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 _____	09/17/2021

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 An unannounced Emergency Preparedness survey was conducted 09/15/21 through 09/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/15/21 through 09/17/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 130 certified bed facility was 91 at the time of the survey. The survey sample consisted of 29 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		10/19/21

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

Electronically Signed | 10/07/2021

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 _____	09/17/2021

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintain Resident dignity for 1 Resident (Resident #23) in a sample size of 29 Residents. For Resident #23, the facility left her meal tray on the tray table next to the bed without setting up the meal or providing feeding assistance. Resident #23 required extensive assistance with meals. The findings included: On 09/16/2021 at 6:35 P.M., Resident #23 was	F 550	1. Resident #23 was immediately assisted by a staff member and was fed her dinner. 2. All residents who are dependent upon staff for meal feeding have the potential to be affected by the alleged deficient practice. An audit was completed of residents to determine who needs fed during meals and a list was provided to Charge Nurses for assignment purposes.	

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 _____	09/17/2021

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 550	Continued From page 2 observed awake, lying sideways in bed. The head of the bed was elevated approximately 60 degrees. This surveyor asked Resident #23 if she needed any assistance. Resident #23 did not respond to questions. At 6:50 P.M., this surveyor and the Director of Nursing observed Resident #23 positioned sideways in the bed and the meal tray not set up. The DON stated that staff should set up the meal tray and assist with feeding when the tray is delivered. The DON stated that the tray should stay in the warmer up until the time it is delivered to the resident and feeding assistance is given. The DON also stated she will ask staff to reposition Resident #23 and assist her to eat. When asked why that is important, the DON stated there were two reasons: 1) to maintain warm food temperatures and 2) it's a dignity issue to look at the food on the table but not be able to eat it [because staff failed to assist with eating]. On 09/17/2021, a review of Resident #23's Minimum Data Set with an Assessment Reference Date of 06/30/2021 revealed that Resident #23 required extensive assistance from staff for eating. On 09/17/2021 by the end of survey, the administrator and DON indicated there was no further information or documentation to submit.	F 550	3. Education will be provided for direct care staff on who requires assistance with feeding and how assignments will be made regarding those residents who need fed. Charge nurses will add those residents who require assistance to the assignment sheet each shift. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 5 residents that require feeding assistance per week x 4 weekly then monthly x two months to ensure they were assigned per the CNA assignment sheet and also that they were assisted with feeding. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review. 5. 10/19/2021	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		10/19/21

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 _____	09/17/2021

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 656	Continued From page 3 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive	F 656	1. Resident #56's medical record was reviewed and his care plan was updated accordingly to include his splint.	

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 _____	09/17/2021

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 656	Continued From page 4 care plan for 1 Resident (#56) in a survey sample of 29 Residents. The findings included: For Resident # 56 the facility staff failed to include the application and use of his left hand splint for contractures in his care plan. On 9/15/21 at approximately 8:30 AM an observation was made of Resident #56 in bed dressed in a hospital gown, eating his breakfast. Resident # 56 has paralysis on the left side of his body from a previous stroke and is unable to walk stand bear weight or use his left hand due to contractures. A hand splint was noted lying on the dresser in front of the television (approximately 10 feet from Resident.) During survey the following observations were made: On 9/15/21 at approximately 4:00 PM an observation was made of the splint still on the dresser in front of the television. Resident #56 lying in bed watching TV. On 9/16/21 at approximately 11:25 AM an interview was conducted with the Resident and he was asked if he has splint for his hand and he stated that he did. He also stated that the splint gets put on when staff "remember." The splint was on dresser in front of the television. On 9/17/21 at approximately 9:30 AM an observation was made Resident #56 was lying in bed and the splint was laying on the dresser in front of the television.	F 656	2. All residents in house with splints have the potential to be affected by the alleged deficient practice. A house audit was conducted focusing on those residents with splints to ensure their care plan addressed their splint use. 3. Minimum Data Set nurses and Unit Managers will be educated by the Director of Clinical Services regarding splinting interventions being captured on the care plans. 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 new orders to capture splints and the care plan will be updated at this time. The Clinical team will also review the splints in the weekly Standards of Care meeting as a double check to ensure interventions are in place and the care plan revised as needed. 4. Director of Nursing/Assistant Director of Clinical Services/Unit Managers/Minimum Data Set nurses will audit 100% of residents with splints 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.	

