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 04/09/2021

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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted 4/7/21 through 4/9/21. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 130 certified bed facility was 104 at the time of the onsite survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and Abbreviated survey was conducted 4/7/21 through 4/9/21. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Four complaints were investigated during the survey. The census in this 123 certified bed facility was 104 at the time of the survey. The survey sample consisted of 14 resident reviews (Residents #1 through #14).	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced	F 558		5/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/29/2021

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 558	Continued From page 1 by: Based on observations, resident interviews, staff interviews, clinical record reviews, and in the course of an investigation, the facility staff failed to accommodate for resident needs/preferences for 6 residents (Resident #11, Resident #4, Resident #5, Resident #6, Resident #8) in a sample size of 14 residents. The findings included: 1). For Resident #11, the facility staff failed to provide a call light within reach when she was in need of staff assistance on 04/08/2021. Resident #11, a 69-year-old female, was admitted to the facility on 08/06/2019. Diagnoses included but were not limited to chronic obstructive pulmonary disease and malignant neoplasm of the lung. Resident #11's most recent Minimum Data Set with an Assessment Reference Date of 02/17/2021 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 bed mobility was coded as requiring extensive assistance from staff. On 04/07/2021 at 10:25 A.M., Resident #11 was observed lying in her bed with the head of the bed elevated approximately 45 degrees. Resident #11 was receiving oxygen at 2 liters per minute via nasal cannula. Resident #11's call bell was observed to be on the bedside table out of Resident #11's reach. When asked about where her call bell was located so she could call staff for assistance if needed, Resident #11 stated she didn't know where it was [located]. At 11:02 A.M., the call bell was observed on the bedside table	F 558	1. Resident #11 call bell was placed within reach on 4/8/21. Resident # 4, #5, and #6 call bell were placed within reach on 4/7/21. Resident #8 clock was corrected on April 9, 2021. 2. Residents may have the potentially affected. An audit was completed on April 23, 2021 to ensure all call bells are within reach and that all clock were accurate. 3. Executive Director and or designee will re-educated the facility staff on the ensuring call bells are within reach and clock are accurate by April 28, 2021 4. The Executive Director and or designee will round for observation of call bells in place 2 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary 5. Date of Compliance – May 3, 2021	

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F 558	Continued From page 2 out of Resident #11's reach. On 04/08/2021 at 10:46 A.M., Resident #11 was observed lying in her bed with the head of the bed elevated approximately 45 degrees. Resident #11 was receiving oxygen at 2 liters per minute via nasal cannula. Resident #11's call bell was observed to be on the bedside table out of Resident #11's reach. Resident #11 stated, "I need help." When asked about calling staff for assistance with her call bell, Resident #11 indicated she didn't know where it was located. This surveyor alerted Licensed Practical Nurse A (LPN A) that [Resident #11] needed assistance. LPN A entered Resident #11's room and asked [Resident #11] what she needed. Resident #11 stated that her nose hurt and stated that she couldn't breathe. LPN A asked Resident #11 if she wanted a breathing treatment and Resident #11 stated, "Yes." LPN A then left the room. Resident #11's call bell remained on the bedside table out of her reach. At 10:50 A.M., LPN A returned to the room and applied the nebulizer mask and initiated a nebulizer treatment. At 11:10 A.M., LPN A removed the nebulizer mask, asked Resident #11 if she felt better, and reapplied the nasal cannula. Resident #11 indicated she felt better and LPN A left the room. Resident #11's call bell remained on the bedside table out of reach. At 11:13 A.M., this surveyor asked LPN A if she observed anything concerning regarding Resident #11. LPN A entered Resident #11's room, looked around, saw call bell on table, then placed it on Resident #11's bed within her reach. Upon exiting the room, this surveyor asked LPN A about the expectation for call bells and LPN A stated that residents should have their call bell in reach so "they can have it in case of an emergency."	F 558		

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	495235	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 558	Continued From page 3	F 558		

On 04/09/2021, Resident #11's care plan was reviewed. A focus revised on 03/04/2021 entitled "The resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to impaired cognition and impaired safety awareness." An intervention associated with this focus documented, "Encourage the resident to use bell to call for assistance."

