continued From page 17 §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, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to investigate an allegation of abuse on 05/31/2021 for 1 Resident (Resident #3) in a sample size of 5 Residents. The findings included: Resident #3, an 81-year old male, was admitted to the facility on 12/15/2020. Diagnoses included but were not limited to dementia and diabetes mellitus type 2. Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 05/18/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "3" out of possible "15" indicative of severe cognitive impairment. Functional status for transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff. On 08/09/2021, the facility staff provided a copy of their facility-reported incidents (FRI) for February 2021 through August 2021. There was no facility-reported incident involving Resident #3 for an allegation of abuse that occurred on 05/31/2021.	F 610	1. An investigation for Resident #3 was completed and a FRI (Facility reported incident follow-up report was submitted on 8/11/21-to Virginia Office of Licensure and Certification, Adult Protective Services and the Ombudsman. 2. All residents have the potential to be affected by the alleged deficiency Residents with a BIMS of 8 or greater will be interviewed regarding abuse/neglect to ensure there are no instances of unreported abuse/neglect. Residents with BIMS of less than 8 will have skin evaluations completed to ensure no evidence of abuse/neglect and their Responsible Party will be interviewed as well regarding abuse/neglect Grievances will be monitored for potential abuse by the Executive Director and investigated and reported as indicated. 3. 100% of facility staff to include agency will be educated by Executive Director/designee on proper reporting of abuse and also completing grievance forms with customer service concerns 4. Executive Director/designee will review	

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F 610 Continued From page 18

On 08/09/2021 at approximately 2:00P.M., Resident #3 was observed in his room seated in his wheelchair. When asked if the staff treated him well, Resident #3 stated, "As well as can be expected." When asked if he felt safe, Resident #3 stated, "Yes."

On 08/09/2021 at 3:00 P.M., an interview with Certified Nursing Assistant A (CNA A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, CNA A stated he would report it to the nurse.

On 08/09/2021 at 3:30 P.M., an interview with Registered Nurse A (RN A) was conducted. When asked about the process if a Resident reports staff was disrespectful toward them, RN A stated that she would immediately tell the administrator. RN A added that staff are supposed to report any allegations of abuse.

On 08/10/2021 at 9:00 A.M., Resident #3's progress notes were reviewed. A nursing progress note dated 05/31/2021 at 9:48 P.M. documented, "Note Text: This writer was informed by 3-11 nurse on [unit name], that this evening when resident was visiting with his daughter, he begin crying and resident stated "I did not like who got me up this morning", "I felt disrespected and they did not put the cap back on my urinal and did not wash me well". Supervisor on duty was notified. Will continue to monitor and follow current plan of care." A nursing progress note dated 06/01/2021 at 12:25 P.M. documented, "Note Text: Late Entry for 5-31-21at 2200 [10:00 P.M.] Resident RP [responsible party] called to the facility at 2200, and voiced her concerns

F 610

all grievances weekly for two months and ongoing to ensure that residents are free from abuse. Additionally the Executive Director/designee will interview 5 residents with a BIMS of greater than 8 weekly for 4 weeks to ensure no unreported abuse/neglect concerns are present. The wound nurse will complete skin evaluations for 5 residents with BIMS of less than 8 weekly for 4 weeks to ensure no signs of abuse/neglect are present Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.

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F 610	Continued From page 19 about her conversation she had with her father earlier that day. Resident was in bed and this writer took cell phone to resident room and called RP so they could talk. Resident stated to RP that he was okay now. RP did thank this writer afterwards." A nursing progress note dated 06/01/2021 at 2:30 P.M. documented, "Note Text: Per daughter (after her private conversation with her father), resident states, "he does not want to be disrespected and he stops [sic] it before it goes far yesterday."" On 08/10/2021 at 9:15 A.M., the administrator was interviewed. When asked about the process if a Resident reports staff was disrespectful toward them, the administrator indicated the process is to interview the Resident and see if it rises to the level of abuse, then it would be reported and an investigation would be initiated. This surveyor and the administrator then observed the progress notes from 05/31/2021 through 06/01/2021 in Resident #3's electronic health record. When asked about the expectation related to this situation, the administrator stated that this would've prompted a further investigation. The administrator also stated he would look into it. On 08/10/2021 at 9:40 A.M., the administrator returned to the conference room and provided a copy of a grievance form dated 06/01/2021. The administrator stated he is an interim administrator that just started working at this facility but he would've reported the incident as an allegation of abuse and would have conducted an investigation if he was working here at the time. The administrator also stated that he would now have an ad hoc QAPI [quality assurance performance improvement] meeting and educate the staff.	F 610		