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 _____	09/17/2021

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 656	Continued From page 5 On 9/15/21 a review of the clinical record revealed that the Resident #56 has a physician's order that read: "Patient to wear left resting hand splint 3-4 hours, 2-3 times per day or as tolerated, for contracture management. Patient is dependent for donning, but is able to doff independently. Check for skin integrity every shift effective 7/16/2." A review of the clinical record revealed that the resting hand splint nor the skin check is not mentioned in the care plan nor is it on the MAR, or the TAR for the nurse to sign off donning and doffing of the splint, or inspection of skin. On 9/16/21 at approximately 2:00 PM an interview was conducted with the LPN B who was asked how do you know if a Resident has a splint or some adaptive equipment they might require, LPN B stated it would be on the care plan the Kardex or the TAR or MAR if the nurses have to put it on or take it off. On 9/17/21 an interview with the DON was conducted at 3:45 PM who stated that she also did not see the splint addressed on the care plan she stated it should be on the care plan, as well as the skin checks for the left hand. On 9/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.	F 656	5. 10/19/2021	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		10/19/21

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 _____	09/17/2021

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 677	Continued From page 6 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide assistance with daily living activities for 2 Residents (Resident #30, Resident #56) in a sample size of 29 Residents. 1) For Resident #30, the facility staff failed to provide nail care. 2) For Resident #56, the facility staff failed to provide adequate showering necessary for maintaining good personal hygiene. The findings included: 1) On 09/16/2021 at 1:57 P.M., Resident #30 was observed in his bed. Resident #30's nails were long. The nails extended out approximately 10-12 millimeters [1/2 inch] beyond the tips of the fingers. There was black debris under all the nails on the right hand. There were flakes of skin and unidentified debris under the nails of the left hand. Resident #30's left hand was contracted. Resident #30 did not respond when asked questions. At 2:00 P.M., this surveyor and Registered Nurse C (RN C) donned PPE and entered Resident #30's room for an observation. When asked about nail care for Resident #30, RN C stated "This needs to be taken care of. RN C also stated "He could cut his skin with those long nails." RN C stated Resident #30 "is aphasic [cannot speak] and uses a whiteboard." RN C	F 677	1. Resident #30 had nail care provided. Resident #56 was provided with a shower. 2. Current residents in house have the potential to be affected by the alleged deficient practice. A house sweep was completed to ensure resident's nails were clean and trimmed per resident preference. A house audit was conducted to ensure adequate personal hygiene per resident preference. 3. Charge Nurses and CNAs in house, to include agency staff, will be educated to shower and nail care expectations and documentation requirement. Unit Managers will review their shower list Monday thru Friday and compare to Point of Care to ensure showers/nail care were offered as indicated. Unit Managers will review medical record to ensure documentation is accurate. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 25% of residents weekly x 4 weeks then monthly x 2 months ensuring that showers/nail care is offered as indicated and the documentation in the medical record is accurate. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review.	

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 _____	09/17/2021

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 677	Continued From page 7	F 677	5. 10/19/2021	

offered Resident #30 the whiteboard and Resident #30 wrote "cannot hear" on the whiteboard. When asked if he needed anything per the whiteboard, Resident #30 did not express any needs at that time.

On 09/16/2021 at approximately 3:40 P.M., Resident #30's care plan was reviewed. One focus dated 07/14/2021 documented that Resident #30 "does not cooperated with nail care, will refuse most times." The intervention associated with this focus documented, "Encourage resident to have his nails trimmed and clean when needed."

On 09/16/2021 at 3:45 P.M., the Director of Nursing (DON) was notified of findings. When asked about the expectation for nail care, the DON stated the expectation is that everyone will have nail care. When asked about the expectation if a Resident refuses nail care, the DON stated that even if a resident is uncooperative, staff should make sure that everyone is taken care of. The DON stated that everyone has a staff member they are more fond of and would cooperate with care. The DON went on to say "we have to figure out who that is [for Resident #30]."

