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 _____	R-C 05/05/2022

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	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 03/27/22 through 03/30/22, was conducted 05/04/22 through 05/05/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. One complaint, VA00055082- unsubstantiated, was investigated during the survey. The census in this 130 certified bed facility was 62 at the time of the survey. The survey sample consisted of 14 resident reviews.	{F 000}		
{F 600} SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, the facility staff	{F 600}	1. Resident #103 blood glucose reading of 453 was reported to Medical Director on 5/5/22, Medication Error completed, Disciplinary action/Termination with Nurse identified, Medical Director & Responsible Party were notified on 5/5/2022 2. The Director of Clinical Services (DCS) or designee will audit all orders for acccuchecks and sliding scale coverage to ensure orders are clear and accurate. Follow up based on findings.	

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

Robin Baschnagel | Executive Director | revised 05/24/22

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{F 600}	Continued From page 1 neglected to call the doctor to obtain treatment orders following a Resident having a blood sugar in excess of 400 for one Resident (Resident #103) in a survey sample of 14 Residents. The findings included: For Resident #103, who had a blood sugar reading of 453, the facility staff neglected to contact the doctor for treatment orders. On 5/4/22, a clinical record review was conducted. This review revealed the following: The medication administration record (MAR) revealed that on 4/30/22 at the scheduled noon dose of sliding scale insulin, Resident #103's blood sugar reading was 453. The nurse noted "12". According to the "Chart Codes / Follow Up Codes" legend, "12=Insulin Not Required". Review of the physician order dated 7/8/21, read, "Humulin R Solution 100 UNIT/ML (Insulin Regular Human) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units and call MD for any BS <60 or >400, subcutaneously before meals and at bedtime for DM [diabetes mellitus]". There was no indication of any orders for insulin given/received on 4/30/22, in response to the blood sugar of 453. Review of the nursing notes revealed no progress notes with regards to the blood sugar reading, Resident assessment/condition and/or that the physician was notified. There were also no progress notes that would indicate Resident #103 was symptomatic due to the elevated blood sugar.	{F 600}	3. All Licensed/Registered Nurses will be educated by DCS/designee to notify MD for blood glucose levels outside of parameters if the Physician is not reached within 30 minutes the nurse will then contact the Medical Director for orders. The nursing education will further include to completion of documentation in the medical record in real time to state complete and accurate information. 4. DCS/designee will monitor accucheck measurement to ensure that orders are followed as written and MD notification was completed for any readings outside of written parameters along with documentation in the medical record. This will be completed 5 x weekly for 4 weeks, then weekly for 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	5/9/22

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{F 600}	Continued From page 2	{F 600}		

There were no findings in the clinical record of Resident #103 to indicate she experienced any adverse events/symptoms as a result of this non-compliance.

On 5/4/22 at 11:28 PM, an interview was conducted with LPN C, a third shift nurse. LPN C was asked what she does for Resident's on sliding scale insulin. LPN C said, "If the blood sugar is within a range and need coverage, you give the insulin ordered for that range. If it is too high, you would immediately call the doctor and they will guide you". LPN C was asked what the purpose of sliding scale insulin is, she said, "It's to help regulate their blood sugar". LPN C said the effects of having a high blood sugar and not getting insulin is, "They might go into a diabetic coma".

On 5/5/22 at 9:13 AM, a telephone interview was conducted with Employee H, the Nurse Practitioner (NP) who was on call for this facility the evening of 4/29/22-5/1/22. The NP checked her phone records and call logs and confirmed she had not received any calls from this nursing facility or its staff on 4/30/22. The NP was asked when she expects the staff to call a provider with regards to a Resident's blood sugar. She stated, "Usually the sliding scale order will saw when to call the provider".