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F 610	Continued From page 20	F 610		

On 08/11/2021 at 9:00 A.M., this surveyor requested from the administrator a copy of the FRI associated with the incident on 05/31/2021 as well as the name of the staff member. At 10:45 A.M., the administrator stated that a FRI was sent today and an investigation was underway. The administrator stated the CNA [CNA B] assigned to Resident #3 on 05/31/2021 and signed off on ADL's [activities of daily living] was no longer working at the facility. The administrator also provided the names of the CNA's assigned to care for Resident #3 (CNA C, new employee; and CNA D) on the night shift into the morning of 05/31/2021.

The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Exploitation & Misappropriation." Under the header "Procedure" in Section 5 entitled, "Investigation", an excerpt documented, "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation."

On 08/11/2021 at 2:40 P.M., the administrator and DON were notified of findings. The administrator stated that the ad hoc meeting was completed and they are actively working on the investigation. The administrator also stated that skin sweeps were performed on all residents with a BIMS [Brief Interview for Mental Status] of 8 or below [indicative of moderate/severe cognitive impairment] and interviews conducted with Residents with BIMS above 8 [moderate/minimal/no cognitive impairment]. The administrator stated that none of the findings so far warranted sending facility-reported incidents. By the end of survey, the administrator stated

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F 610	Continued From page 21 there was no further information or documentation to submit.	F 610		
F 657 SS=D	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 interview, facility documentation, and clinical record review and in the course of an investigation the facility staff failed review and revise the care plan for 2 Residents (#1 and # 5)	F 657	1. Resident #1 longer resides in the facility. Resident #5's medical record was reviewed the by Director of Clinical Services/Assistant Director of Clinical	9/22/21

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F 657	Continued From page 22 in a survey sample of 5 Residents. The findings included: For Resident #1 the facility staff failed to review and revise care plan to include actual wounds and interventions for those wounds. Resident # 1, a 61-year-old woman, admitted to the facility on 8/6/15, with diagnoses of but not limited to multiple sclerosis, unspecified psychosis, major depressive disorder, dermatitis, Seborrheic dermatitis, hypertension and glaucoma. Resident #1's most recent MDS (minimum data set) with an ARD (Assessment reference date) of 5/3/21, coded the resident is having a BIMS (Brief interview of mental status) score of 12 out of 15 indicating minor cognitive impairment. Resident #1, is also coded as requiring extensive assistance for bed mobility requiring two persons physical assistance. The resident was coded as (4) total dependence with 2 person physical assistance and a Mechanical lift for all transfers. Resident number one is unable to walk, stand, or bear weight. She uses a wheelchair with assistance for locomotion on and off the unit. She is coded as (3) requiring extensive assistance for dressing with one person physical assistance she needs supervision and set up for eating she is fully dependent on staff for toileting personal hygiene and bathing with one person physical assistance. Resident #1 was also coded as being incontinent of bowel and bladder. On 8/10//21 during clinical record review it was discovered that Resident #1 had wounds that developed on the following dates:	F 657	Services/Unit Managers/Minimum Data Set Nurses on 8/12/21 regarding his falls and his care plan was updated to reflect interventions as indicated. 2. All residents in house have the potential to be impacted by the alleged deficient practice. In house residents had their medical records audited on 8/17-19/21 focusing on fall interventions and on 8/25/21 for wounds. Medical records identified with issues were addressed and the care plan was revised accordingly to include fall interventions and/or wounds when applicable. 3. Minimum Data Set Nurses/Assistant Director of Clinical Services/Unit Managers will be educated by the Director of Clinical Services regarding fall and wound interventions with care plan revision. During the am clinical meeting, that occurs Monday thru Friday, the clinical management team (Director of Clinical Services, Assistant Director of Clinical Services, Minimum Data Set Nurses, Unit Managers and Medical Records) will review falls and wounds to ensure interventions are assigned appropriately and the care plan will be updated at this time. The clinical team will also review the falls and wounds in the weekly Standards of Care meeting as a double check to ensure interventions are in place and the care plan is revised as needed. 4. Director of Clinical Services/ Assistant Director of Clinical Services/Unit	