On 09/16/2021 at approximately 4:05 P.M., Certified Nursing Assistant B (CNA B) was observed at Resident #30's bedside. CNA B indicated that he was performing nail care for Resident #30.

On 09/17/2021 at approximately 11:00 A.M., this surveyor and the DON entered Resident #30's room to observe Resident #30's nails. Resident #30's nails were trimmed and clean.

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 _____	09/17/2021

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 677	Continued From page 8 On 09/17/2021, the facility staff provided a copy of their policy entitled, "Grooming Activities." Section 1 documented, "Grooming activities shall be offered daily. Section 2 documented, "Grooming Activities shall include but are not limited to: .....nail care." On 09/17/2021 by the end of survey, the administrator and DON stated they had no further information or documentation to submit. 2. For Resident #56 the facility staff failed to provide adequate showering necessary for maintaining good personal hygiene. On 9/15/21 at approximately 8:30 AM surveyor observed Resident #56 lying in bed head of bed elevated 45 degrees. Resident was dressed in hospital gown and eating breakfast. On 9/15/21 at 4:00 PM observed Resident #56 lying in bed with hospital gown on an interview was conducted with the Resident and he stated "I would like to get out of this bed. I would like to get a shower I know I haven't had a shower in at least 6 weeks. They wash me up but that isn't a shower Lord only knows the last time I had my hair washed. I know I have refused a couple of times but that didn't mean I never wanted a shower again. That was just me not wanting to go at that time." The Resident was asked if he had told anyone about wanting a shower and Resident #56 stated "Yes I have told them and they say they don't have time or they don't have enough staff."	F 677		

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 _____	09/17/2021

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 677	Continued From page 9	F 677		

A review of the POC (Point of Care - system where CNA's document ADL care provided) revealed the following:

Resident #56 is supposed to get showers on Monday and Wednesday on 7-3 shift.

June 2021 - Resident #56 received 6 bed baths and 4 showers in the month of June the last shower was 6/30/21.

July 2021- Resident #56 did not receive any showers in July - Resident #56 received 11 bed baths and 2 partial baths.

August 2021 - Resident #56 did not receive any showers in August - Resident #56 received 7 bed baths and 2 partial baths.

From September 1-15th Resident #56 had not received any showers but had received 4 bed baths and 2 partial baths.

On 9/16/21 at approximately 11:30 AM CNA B was asked how he knew what showers were to be given for the Residents, CNA B stated that it is written on the Kardex in the POC system. When asked what to do if a Resident refuses a shower CNA B stated that you give them some time and ask again later or ask them what would be a good time to come back.

On 9/16/21 at approximately 5 PM the DON was interviewed and when asked how often are Residents bathed or showered she stated they are all scheduled for 2 showers a week but it can be more frequent if necessary or requested. When asked about Resident #56 showers she

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 _____	09/17/2021

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 677	Continued From page 10 stated that he refuses sometimes. When asked what are the CNA's expected to do if a Resident refuses she stated they should offer a bed bath or a better time to come back to do the shower. On 9/17/21 at approximately 9:00 AM Resident #56 was observed in bed. When asked how he was doing he stated "I feel like a new man. I got my shower last night and I feel good." A review of the clinical record revealed the Resident was not care planned for resisting care or refusal of care. Review of the progress notes did not reveal refusal of care. On 9/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		10/19/21

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 _____	09/17/2021

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 688	Continued From page 11 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review the facility staff failed to ensure that Residents receive appropriate treatment and services to maintain or improve range of motion and mobility. The findings included: For Resident #56 the facility staff failed to apply left hand splint. On 9/15/21 at approximately 8:30 AM an observation was made of Resident #56 in bed, eating his breakfast. Resident # 56 has paralysis on the left side of his body from a previous stroke and is unable to walk stand bear weight or use his left hand due to contractures. A hand splint was noted lying on the dresser in front of the television (approximately 10 feet from Resident.) During survey the following observations were made: On 9/15/21 at approximately 3:00 PM an observation was made of the splint still on the dresser in front of the television. Resident #56 lying in bed watching TV. On 9/16/21 at approximately 11:25 AM an interview was conducted with the Resident and he was asked if he has splint for his hand and he stated that he did. He also stated that the splint gets put on when staff "remember." Resident #56 also stated "I want to get out of this	F 688	1. Resident's medical record was reviewed and updated as indicated. Resident's splint was applied as ordered. 2. Current residents in house with splints have the potential to be affected by the alleged deficient practice. In house residents with splint orders were reviewed to ensure device was in place and medical record documentation was accurate. 3. Charge Nurses and CNAs will be educated by the Director of Clinical Services/designee regarding splinting expectations and documentation. Unit Managers will review Point of Care documentation in the daily clinical meeting that occurs Monday thru Friday, to ensure splints were donned and doffed as indicated and that the medical record documentation is accurate. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 25% of residents with splints weekly x 4 weeks then monthly x 2 months ensuring that splinting is offered as indicated and the documentation in the medical record is accurate. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review. 5. 10/19/2021	