On 04/09/2021 at approximately 11:30 A.M., the administrator and Regional Director of Nursing were notified of findings. The Regional Director of Nursing stated that the expectation is that the call bell should be within reach and located wherever the resident prefers.

2) For Resident #4, the facility staff failed to ensure Resident #4 had her call bell within reach on 04/07/2021 resulting in Resident #4 not being able to call for assistance with emesis basin.

Resident #4, a 72-year-old female, was admitted to the facility on 03/22/2021. Diagnoses included but not limited to chronic obstructive pulmonary disease, dysphasia, and COVID-19.

Resident #4's most recent Minimum Data Set with an Assessment Reference Date of 03/31/2021 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "14" out of possible "15" indicative of intact cognition. Functional status for toileting and personal hygiene were coded as requiring extensive assistance from staff.

On 04/07/2021 at 11:26 A.M., this surveyor and

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 04/09/2021

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F 558	Continued From page 4	F 558		

Employee H, Director of Maintenance, entered through a set of closed doors and a zipped plastic partition approximately 10 feet beyond the doors to enter the COVID unit. There was no nursing staff observed on the COVID unit. There were 7 residents on the COVID unit. At 11:39 A.M., this surveyor requested to speak with nursing staff and Employee H then made a call requesting nursing staff come to the COVID unit.

On 04/07/2021 at 12:00 P.M., Licensed Practical Nurse B (LPN B) and Certified Nursing Assistant C (CNA C) entered the COVID unit. This surveyor, LPN B, and CNA C entered Resident #4's room. As we were exiting the room, this surveyor pointed out that Resident #4's call light was clipped to her blanket but hanging down off this side of the bed where the call bell and cord were out of Resident #4's reach. CNA C stated that it "must have fallen" because "she moves around." CNA C did not put Resident #4's call light within reach at that time. At 12:15 P.M., LPN B and CNA C doffed their personal protective equipment (PPE) and left the COVID unit (exiting through the plastic partition, zipped it shut, and walked through the set of doors beyond the plastic partition). At 1:16 P.M., CNA C returned to the COVID unit with a lunch for Resident #4 and entered her room. At 1:18 P.M., CNA C then left Resident #4's room and exited the COVID unit. At 1:19 P.M., this surveyor entered Resident #4's room to observe the call bell location. It remained hanging off the bed out of Resident #4's reach. When asked about her call bell, Resident #4 stated, "I don't know. She [CNA C] took my spit pan." When asked if she could call for assistance, Resident #4 stated, "She [CNA C] said she would bring it right back." Resident #4 had a moist cough occasionally throughout this observation.

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 04/09/2021

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F 558	Continued From page 5	F 558		

At 1:20 P.M., an emesis basin was observed on the sink in the Resident #4's bathroom. At 1:26 P.M., CNA C returned to Resident #4's room to deliver lunch to Resident #4's roommate (Resident #14). CNA C then exited the room and left the COVID unit.

At 1:45 P.M., this surveyor was standing on the COVID unit and heard a voice from Resident #4's room state, "Anybody out there?" This surveyor entered Resident #4's room. Resident #4's roommate (Resident #14) stated, "My roommate needs something." Resident #4 then stated "I keep spitting up." Resident #4 also stated she wanted her spit pan. Resident #4's call bell remained hanging down off the bed out of Resident #4's reach. Resident #14 activated her own call bell at that time. At 1:49 P.M., CNA C entered the COVID unit and then to Resident #4's room to answer the call bell. Resident #4 requested her spit pan [emesis basin] and CNA C gave her the emesis basin from the bathroom. CNA C did not ensure Resident #4 had her call bell within reach at that time. At 1:55 P.M., this surveyor and CNA C entered Resident #4's room. When asked about the call bell, CNA C stated that Resident #4 moves around and "it just fell." CNA C then placed Resident #4's call bell within her reach.