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F 657	Continued From page 23	F 657		

"5/5/21(site 2) wound (back)
Wound details:
Duration: > 1 day Objective: healing. Skin tear from brief
Wound size 5.3 x 1.7 x 0.1 cm. Surface area 9.01 cm²
Exudate light serosanguinous
Slough 35% Granulation tissue 30% other viable tissues 20% (dermis) skin 15%
Site to surgical excision of debridement procedure"

"5/26/21 - 10:55 AM -Pressure Wound Rounds - R Foot 2.3 cm x 2.3 cm Deep Tissue Injury"

"5/26/21 Focused wound exam (site 3) wound: Sacrum
Duration: >1 day. Objective healing, excoriation in a setting of moisture dermatitis
Wound size 0.6 x 0.7 x (by not measurable) cm. Surface area 0.42 cm²

"6/30/21 Focused wound exam (site 1)
Wound: Sacrum
Duration: > 1 day
Objective healing skin tear in a setting of moisture dermatitis
Wound size (l x w x d) 1 x .09 x .01 cm surface area .90 cm² exudate light serosanguinous granulation tissue 100%
Dressing is Xeroform sterile gauze with island gauze change daily."

On 8/10/21 a review of the care plan read:

"FOCUS:
[Resident #1's name redacted] has potential for

Provider's plan of correction (F 657):

Managers will audit 100% of residents who experience falls or wounds for accurate documentation ensuring that the care plan has been implemented and revised as indicated weekly x 4 weeks then monthly x two months. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.

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ENVOY OF WILLIAMSBURG, LLC	**1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185**

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F 657	Continued From page 24	F 657		

pressure injury development r/t decreased mobility, incontinence AEB: requires staff assist with ADL's. Date Initiated: 12/13/2019 Revision on: 12/13/2019"

GOAL:

The resident will have intact skin, free of redness, blisters or discoloration by/through review date. Date Initiated: 12/13/2019 Revision on: 02/18/2021

The resident's pressure injury will show signs of healing and have minimal risk of infection by /through review date. Date initiated 6/17/21

Interventions:

Administer treatments as ordered and monitor for effectiveness. Date Initiated: 12/13/19 Revision Date: 05/10/2021

Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 12/13/2019

Braden Scale Quarterly Date Initiated: 12/13/2019

Float heels as tolerated. Date Initiated: 12/13/2019

Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 12/13/2019

If the resident refuses treatment, confer with the resident, IDT and resident representative to determine why and try alternative methods to gain compliance. Document alternative methods. Date

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Initiated: 12/13/2019

If the resident refuses treatment, confer with the resident, IDT and resident representative to determine why and try alternative methods to gain compliance. Document alternative methods. Date Initiated: 12/13/2019

Inform the resident/resident representative of any new area of skin breakdown. Date Initiated: 12/13/2019

Instruct/assist to shift weight in W/C Date Initiated: 12/13/2019

LAL mattress Date Initiated: 12/13/2019

Moisture barrier after incontinence changes and PRN or as ordered. Date Initiated: 12/13/2019

Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 12/13/2019

On 8/11/21 at approximately 2:00 PM an interview was conducted with the DON who stated "The care plan should be updated quarterly and with any change in condition or Resident care needs." When asked if that included the development of new pressure areas or wounds being treated, she stated that it would. When asked if new interventions should be added with the new wounds that develop she stated they should. When asked if the old or resolved wounds should be marked as "Resolved" and the date noted on the care plan and she stated that they should. When asked why is this important and she responded that it was important for wound tracking to know if and when a wound resolves

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and if the interventions are effective.