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 _____	09/17/2021

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 688	Continued From page 12 bed and get up and move around." When asked if the staff get him out of bed he stated that he has not been out of bed since the last time he got a shower. [Per CNA documentation Resident #56's last shower was 6/30/21] On 9/17/21 at approximately 9:30 AM an observation was made Resident #56 was lying in bed dressed in a hospital gown and the splint was laying on the dresser in front of the television. On 9/15/21 a review of the clinical record revealed that the Resident #56 has a physician's order that read: "Patient aware left resting hand splint 3-4 hours, 2-3 times per day or as tolerated, for contracture management. Patient is dependent for donning, but is able to doff independently. Check for skin integrity every shift effective 7/16/2." On 9/15/21 at approximately 2:00 PM an interview was conducted with the LPN B who was asked how do you know if a Resident has a splint or some adaptive equipment they might require, LPN B stated it would be on the care plan the Kardex or the TAR or MAR if the nurses have to put it on or take it off. On 9/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		10/19/21

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 _____	09/17/2021

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 689	Continued From page 13 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement fall precaution measures for 1 Resident (Resident #30) in a sample size of 29 Residents. For Resident #30, the facility failed to maintain the bed in the lowest position and the fall mat to the side of the bed for two occurrences on 09/16/2021. The findings included: On 09/16/2021 at 1:57 P.M., Resident #30 was observed in his bed. The head of the bed was elevated approximately 90°. The tray table was observed in front of Resident #30 and Resident #30 was eating oatmeal. Resident #30's bed was in an elevated position and the fall mat was approximately 2 feet in distance from the foot of the bed and not located at the side of the bed. Resident #30 did not respond when asked questions. At 2:00 P.M., this surveyor and Registered Nurse C (RN C) donned PPE and entered Resident #30's room for an observation. When asked if any concerns were observed, RN C stated the fall mat needs to be by the bed. Resident #30 was no longer eating oatmeal. RN C moved the tray table and put the fall mat by the left side of the bed. The right side of the bed was up against the wall. RN C also stated that the bed was too high and lowered the bed to its lowest position. When asked about the expectation of the fall mat when using a tray table, RN C stated	F 689	1. Resident #30 had his bed lowered and his fall mat was placed by the side of his bed. CNA B was educated to fall prevention/interventions for resident #30. 2. Current residents with fall interventions have the potential to be affected by the alleged deficient practice. Current residents in house had their fall interventions audited to ensure their interventions were in place and appropriate for the resident. 3. Facility staff to include agency will be educated by the Director of Clinical Services/designee regarding fall precautions and interventions. Mock Surveyors will audit their rooms for fall interventions Monday thru Friday morning prior to the daily stand up meeting to ensure interventions are in place as indicated. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 25% of residents weekly x 4 weeks then monthly x 2 months ensuring that fall interventions are in place as indicated and the documentation in the medical record is accurate. Any negative findings will be addressed immediately and brought	

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 _____	09/17/2021

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 689	Continued From page 14	F 689		

the tray table should go over the mat and keep the mat in place. RN C stated Resident #30 has a history of many falls. RN C stated Resident #30 "is aphasic [cannot speak] and uses a whiteboard." RN C offered Resident #30 the whiteboard and Resident #30 wrote "cannot hear" on the whiteboard. When asked if he needed anything per the whiteboard, Resident #30 did not express any needs at that time.