During the above interview the NP stated that when she receives calls regarding elevated blood sugars she will ask what the highest scale of insulin is on the order and will use that to determine how much insulin needs to be given. She will then give an order telling the nurse how much insulin is to be administered and for the

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{F 600}	Continued From page 3	{F 600}		

staff to recheck the blood sugar in 1 hour and if it is still elevated to give me a call back". The NP was asked if there is ever a time that she would not treat a blood sugar and give orders when notified of a blood sugar reading over 400. The NP said, no, the purpose of the on-call provider is to fix the situation and then notify the regular provider. The NP again confirmed that she was not given the opportunity to provide any treatment orders for Resident #103 on 4/30/22, when her blood sugar reading was 453.

On 5/5/22 at 9:38 AM, a telephone interview was conducted with LPN D. LPN D was asked to describe sliding scale insulin. LPN D said, "It means that depending on the blood sugar reading is, will determine how much insulin they get". LPN D confirmed that insulin is always given based on physician orders. LPN D was asked what happens in the event that the blood sugar is outside of the range in the sliding scale order. LPN D said, "If it is too low we give something to bring it up and re-check it and notify the doctor. If it over the parameter we call the doctor and they will tell us what to do". LPN D repeated that if the blood sugar is too high or too low they always call the doctor.

LPN D was asked what symptoms a person may experience if their blood sugar is too high. She went on to say that she has one Resident that isn't even symptomatic, that without checking the blood sugar you wouldn't know that it is too high. LPN D said this particular Resident has snacks in her room and is very non-complaint. LPN D said, "One day last week her sugar was 448, if over 400 you have to call the doctor. [Resident's name redacted] will tell you to just give her 12 units and when you explain that you have to call

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{F 600}	Continued From page 4	{F 600}		

the doctor to get an order, she gets agitated and will say she isn't going to take it and will go down the hall. If you give her a minute and re-approach she will then take it". LPN D was asked to identify the Resident she was speaking of and she called Resident #103's name.

LPN D then went to the computer and was asked to access the record and describe what happened on 4/30/22, and what actions had been taken when Resident #103's blood sugar was 453. LPN D was heard typing and then paused and said she was having difficulty pulling it up and needed to go get some help. LPN D then placed the surveyor on hold. After holding for approximately 15-20 minutes, LPN D never came back to the line and Surveyor C then hung up.

The facility staff confirmed that their abuse policy had not changed since the survey ending on 3/30/22. A review of the policy was conducted and it read, "Abuse, Neglect, Exploitation & Misappropriation" policy on page 3 read, "Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress".

Review of "Potter & Perry Fundamentals of Nursing" eighth edition was conducted. On page 302, Box 23-2 "Common Negligent Acts" it read, "Failure to notify the health care provider of problems, failure to follow orders, failure to follow the six rights of medication administration, .. failure to follow policy and procedures"...

On 5/5/22, during an end of day meeting the facility Administrator, Director of Nursing and

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{F 600}	Continued From page 5 Corporate staff were made aware of the findings. They then presented the team with evidence that an "ad hoc" quality assurance meeting had been held on 5/5/22 at 10:55 AM, with regards to sliding scale insulin. The survey team reviewed the evidence submitted. Included in the documents was a copy of a late entry note entered into the clinical record of Resident #103 on 5/5/22 at 11:09 AM by LPN D. This note read, "Residents BS [blood sugar] was 453 called on call received VM [voicemail], Left message waiting for call back. Resident was given 10 units of coverage till here [sic] back from on call MD [medical doctor]". NOTE: This late entry was written after LPN D was interviewed by the surveyor. The survey team met with the facility Administration and Corporate staff to review the additional documents submitted. The facility management staff were notified that the survey team had spoken to the on-call provider for 4/30/22, and they reviewed their call records and call history and had no evidence of a call being received by the facility staff on that day. The facility administration confirmed that prior to the late entry note there had been no evidence that the facility staff had made any entry into the clinical record that any actions had been taken with regards to Resident #103's blood sugar reading of 453. No further information was provided.	{F 600}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	{F 658}	1. Resident #103 blood glucose reading of 453 was reported to Medical Director on 5/5/2022, Medication Error completed, Disciplinary action/Termination with Nurse identified, Medical Director & Responsible Party were notified on 5/5/2022	