On 8/11/21 during the end of day meeting the Administrator was made aware of the concerns and no further documentation was provided

2. For Resident #5 the facility staff failed to review and revise care plan to include actual falls and new interventions for each fall.

Resident # 5, a 72-year-old man admitted to the facility on 3/3/21 with diagnosis of but not limited to hypertension high cholesterol history stroke chronic diastolic heart failure schizophrenia adult failure to thrive Dysphasia severe protein calorie malnutrition.

Resident # 5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/2/21 a quarterly review how did the resident is having a Benz (brief interview of mental status) score of nine indicating moderate cognitive impairment. Resident # 5's was also coded the as requiring (#3) extensive assistance of (#2) one person physical assistance for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing. He is coded as setup up with supervision for meals.

On 8/10/21 during clinical record review it was noted that resident number five has had 7 falls since his admission on 3/3/21. The clinical record revealed falls on the following dates' 3/11/21, 3/13/21, 3/22/21, 4/27/21, 5/18/21,

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5/24/21, and 7/26/21.

On 8/11/21 a review of the care plan read:

FOCUS:

"[Resident #5 name redacted] is at risk for falls related to deconditioning, medication side effects, incontinence, and history of falls.
Date initiated: 03/12/21 Revision: 06/15/21"

"Fall risk score 25 on 06/05/21"

"GOAL:
Minimize the risk of sustaining serious injury through the review date. Date initiated: 03/12/21: Revision: 3/23/21"

"Interventions:
05/18/21 staff education, resident to be in visual [sic] while awake and toilet as indicated
Date initiated: 5/19/21
Nonskid footwear when sitting on the side of the bed
Date initiated: 3/11/21
Anti-Rollback to be applied
Date initiated: 5/24/21
Be sure the residents call light within reach and encourage the resident to use it.
Date initiated: 3/12/21
Bed in low position
Date initiated: 3/12/21
Educate the resident and resident's representative caregivers about safety reminders and what to do if fall occurs. Date initiated: 3/12/21
Ensure that the resin is wearing appropriate footwear with non-slip bottoms when ambulating or mobilizing in wheelchair.

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F 657	Continued From page 28 Date initiated: revision on 3/16/21 Fall mat to bedside Date initiated: 6/15/21 Med review Date initiated: 4/27/21 Move resident to a room closer to nursing station Date initiated: 3/29/21 PT evaluate and treat as ordered and PRN Date initiated: 3/12/21" On 8/11/21 at approximately 2:00 PM an interview was conducted with the DON who stated "The care plan should be updated quarterly and with any change in condition or Resident care needs." She also stated "It is my expectation that the care plan be updated to include any new falls and new interventions. A review of the fall policy revealed: "C. Post fall strategies: Resident will be evaluated and post fall care provided 3. Notify physician and resident representative. 4. Re-evaluate using post fall eval. 5 Update care plan and Kardex with new interventions 7. Interdisciplinary team to review fall documentation and complete root cause analysis 8 Update care plan as appropriate" On 8/11/21 during the end of day meeting the Administrator was made aware of the concerns and no further documentation was provided	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		9/22/21