On 09/16/2021 at 4:00 P.M., Resident #30 was observed in his bed. The fall mat was approximately 5 feet away from the left side of the bed. The bed was in an elevated position. At approximately 4:02 P.M., Certified Nursing Assistant B (CNA B) then donned personal protective equipment (PPE) and entered Resident #30's room and closed the door. At approximately 4:03 P.M., RN B donned PPE and entered Resident #30's room. This surveyor and RN B observed CNA B standing next to Resident #30's bed rendering care. CNA B stated that he was doing nail care [for Resident #30]. When asked about the fall mat, RN B stated that [CNA B] probably moved it when doing care. When informed of observation at 4:00P.M., RN B stated the fall mat should be by the bed and the bed in lowest position when [Resident #30] not receiving care. When asked about the fall mat and bed position, CNA B stated that he had to go get a chair and other supplies to do nail care. When asked if he left the mat away from the bed and the bed elevated, CNA B stated that he left the mat by the bed and the bed in the lowest position.

On 09/16/2021 at approximately 5:00 P.M., the Director of Nursing (DON) was notified of findings. When asked about the expectation of the location of the fall mat during meals, the DON

before the monthly Quality Assurance meeting for review.

5. 10/19/2021

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 _____	09/17/2021

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 689	Continued From page 15	F 689		

stated she would rather have the fall mat by the bed when the tray table is in use in case the resident falls. The DON stated that a fall mat could prevent a broken hip.

On 09/16/2021, Resident #30's clinical record was reviewed. According to Change in Condition assessments and nursing progress notes, Resident #30 had 11 falls between January 2021 and September 2021. Of the 11 falls, there were 5 occurrences where Resident #30 was found on his fall mat at the side of bed and had no injuries.

On 09/16/2021, Resident #30's care plan was reviewed. For fall risk and actual falls, interventions included but were not limited to "bed in low position" and "protective mat to bedside floor."

On 09/17/2021 at 9:30 A.M., an interview with Employee P, the Minimum Data Set (MDS) nurse, was conducted. Employee P stated that staff let her know any time Resident #30 has a fall. When asked about falls for Resident #30, Employee P verified the number of falls Resident #30 had from January 2021 through September 2021 (11). Employee P acknowledged the importance of Resident #30 having a fall mat by the side of the bed and having the bed in the lowest position. Employee P stated that Resident #30 has cognitive issues, can be impulsive, and the goal is to prevent major injury from falls.

On 09/17/2021, the facility staff provided a copy of their policy entitled, "Fall Management." Under the header "Purpose", it was documented, "Is to identify residents at risk for falls and establish/modify interventions to decrease the risk of a future fall(s) and minimize the potential

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 _____	09/17/2021

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 689	Continued From page 16 for a resulting injury." On 09/17/2021 by the end of survey, the administrator and DON stated there was no further information or documentation to submit.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		10/19/21

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 _____	09/17/2021

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 758	Continued From page 17 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents are free from unnecessary psychotropic medications for 1 Resident (# 53) in a survey sample of 29 Residents. The findings included: For Resident #53 the facility staff failed to ensure the PRN Alprazolam (trade name, Xanax, an anti-anxiety medication) was ordered for no more than 14 days at a time. On 9/15/21 at approximately 8:45 AM during the medication pass observed RN B ask resident #53 if she needed her PRN Alprazolam prior to going to an appointment. A review of the clinical record revealed that Resident # 53 had orders for PRN Alprazolam that read:	F 758	1. The Nurse Practitioner was notified and a stop date was issued for Resident #53's PRN alprazolam. 2. Current residents receiving PRN anti-psychotics have the potential to be affected by the alleged deficient practice. In house residents with PRN antipsychotic medications ordered had their medical record audited and updated as indicated. 3. Facility nurses, to include agency, will be educated by the Director of Clinical Services/designee regarding unnecessary medications and PRN antipsychotic medication stop dates/reevaluation requirements. During the am clinical meeting, that occurs Monday thru Friday the clinical management team (Director of Clinical Services, Assistant Director of Clinical	