On 04/09/2021, Resident #4's care plan was reviewed. Providing a call bell was not addressed on the care plan.

On 04/09/2021 at approximately 11:30 A.M., the administrator and Regional Director of Nursing were notified of findings. The Regional Director of Nursing stated that the expectation is that the call bell should be within reach and located wherever

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 04/09/2021

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 558	Continued From page 6	F 558		

the resident prefers.

3) For Resident #5, the facility staff failed to ensure she had her call bell in reach to call for assistance as needed on 04/07/2021.

Resident #5, a 67-year-old female, was admitted to the facility on 04/05/2021. Medical diagnoses included but not limited to COVID-19, dysphagia following a cerebral infarction, and aphasia. Resident #5's admission Minimum Data Set was not completed at the time of survey.

On 04/07/2021 at 11:27 A.M., Resident #5 was observed lying in her bed with the head of the bed elevated approximately 45 degrees. Resident #5's eyes were open but did not answer when asked about how to call staff for assistance. Resident #5 closed her eyes again. The call bell was observed on the floor under the head of the bed.

On 04/07/2021 at approximately 2:00 P.M., an interview with Certified Nursing Assistant C (CNA C) was conducted. When asked if [Resident #5] uses her call bell, CNA C stated she didn't really know much about [Resident #5] but that she was total care and "she just got here yesterday." This surveyor and CNA C then entered Resident #5's room for the call bell observation. CNA C retrieved the call bell from the floor and placed it within Resident #5's reach. CNA C also asked Resident #5 if she was able to use the call bell and Resident #5 demonstrated she was able to press the call bell.

On 04/09/2021 at approximately 11:30 A.M., the

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 04/09/2021

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F 558	Continued From page 7	F 558		

administrator and Regional Director of Nursing were notified of findings. The Regional Director of Nursing stated that the expectation is that the call bell should be within reach and located wherever the resident prefers.

4) For Resident #6, the facility staff failed to ensure he had his call bell in reach to call for assistance as needed on 04/07/2021.

Resident #6, a 68-year-old male, was admitted to the facility on 12/18/2020. Diagnoses included but were not limited to Alzheimer's disease and COVID-19. The most recent Minimum Data Set with the Assessment Reference Date of 02/10/2021 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 dressing and toileting required extensive assistance from staff.

On 04/07/2021 at 11:38 A.M., Resident #6 was observed lying in his bed. The call bell was observed looped around and hanging on the wall out of Resident #6's reach. When asked about how to call for assistance, Resident #6 mumbled incomprehensively.

On 04/07/2021 at 12:55 P.M., Certified Nursing Assistant C (CNA C) entered Resident #6's room to serve lunch. After assisting to set-up the meal, CNA C left Resident #6's room. At 1:07 P.M., the call light was observed still out of Resident #6's reach looped around and hanging on the wall. At 1:37 P.M., the call light was observed to be within Resident #6's reach on the bed.

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 04/09/2021

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 558	Continued From page 8	F 558		

On 04/07/2021 at approximately 2:05 P.M., an interview with CNA C was conducted. When informed of call bell observations not within Resident #6's reach, CNA C indicated she saw the call bell was out of reach and gave it back to him. When asked about why it was looped on the wall, CNA C stated she forgot to give it back to him after A.M. care.

On 04/09/2021, Resident #6's care plan was reviewed. A focus revised on 02/11/2021 entitled "The resident has communication problem r/t [related to] unclear speech s/p [status post] CVA [cerebral vascular accident]." An excerpt of an intervention associated with this focus documented, "Ensure/provide a safe environment: Call light in reach ..."