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F 658	Continued From page 29 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to provide care and services that meet professional standards, for 1 Resident (#1) in a survey sample of 5 Residents. The findings included: For Resident #1 the facility staff failed to turn and repositiion per physician recommendation and professional standards of practice for an elderly, non ambulatory Resident. Resident # 1, a 61-year-old woman, admitted to the facility on 8/6/15, with diagnoses of but not limited to multiple sclerosis, unspecified psychosis, major depressive disorder, dermatitis, Seborrheic dermatitis, hypertension and glaucoma. Resident #1's most recent MDS (minimum data set) with an ARD (Assessment reference date) of 5/3/21, coded the resident is having a BIMS (Brief interview of mental status) score of 12 out of 15 indicating minor cognitive impairment. Resident #1, is also coded as requiring extensive assistance for bed mobility requiring two persons physical assistance. The resident was coded as (4) total dependence with 2 person physical assistance and a Mechanical lift for all transfers. Resident number one is unable to walk, stand, or bear weight. She uses a wheelchair with assistance for locomotion on and off the unit. She is coded as (3) requiring extensive assistance for	F 658	1. Resident #1 no longer resides in the facility. 2. All residents in house who are currently dependent or require extensive assistance have the potential to be impacted by the alleged deficient practice. 100% of current residents who are coded dependent or extensive assist in the medical record will be audited for turning and repositioning interventions. Medical records identified with issues were addressed and the care plan was revised according to include repositioning interventions as tolerated. 3. Minimum Data Set Nurses/Assistant Director of Clinical Services/Unit Managers will be educated by the Director of Clinical Services regarding interventions for turning and repositioning implementation and care planning. During the am clinical meeting that occurs Monday thru Friday, the clinical management team (Director of Clinical Services, Assistant Director of Clinical Services, Minimum Data Set Nurses, Unit Managers and Medical Records) will review recently submitted Minimum Data Set to ensure interventions including turning and repositioning are assigned appropriately and the care plan and or Kardex will be updated at this time to ensure staff will be providing care and	

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F 658	Continued From page 30 dressing with one person physical assistance she needs supervision and set up for eating she is fully dependent on staff for toileting personal hygiene and bathing with one person physical assistance. Resident #1 was also coded as being incontinent of bowel and bladder. A review of the clinical record revealed that Resident had received treatment for a sacral wound which was documented as healed on 6/23/21. The physicians note read as follows: "Wound Sacrum (Resolved on 6/23/21) - Anatomic location of previously existing wound examined today. Epithelialized and Resolved. Follow up only as needed." "At the request of the provider [physician name redacted] a thorough wound care assessment and evaluation was performed today. She has a wound sacrum [sic] for at least 27 days duration. Prior healing wound has improved and requires confirmation of current clinical status and evaluation with preventive recommendations to prevent recurrence." 8/10/21 at approximately 9:55 AM, an interview was conducted with RN A who was asked if turning and repositioning was documented in the nurse's notes, and she stated it was not. When asked if the CNA documentation included turning and repositioning and she stated that it did not. A review of the clinical record revealed no documentation of turning and repositioning either by nurse or CNAs. .On 8/11/21 at approximately 2:56 PM an interview was conducted with the wound care physician who was asked what measures were put into place to prevent the sacrum wound from	F 658	services to meet the requirements of professional standards. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit submitted Minimum Data Sets to ensure accurate documentation regarding resident level of dependency is captured and that the care plan and kardex has been implemented/revised as indicated weekly x 4 weeks then monthly x two months. The Clinical Management team (Director of Clinical Services, Assistant Director of Clinical Services, Minimum Data Set Nurses, Unit Managers and Medical Records) will audit 25% of residents coded as dependent or extensive assist weekly to ensure they are being turned and repositioned in accordance with professional standards. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.	

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returning or reopening once it healed on 6/23/21. The wound care physician stated "I recommended the air mattress, the house barrier cream and turn and reposition per facility protocol."

On 8/11/21 surveyor B requested policy and procedures for wound care, and turning and repositioning of dependent Residents.

On 8/11/21 at approximately 2:00 PM an interview was conducted with the DON who stated "We don't have a specific policy or procedure for turning and repositioning dependent Residents it's just a nursing standard." When asked what nursing guidance they used the DON stated that they used Lippincott.