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 _____	09/17/2021

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 758	Continued From page 18 "Alprazolam 0.5 mg give 1 tab every 12 hours PRN anxiety order start date 7-7-21" [The order was still in effect as of 9/15/21.] On 9/15/21 a request was made of the DON for the pharmacy recommendations as they were not available on the EHR. On 9/16/21 a review of the pharmacy recommendations revealed that Resident #53 had 2 pharmacy recommendations about this medication that read as follows: 7/26/21- "[Resident #53 name redacted] has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date as required by CMS guidance: Alprazolam." This recommendation was not signed nor addressed by physician. 8/27/21- "Repeated recommendation from 7/26/21: Please respond promptly to assure facility compliance with Federal regulations. [Resident #53 name redacted] has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date as required by CMS guidance: Alprazolam." This recommendation was signed by physician on 9/8/21 and the box was checked that read: "I accept the recommendation above please implement as written." A review of the clinical record revealed the orders were not changed until 9/16/21. On 9/16/21 at 9 AM an interview with the DON	F 758	Services, Minimum Data Set nurses, Unit Managers and Medical Records) will review new orders to capture PRN antipsychotics and ensure a 14 day stop date/reevaluation is obtained from medical team. The Clinical team will also review the PRN antipsychotic medications will be reviewed in the weekly Standards of Care meeting as a double check to ensure reevaluations are in place and the medical record is revised as needed. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 25% of residents weekly x 4 weeks then monthly x 2 months ensuring that PRN antipsychotic reevaluations are in place as indicated and the documentation in the medical record is accurate. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review 5. 10/19/2021	

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 _____	09/17/2021

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 758	Continued From page 19 was conducted and she stated "The first recommendation was not addressed it got missed. The second one got addressed last night and the doctor d/c'd the old order and wrote a new one that starts on 9/16/21 and ends on 9/30/21." On 9/16/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from significant medication errors for 1 Resident (#60) in a survey sample of 29 Residents. The findings included: For Resident #60 the facility staff failed to ensure that Resident #60 had an adequate supply of the medication Gabapentin (an anti-convulsant) causing him to miss 10 doses of medication from 9/11/21 until 9/16/21. On 9/15/21 during clinical record review it was noted that Resident #60 had a physician's order for Neurontin (Gabapentin) 300 mg. twice a day. A review of the MAR (medication administration	F 760	1. Resident #60□s Gabapentin was received from the pharmacy on 9/16 and the medical team was notified with no new orders. 2. Current residents in house have the potential to be affected by the alleged deficient practice. An audit of medication carts/MARS was conducted to ensure medications for residents were available and/or ordered as indicated. 3. Facility nurses, to include agency staff, will be educated by the Director of Clinical Services/designee regarding the reordering of medications and medication availability processes. Unit Managers will audit the medication carts once a week to ensure that	10/19/21

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 _____	09/17/2021

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 760	Continued From page 20 record) revealed that the nurses had documented "#9" on the MAR for 9/11/21 5 PM, 9/12/21 9 AM and 5 PM, 9/13/21 9 AM and 5 PM, 9/14/21 9 AM and 5 PM, 9/15/21 9 AM and 5 PM. On the MAR key, #9 means "See Nurses Notes." A review of the progress notes revealed no information why the medication was not given. On 9/16/21 at 9 AM the MAR was coded as "#5 - Held." A review of the progress notes revealed the RN C wrote "Unable to locate" for reason the medication was held. On 9/16/21 at 5:00 PM an interview was held with RN B who was asked why the MAR showed #9 from 9/11/21-9/16/21 she stated that the medication was unavailable. She further stated "I know it was unavailable and not given because I just received it and put it away." When asked what a nurse should do if a medication is running low she stated that the nurse should call the pharmacy and let them know, and if a new script is needed the nurse should notify the physician and get a new script. The nurse should also get the medication out of the stat box to use until the medication arrives. When asked how you would know if this was done she stated the MAR would be signed off as medication given not "#9." On 9/16/21 at 5:05 PM revealed that the Narcotic count sheet stopped on 9/11/21 at 9 AM when the last dose was administered and a new sheet was not started until 9/16/21. On 9/16/21 an interview was held with the DON who stated that if a medication is unavailable the nurse is to notify the pharmacy and if a new script is needed notify the MD. The nurse should use medication from the stat box if it is available and if not they should let a supervisor or DON know	F 760	medications are available and reordered timely. 4. Director of Clinical Services/Assistant Director of Clinical Services/Unit Managers will audit 25% of residents weekly x 4 weeks then monthly x 2 months ensuring that medications are available and the documentation in the medical record is accurate. Any negative findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review 5. 10/19/2021	