On 04/09/2021 at approximately 11:30 A.M., the administrator and Regional Director of Nursing were notified of findings. The Regional Director of Nursing stated that the expectation is that the call bell should be within reach and located wherever the resident prefers.

5. For Resident # 8, the facility staff failed to ensure the clock in his room was correct.

Resident # 8, a 74 year old, was admitted to the facility on 2/25/2021. Diagnoses included but were not limited to: Rhabdomyolysis, COVID-19, Hypertension, Cerebral Infarction and Metabolic Encephalopathy.

Resident # 8's most recent Minimum Data Set (MDS) was an Admission assessment with an

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 04/09/2021

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 558	Continued From page 9	F 558		

Assessment Reference Date (ARD) of 3/1/2021. The MDS coded Resident # 8 with a BIMS (Brief Interview for Mental Status) score of "15" out of 15, indicating no cognitive impairment. Resident # 8 was coded as requiring extensive to total assistance of one staff person for Activities of Daily Living except extensive assistance of two staff persons for transfers and limited assistance of one staff person for dressing. Resident # 8 was coded as always incontinent of bowel and bladder.

During the initial tour of the facility on 4/7/2021 at 12:23 PM, Surveyor A observed in Resident # 8's room a white faced clock with black trim located on the wall facing the foot of the bed. The clock was observed to have the time "8:35."

Surveyor A submitted a written report regarding the interaction with Resident # 8 on the COVID 19 Unit:

"Observed (Resident # 8) in room (Room #) Asked the time, said he's hungry for lunch. Said the Clock on the wall is wrong. Clock stated 0835 (8:35 AM)"

Surveyor A also wrote Resident # 8 was "lying in bed, asked what time was it, stated I'm hungry, pointed to clock, Stated it needs to be fixed, told staff and it still is not fixed.

4/7/2021 at 1308 (1:08 PM) Resident # 8 saw Surveyor A in the hall and asked her to reset his clock. Surveyor A told Certified Nursing Assistant(CNA) C who entered the room at 1309 (1:09 PM) and left at 1310 (1:10 PM.) The clock stated 0920 (9:20 AM). Resident # 8 stated he asked CNA C to fix the clock and it still was not

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 04/09/2021

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 558	Continued From page 10	F 558		

fixed.

On 4/9/2021 at approximately 9:38 AM, the Director of Nursing was interviewed. The Director of Nursing stated that clocks were used to help with orientation to time. The Director of Nursing stated the clocks should have been accurate.

On 4/9/2021 at 10:09 AM, an interview was conducted with the Maintenance Director by Surveyor A and Surveyor B. The Maintenance Director stated he was not aware of the clock not functioning properly in Resident # 8's. The Maintenance Director stated the facility staff "just needed to fill out the maintenance request form" to notify Maintenance and he would put it in the computer system to remind maintenance to check batteries at least twice a year when the time changes.

The Maintenance Director was asked if checking the clocks for accuracy was a part of the normal routine of the Maintenance Department. The Maintenance Director stated the Maintenance department responded to requests submitted by facility staff. However, the Maintenance Director stated he would begin to conduct audit rounds on clocks in rooms. The Maintenance Director stated it was important for any facility staff person to notify the Maintenance Department of a need to replace batteries in any clocks when needed. The Maintenance Director stated all employees receive orientation about the process of requesting Maintenance services during the new employee orientation and during regular inservices. The Maintenance Director stated it was important for clocks to be correct for the residents to help with their orientation.