According to Lippincott Manual of Nursing Practice 11th Edition page 151
"Nursing and patient care considerations:
1. Provide meticulous care and positioning for immobile patients.
 a. Inspect skin several times a day.
 e. Employ bowel and bladder programs to prevent incontinence.
 g. Promote nutritious diet with optimal protein, vitamins, and iron.
2. Teach older adult and family or significant other the importance of good nutrition, hydration positioning and avoidance of pressure shearing, friction and moisture

"Relieve the Pressure:
2. Reposition every 2 hours.
3. Use special devices to cushion areas, (especially boney areas) such as floatation rings, lamb's wool, convoluted foam mattress, booties, and elbow pads. Lift heels off the bed in

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F 658	Continued From page 32 bedbound patients. 6. Advise frequent shifting of weight, and occasional raising of the buttocks off the chair while sitting." "Lippincott's Advances in Skin & Wound Care [journals.lww.com]" "Plans and scheduling- A written plan for the use of positioning devices and schedules are helpful for the chair bound and bed ridden patients." "Repositioning at risk patients in bed should be repositioned at least every 2 hrs. If consistent with overall patients goals, Use a written schedule for turning and repositioning" On 8/11/21 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		9/22/21

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Based on interview, facility documentation, clinical record review and in the course of an investigation the facility staff failed to adequately prevent, identify and treat pressure areas for 1 Resident (#1) in a survey sample of 5 Residents.

The findings included:

For Resident #1 the facility staff failed to implement the preventative measures, and accurately identify a pressure area.

Resident # 1, a 61-year-old woman, admitted to the facility on 8/6/15, with diagnoses of but not limited to multiple sclerosis, unspecified psychosis, major depressive disorder, dermatitis, seborrheic dermatitis, hypertension and glaucoma. Resident #1's most recent MDS (minimum data set) with an ARD (Assessment reference date) of 5/3/21, coded the resident is having a BIMS (Brief interview of mental status) score of 12 out of 15 indicating minor cognitive impairment.

Resident #1, is also coded as requiring extensive assistance for bed mobility requiring two persons physical assistance. The resident was coded as (4) total dependence with 2 person physical assistance and a Mechanical lift for all transfers. Resident number one is unable to walk, stand, or bear weight. She uses a wheelchair with assistance for locomotion on and off the unit. She is coded as (3) requiring extensive assistance for dressing with one person physical assistance she needs supervision and set up for eating she is fully dependent on staff for toileting personal hygiene and bathing with one person physical assistance. Resident #1 was also coded as being incontinent of bowel and bladder.

F 686

1. Resident #1 no longer resides in the facility.

2. All residents in house have the potential to be impacted by the alleged deficient practice.

In house residents had their medical records audited on 8/25/21 for skin issues with regarding to identification and care planning. Medical records identified with issues were addressed and the care plan was revised accordingly and wound documentation revised as needed.

Residents in house had a skin evaluations to determine base line skin status.

3. Minimum Data Set Nurses/Assistant Director of Nursing/Unit Managers will be educated by the Director of Clinical Services regarding wound identification and interventions with care plan revision. During the am clinical meeting that occurs Monday thru Friday, the clinical management team (Director of Clinical Services, Assistant Director of Clinical Services, Minimum Data Set Nurses, Unit Managers and Medical Records) will review skin issues to ensure proper identification and interventions are assigned appropriately and the care plan will be updated at this time.

The clinical team (Director of Clinical Services, Assistant Director of Clinical Services, Minimum Data Set Nurses, Unit Managers and Medical Records) will also review wounds in the weekly Standards of

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F 686	Continued From page 34 On 8/10/21 during the clinical record review it was discovered that Resident #1 had wounds and was seen by the wound care doctor. On 5/5/21 the Resident was seen for a wound to her lower back, described by the wound doctor as a "skin tear from brief." Excerpts from the physician notes are as follows: "5/5/21(site 2) wound (back) Wound details: Duration: > 1 day Objective: healing. Skin tear from brief Wound size 5.3 x 1.7 x 0.1 cm. Surface area 9.01 cm² Exudate light serosanguinous Slough 35% Granulation tissue 30% other viable tissues 20% (dermis) skin 15% Site to surgical excision of debridement procedure" "Indication for procedure: Remove necrotic tissue and establish the margins of viable tissue Procedure Notes: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade pickups were used to surgically excise 3.15 cm² of the vitalize tissues including slough biofilm and non-viable subcutaneous fat and surrounding connective tissue were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. Hemostasis was achieved and clean dressing was applied post op recommendation and updates to the plan of care a document in the system at assessment and plan section below." "Other diagnoses" Incontinence associated	F 686	Care meeting as a double check to ensure interventions are in place and the care plan is revised as needed, and the clinical team will also ensure that residents have their weekly skin evaluation scheduled and completed in PCC. 4. Director of Clinical Services/ Assistant Director of Clinical Services/Unit Managers/Minimum Data Set Nurses will audit 25% of residents with wounds for accurate documentation and care plan implementation/revision weekly x 4 weeks then monthly x two months. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.	