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{F 658}	Continued From page 6 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, the facility staff failed to follow the nursing standards of practice, for one Resident (Resident #103) in a survey sample of 14 Residents. The findings included: For Resident #103, who had a blood sugar reading of 453, the facility staff failed to follow the physician orders with regards to a blood sugar reading of 400 or greater and call the doctor for further orders. During the survey, a late entry was made into the clinical record of Resident #103 which stated 10 units of insulin had been administered, which there was not a physician order for. On 5/4/22, a clinical record review was conducted. This review revealed the following: The medication administration record (MAR) revealed that on 4/30/22 at the scheduled noon dose of sliding scale insulin, Resident #103's blood sugar reading was 453. The nurse noted "12". According to the "Chart Codes / Follow Up Codes" legend, "12=Insulin Not Required". Review of the physician order dated 7/8/21, read, "Humulin R Solution 100 UNIT/ML (Insulin Regular Human) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units and call MD for any BS <60 [less than]	{F 658}	2. The DCS or designee will audit all orders for acccuchecks and sliding scale coverage to ensure orders are clear and accurate. Follow up based on findings. 3. All Licensed/Registered Nurses will be educated by DCS/designee to notify MD for blood glucose levels outside of parameters if the Physician is not reached within 30 minutes the nurse will then contact the Medical Director for orders. The nursing education will further include to completion of documentation in the medical record in real time to state complete and accurate information. 4. DCS/designee will monitor accucheck measurement to ensure that orders are followed as written and MD notification was completed for any readings outside of written parameters along with documentation in the medical record. This will be completed 5 x weekly for 4 weeks, then weekly for 4 weeks. DCS/designee will monitor sliding scale insulin out of range, documentation and Physician notifications 5 x weekly for 4 weeks, then weekly for 4 weeks.	

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{F 658}	Continued From page 7 or >400 [greater than], subcutaneously before meals and at bedtime for DM [diabetes mellitus]". Review of the nursing notes revealed no progress notes with regards to the blood sugar reading, Resident assessment/condition and/or that the physician was notified. There were also no progress notes that would indicate Resident #103 was symptomatic due to the elevated blood sugar. There was no evidence in the clinical record that Resident #103 experienced any untoward events as a result of the staff not calling the physician. On 5/5/22 at 9:13 AM, a telephone interview was conducted with Employee H, the Nurse Practitioner (NP) who was on call for this facility the evening of 4/29/22-5/1/22. The NP checked her phone records and call logs and confirmed she had not received any calls from this nursing facility or its staff on 4/30/22. The NP was asked when she expects the staff to call a provider with regards to a Resident's blood sugar. She stated, "Usually the sliding scale order will say when to call the provider". During the above interview the NP stated that when she receives calls regarding elevated blood sugars she will ask what the highest scale of insulin is on the order and will use that to determine how much insulin needs to be given. She will then give an order telling the nurse how much insulin is to be administered and for the staff to recheck the blood sugar in 1 hour and if it is still elevated to give me a call back". The NP was asked if there is ever a time that she would not treat a blood sugar and give orders when notified of a blood sugar reading over 400. The	{F 658}	The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	5/9/22

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{F 658}	Continued From page 8	{F 658}		

NP said, no, the purpose of the on-call provider is to fix the situation and then notify the regular provider. The NP again confirmed that she was not given the opportunity to provide any treatment orders for Resident #103 on 4/30/22, when her blood sugar reading was 453.

On 5/5/22 at 9:38 AM, a telephone interview was conducted with LPN D. LPN D was asked to describe sliding scale insulin. LPN D said, "It means that depending on the blood sugar reading is, will determine how much insulin they get". LPN D confirmed that insulin is always given based on physician orders. LPN D was asked what happens in the event that the blood sugar is outside of the range in the sliding scale order. LPN D said, "If it is too low we give something to bring it up and re-check it and notify the doctor. If it is over the parameter we call the doctor and they will tell us what to do". LPN D repeated that if the blood sugar is too high or too low they always call the doctor.