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 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 11 On 4/9/2021 during the end of day debriefing, the facility Administrator, Regional Nurse and Director of Nursing were informed of the findings. The Administrator stated the Maintenance Director corrected the problem with Resident # 8's clock immediately when told by the surveyors. The Regional Nurse stated new batteries had been placed in the clock and that the clock should be accurate. The Administrator stated the Maintenance Director had developed a new plan for batteries to be checked at least twice a year "when the time changes'. All stated the facility staff should notify Maintenance if batteries need to be replaced. No further information was provided.	F 558		
F 607 SS=D	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, clinical record review, facility documentation review, and in the course of an investigation, the facility staff failed to implement their abuse policy to investigate an allegation of verbal abuse on 09/02/2020 for one	F 607	1. The Executive Director is no longer employed at the facility. 2. Residents have the potential to be affected. An audit was completed asking	5/3/21

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 04/09/2021

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F 607	Continued From page 12 resident (Resident #2) in a sample size of 14 residents. The findings included: Resident #2, a 53-year old male, was admitted to the facility on 08/04/2020 and discharged on 11/17/2020. Diagnoses included but were not limited to muscular dystrophy and chronic obstructive pulmonary disease. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/2020 was coded as a discharge assessment. The Brief Interview for Mental Status was not coded. Functional status for bed mobility, transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff. The MDS with an ARD of 11/11/2020 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. On 04/07/2021, a facility document dated 09/02/2020 entitled, "Complaint/Grievance Report" was reviewed. Excerpts of the following headers and entries included: "Communicated by: [Resident #2's full name] Communicated to: Social Services, [Employee F's name] Describe concern in detail: "He also feels that staff members do not display professional conduct on the floor. He says staff uses foul language and are rude to residents. Documentation of Investigation Assigned by: [Employee I, a previous Director of Nursing]. Findings of investigation: [illegible] Plan to resolve complaint/grievance: [illegible]."	F 607	interviewable residents regarding abuse completed on April 12, 2021. No other allegations were reported. 3. Executive Director and or designee has re-educated the facility staff on the abuse policy to ensure an allegation of abuse is investigated by April 28, 2021. 4. Reported allegations will be investigated and reported according to the facility policy. The Executive Director will ensure that a comprehensive investigation was completed. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. 5. Date of Compliance – 5/3/2021	

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	495235	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 607	Continued From page 13	F 607		

On 04/09/2021 at 10:45 A.M., an interview with Employee E, Social Worker, was conducted. When asked about the process after receiving a grievance/complaint from a resident stating that staff are using foul language and are rude to residents, Employee E stated that it would be treated like an allegation of abuse. Employee E stated that the Executive Director would be notified immediately and an investigation would be initiated. Employee E stated that the investigation would include obtaining written statements and reporting it to the state agency. A copy of the investigation, Facility Reported Incident, and follow-up were requested.

On 04/09/2021 at 1:06 P.M., an interview with Employee F, Social Services Assistant, was conducted. When asked about the grievance dated 09/02/2021, Employee F stated that he remembered [Resident #2] complained staff were rude to residents. When asked what was done about that, Employee F stated he notified [Employee J, previous executive director] via email about it. When asked if he knew what the executive director [Employee J] did about it, Employee F stated "I think they conducted an in-service for the staff. When asked if an investigation concerning an allegation of abuse was conducted, Employee F stated he wasn't sure if an investigation was done. A copy of the email correspondence was requested. Employee F stated he had the email and would provide a copy.

On 04/09/2021 at approximately 1:15 P.M., the administrator and regional Director of Nursing, Employee D were notified of findings. When asked about an investigation regarding the allegation of abuse, Employee D indicated an

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F 607	Continued From page 14	F 607		

investigation, FRI, and follow-up for an allegation of abuse on 09/02/2020 wasn't found. Employee D stated that staff received an in-service on customer service. Employee D added that it (the complaint) "sounded like unprofessional conduct." When asked if a complaint of 'staff being rude to residents' is considered a form of abuse, Employee D stated, "Not always, it depends." Employee D then stated the facility staff submitted documents for an allegation of neglect for 09/02/2020 and would provide a copy of the follow-up of that investigation. A copy of the email from Employee F to Employee J on 09/02/2020 was requested.