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dermatitis, treatment house barrier cream to buttocks Q shift."

"5/26/21 Focused wound assessment (site 2) wound back (resolved 5/26/21) duration > 20 days
Objective healing Skin tear from brief. Wound progress resolved follow up as needed.

"5/26/21 - 10:55 AM -Pressure Wound Rounds - R Foot 2.3 cm x 2.3 cm Deep Tissue Injury"

"5/26/21 Focused wound exam (site 3) wound: Sacrum
Duration: >1 day. Objective healing, excoriation in a setting of moisture dermatitis
Wound size 0.6 x 0.7 x (by not measurable) cm.
Surface area 0.42 cm²
Exudate light serosanguinous
Granulation tissue 100%
Treatment plan Xeroform sterile gauze apply once daily for 30 days secondary dressing island gauze with border apply once a day for 30 days
Procedure: cauterization for abnormal granulation tissue - Chemical cauterization of abnormal granulation tissue was performed on the sacrum wound with topical anesthetic to facilitate healing, no complications or bleeding."

"6/2/21 -Wound sacrum - improved evidenced by decreased surface area procedure surgical excision of debridement primary dressing frequency continue Xeroform sterile gauze and island gauze with border
Surgical excisional debridement procedure the wound was cleaned a normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curate was used to surgically excise 0.02 cm² of

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devitalized tissue including soft biofilm and non-viable subcutaneous fat and surrounding connective tissues were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. Hemostasis was achieved and clean dressing was applied postoperative recommendations updates of the care plan or documented in the assessment plan section below. "

"Unstageable DTI of the right foot resolved 6/2/21 Etiology: pressure stage DTI unstageable with intact skin duration more than seven days objective healing wound progress RESOLVED follow up as needed. "

"6/9/21 Focused Wound Exam (site three)
Duration > 14 days Objective healing, excoriation in a setting of moisture dermatitis. Wound size 0.3 x 0.8 x 0.1 cm. Surface area 0.24 cm^2.
Slough 5% Granulation tissue 95%
Excisional debridement procedure
Indication for procedure to remove necrotic tissue and establish margins a viable tissue procedure note wound was cleaned with normal saline anesthesia was achieved using topical benzocaine. Then with clean surgical technique was used to surgically excise 0.01 cm^2 devitalized tissue including soft biofilm and non-viable subcutaneous fat and surrounding connective tissues were removed at a depth of 0.12 cm and healthy bleeding tissue was observed.
Hemostasis was achieved and a clean dressing was applied. Postoperative recommendations and updates to the plan of care or document in the assessment plan section below.
Dressing Xeroform sterile gauze continue island dressing daily. "

6/16//21 Focused wound (site three) Wound

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Sacrum"
"Duration :> 21 days"
"Objective healing, excoriation in a setting of moisture dermatitis wound size 0.2 x 0.7 x 0.1 surface area 0.14 cm² exudate light serosanguinous slough 5%, granulation tissue 95%, and wound progress improved.
Site three surgical excision of debridement procedure:

Indication for procedure remove necrotic tissue and establish margins of viable tissue.