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 _____	09/17/2021

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 760	Continued From page 21 so that it can be obtained from the back up pharmacy. A review of the Facility policy entitled ""07-Medication Shortage or Medication Unavailable" read as follows: ""If a medication shortage is discovered during normal pharmacy hours: "A facility nurse should call the pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order and re-order for the next scheduled delivery. If the next available delivery causes a delay or missed dose in the resident's medication schedule, the facility nurse should obtain the medication from the emergency medication supply to administer the dose. If the medication is not available in the emergency medication supply, facility staff should notify the pharmacy and arrange for an emergency delivery." "If a medication shortages discovered after normal pharmacy hours: A licensed facility nurse should obtain the ordered medication from the emergency medication supply. If the medication is not available in the emergency medication supply, the licensed facility nurse should call via pharmacies emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: emergency delivery; or, use of an emergency backup (third-party) pharmacy."	F 760		

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 _____	09/17/2021

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 760	Continued From page 22 On 9/17/21 during the end of day meeting the Administrator was made aware of concerns and no further information was provided.	F 760		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation the facility staff failed to serve food that is palatable, and served at a safe and appetizing temperature for 1 Resident in a survey sample of 29 Residents. The findings included: For Resident #56 the tray arrived at the Residents room 1 hour and 15 minutes after it was loaded in the warming cart and the food was cold by the time it reached the Resident. On 9/15/21 at approximately 8:30 AM an interview was conducted with Resident #56 who stated the hot food is never hot and the cold food is never cold it all room temperature by the time it gets to the room. On 9/16/21 at approximately 8:00 AM Surveyor E was doing medication pass observation with the	F 804	1. Resident #56 was given a meal that was safe with an appetizing temperature. 2. Current residents in house have the potential to be impacted by the alleged deficient practice. 3. Facility staff, including agency staff, will be educated on passing meal trays timely to ensure proper temperatures. Unit managers/house supervisors will observe tray passes weekly to encompass all three meals to ensure trays are passed timely and meal temperatures are appetizing. 4. Director of Clinical Services/Dietary Director will audit tray pass 5 times weekly times 4 weeks, then bi- weekly x 2 months to assess appropriate temperatures and timely meal pass times. Any negative	10/19/21

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 _____	09/17/2021

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 804	Continued From page 23 RN on the floor and noticed the tray cart was sitting in the hall and there was no one passing the trays. At 8:50 AM when med pass was completed Surveyor E observed the Social Worker passing breakfast trays. Staff were pulling the tray for Resident #56 and Surveyor E requested the tray be left on the cart and to please request dining staff to come and check the temp. The tray was left on the "Warming Cart" until the dietary staff got to the floor with the thermometer at 8:52 AM. Dietary Staff Employee N appropriately cleaned the thermometer and checked the temperature of the food. The results are as follows: Coffee - 106 degrees F Oatmeal - 108 degrees F Eggs - 97 degrees F Ham - 89 degrees F Juice - 60 degrees Milk - 60 degrees 09/16/2021 at 7:35 A.M. Surveyor C made the following notes about trayline observation: Scrambled Eggs 156.7 F Ham 159.2 F Mechanical ham 160.5 F Pureed eggs 150.8 F Oatmeal 176 F Pureed ham 136.7 F Pureed bread 136.2 F Milk 38.4 F On 9/16/21 at approximately 12:30 PM an interview was conducted with LPN C who stated that the meals are served in the Resident rooms	F 804	findings will be addressed immediately and brought before the monthly Quality Assurance meeting for review 5. 10/19/2021	

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 _____	09/17/2021

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 804	Continued From page 24 due to the outbreak. She stated "Anyone who is available comes to help pass trays the Social Workers, Activities, Administrator, and anyone who can because there are just 2 Nurses and 2 CNA's on the floor and only the Nurses and CNA's can feed Residents so we try to do the feeding while others are passing trays to those who can feed themselves." On 9/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 804		