On 04/09/2021 at approximately 2:46 P.M., the facility staff provided a typewritten document dated 09/10/2021 addressed to the state agency from Employee J [previous executive director]. Excerpts of headers and entries included the following:

"RE [regarding]: 9/2/2020
Incident: Allegation of Neglect
Investigation: It was reported to the Executive Director that [Resident #2] felt he was being neglected because he was assisted to bed late. [The allegation of "staff rude to residents" was not addressed].
Findings: After completion of the investigation the allegation of neglect will not be substantiated.
Actions taken: Upon receiving the initial allegation of neglect an investigation was initiated. Resident and staff interviews were completed to rule out abuse or neglect. No other allegations were noted. Education will be provided as needed to staff and residents regarding abuse, customer service, and resident rights."

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F 607	Continued From page 15 The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Exploitation, & Misappropriation." Excerpts under the header, "Definitions" documented the following: "Mental Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered a form of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within the hearing distance regardless of age ability to comprehend or disability. Mental and verbal abuse include, but are not limited to: Harassing a resident; mocking, insulting, ridiculing; yelling or hovering over a resident, with the intent to intimidate." In Section 5 entitled, "Investigation" it was documented, "The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents." "The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse." On 04/09/2021 at 3:05 P.M., the administrator indicated there was no further information to submit.	F 607		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		5/3/21

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F 880	Continued From page 16	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 17 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and in the course of an investigation, the facility staff failed to adhere to infection control protocol according to The Centers for Disease Control and Prevention (CDC) guidance to mitigate the spread of COVID-19 for one unit (Colonial) out of three units (Colonial, Freedom, Liberty). The findings included: On 04/07/2021 at 11:11 A.M., this surveyor observed Certified Nursing Assistant C (CNA C) with a folded paper towel across the bridge of her nose under her N-95 mask. When asked about	F 880	1. CNA C no longer works at the facility. Employee D was provided education by the Infection Preventionist on proper PPE usage, donning/doffing on April 23, 2021. 2. Residents have the potential to be affected. 3. The Director of Clinical Services and or designee will educate the direct care nursing assistant staff on infection control practices (regarding donning and doffing PPE) by April 28, 2021. 4. The Executive Director and or designee	

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F 880	Continued From page 18 the paper towel, CNA C stated that the mask hurts the bridge of her nose and she uses the paper towel for padding. The metal piece across the bridge of her nose was not compressed to fit to her face. When asked if she pressed on the metal nose piece to conform it to her nose, CNA C indicated that she had not done that. Upon pressing the metal piece to mold the shape over the bridge of her nose, CNA C removed the paper towel and stated that it felt better. On 04/07/2021 at 11:24 A.M., this surveyor observed Employee H, Director of Maintenance, don personal protective equipment (PPE) prior to entering the COVID unit beyond a zipped plastic partition. After donning his gloves, Employee H adjusted the gown sleeve cuffs to lay over the gloves. When asked if he always wore the gown cuffs over the gloves, Employee H stated "Yes." On 04/09/2021 at approximately 11:45 A.M., the administrator, interim Director of Nursing, and Employee D, Regional Nurse, were notified of findings. When asked about the expectation of donning gown and gloves, Employee D stated the expectation is to wear the gloves on the outside of the gown cuffs. When asked about the expectation for wearing an N-95, Employee D indicated the expectation would be to not have a paper towel under the N-95. When asked why that's important, Employee D stated the N-95 needs to "have a seal to prevent the spread of Covid." A copy of their donning/doffing protocol was requested. On 04/09/2021 at approximately 1:15 P.M., the facility staff provided a copy of their donning/doffing protocol. An excerpt of a CDC publication entitled, "Sequence for Putting On	F 880	will round for observation of proper donning/doffing PPE and staff following proper precautions 2 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. 5. Date of Compliance – 5/3/21	

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F 880	Continued From page 19 Personal Protective Equipment (PPE)" documented, "Gloves: Extend to cover wrist of isolation gown." On 04/09/2021 at 3:05 P.M., the administrator indicated there was no further information to submit.	F 880		