Procedure note: The wound was cleaned with normal saline anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 0.01 cm² of devitalized tissue including soft biofilm and non-viable subcutaneous fat and surrounding connective tissues were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied postoperative recommendations and updates to the care plan or document in the assessment and plan section below
Dressing Xeroform sterile gauze and island border dressing. "

"Wound Sacrum (Resolved on 6/23/21) - Anatomic location of previously existing wound examined today. Epithelialized and Resolved. Follow up only as needed. "
"At the request of the provider [physician name redacted] a thorough wound care assessment and evaluation was performed today. She has a wound sacrum [sic] for at least 27 days duration. Prior healing wound has improved and requires confirmation of current clinical status and

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evaluation with preventive recommendations to prevent recurrence."

"6/30/21 Focused wound exam (site 1)
Wound: Sacrum
Duration: > 1 day
Objective healing skin tear in a setting of moisture dermatitis
Wound size (l x w x d) 1 x .09 x .01 cm surface area .90 cm² exudate light serosanguinous granulation tissue 100%
Dressing is Xeroform sterile gauze with island gauze change daily."

"7/7/21 - Focused wound exam (site 1)
Duration: >7 days
Objective: Healing skin tear in a setting of moisture dermatitis.
Size 4.6 x 4.0 x 0.1 surface area 18.40 cm²
Exudate light serosanguinous, thick adherent devitalized necrotic tissue 30%, granulation tissue 60%, and skin 10%
Progress: deteriorated"

(Site 1) Surgical excisional debridement
Procedure: Indication for procedure to remove necrotic tissue and establish margins a viable tissue.
Procedure note: Wound was cleaned with normal saline and anesthesia was achieved using topical benzocaine. Then with a clean surgical technique, 15 blade pick-ups were used to surgically excise 5.5 cm² of devitalized tissue and necrotic muscle and surrounding fascial fibers were removed at a depth of 1 cm and healthy bleeding tissue was observed. Hemostasis was achieved and a clean dressing was applied. Postoperative recommendations and updates to the plan of care or documented in the assessment plan section

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below."

Additional Wound Detail:

Wound larger this week with necrosis in center. Given rapid worsening suspect wound infection. No erythema or tenderness surrounding it so no need for oral antibiotics at this point.
Dressing treatment plan: Discontinue Xeroform add triple antibiotic ointment and island border gauze
A review of the clinical record revealed that on 7/12/21 the Resident had a fall, after the fall the staff noticed that Resident #1 was running a fever and that her wound was draining and foul smelling. The Resident was sent to the ER and ER Record read as follows:

"There is evidence of sacral decubitus ulcer. There is evidence of osteomyelitis of the junction of the inferior sacral and proximal coccygeal segment. Locules of air and phlegmon identified in the soft tissues in this region. Similar changes extend to the left posterior hemi-pelvis which also extend into the left S1 neural foramen and spinal canal. Locules of air and fluid are also identified in the posterior medial right piriformis muscle extending into the right S3 neural foramen. This is consistent with an abscess which measures 46 mm transfers by 26 mm AP."

"Impression:"
"A sacral decubitus ulcer is identified, there is evidence of secondary osteomyelitis in the sacrococcygeal region. A secondary abscess is identified within the right piriformis muscle extending into the right S3 neural foramen. Locules of air and limb are identified in the left posterior hemi pelvis which extends into the left

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F 686	Continued From page 40 S1 neural foramen Locules of air and possibly infection extend into the lumbosacral spinal canal (likely intradural extramedullary in location) to the T 12- L1 level. " 8/10/21 at approximately 9:55 AM, an interview was conducted with RN A who was asked if turning and repositioning was documented in the nurse's notes, and she stated it was not. When asked if the CNA documentation included turning and repositioning and she stated that it did not. A review of the clinical record revealed no documentation of turning and repositioning either by nurse or CNAs. On 8/11/21 surveyor B requested policy and procedures for wound care, and turning and repositioning of dependent Residents. On 8/11/21 at approximately 2:00 PM an interview was conducted with the DON who stated "We don't have a specific policy or procedure for turning and repositioning dependent Residents it's just a nursing standard." When asked what nursing guidance they used the DON replied Lippincott. On 8/11/21 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 686		