LPN D was asked what symptoms a person may experience if their blood sugar is too high. She went on to say that she has one Resident that isn't even symptomatic, that without checking the blood sugar you wouldn't know that it is too high. LPN D said this particular Resident has snacks in her room and is very non-complaint. LPN D said, "One day last week her sugar was 448, if over 400 you have to call the doctor. [Resident's name redacted] will tell you to just give her 12 units and when you explain that you have to call the doctor to get an order, she gets agitated and will say she isn't going to take it and will go down the hall. If you give her a minute and re-approach she will then take it". LPN D was asked to identify the Resident she was speaking of and

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{F 658}	Continued From page 9	{F 658}		

she called Resident #103's name.

LPN D then went to the computer and was asked to access the record and describe the events on 4/30/22, when Resident #103's blood sugar was 453. LPN D was heard typing and then paused and said she was having difficulty pulling it up/accessing it and needed to go get some help. LPN D then placed the surveyor on hold. After holding for approximately 15-20 minutes, LPN D never came back to the line and Surveyor C then hung up.

The facility policies for diabetic management and physician orders were requested. Review of these policies read,
1. "Insulin Administration" policy read, "...Check MAR for order three times...Select the dose according to the manufacturer's instructions and physician's order...Document in medical record..."
2. "Physician Orders" read, "The center will ensure that Physician orders are appropriately and timely documented in the medical record".
3. "Notification of Change in Condition" policy read, "The nurse to notify the attending physician and Resident Representative when there is a (n): Need to alter treatment significantly. New treatment. Discontinuation of a current treatment due to but not limited to: Adverse consequences. Acute condition. Exacerbation of a chronic condition...The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. The nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the Medical Director may be contacted. If the Medical Director does not respond, call 911 and document in the medical record. Notify the patient/resident and the

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{F 658}	Continued From page 10	{F 658}		

resident representative of the change in condition. Document notification in the medical record."

The facility's corporate clinical director stated they use "Potter and Perry" as their professional standards of practice for nursing services.

Review of "Potter & Perry Fundamentals of Nursing" eighth edition was conducted. On page 302, Box 23-2 "Common Negligent Acts" it read, "Failure to notify the health care provider of problems, failure to follow orders, failure to follow the six rights of medication administration, .. failure to follow policy and procedures"...

On 5/5/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the findings. The regional clinical director stated that the facility follows Potter and Perry as their nursing standard of practice. They then presented the team with evidence that an "ad hoc" quality assurance meeting had been held on 5/5/22 at 10:55 AM, with regards to sliding scale insulin. The survey team reviewed the evidence submitted. Included in the documents was a copy of a late entry note entered into the clinical record of Resident #103 on 5/5/22 at 11:09 AM by LPN D. This note read, "Residents BS [blood sugar] was 453 called on call received VM [voicemail], Left message waiting for call back. Resident was given 10 units of coverage till here [sic] back from on call MD [medical doctor]".

The survey team met with the facility Administration and Corporate staff to review the additional documents submitted. The facility staff stated that they identified the nurse should have

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{F 658}	Continued From page 11 called the medical director if she did not receive a return call from the on-call provider. The facility administration was asked to identify what physician order LPN D had been operating under if she administered the 10 units of insulin as the late entry note had indicated. They reviewed the chart of Resident #103 and confirmed there had not been a physician order with regards to this. The facility administration also confirmed that prior to the late entry note there had been no evidence that the facility staff had made any entry into the clinical record that any actions/call to the provider had been made with regards to Resident #103's blood sugar reading of 453. No further information was provided.	{F 658}		
F 880 SS=D	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 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,	F 880	1. Resident #107 was tested on 5/5/2022 with negative results. Resident #107 will be retested on 5/12/2022. Resident #107 placed on Transmission Based Precautions on 5/5/2022 2. A review of new admissions within the past 2 weeks will be completed by the DCS/ designee to ensure that they were tested for Covid-19 immediately upon admission and if negative, again in 5-7 days after admission. Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission)	

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F 880	Continued From page 12 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 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.	F 880	will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. Follow up based on findings. 3.DCS/designee will educate all licensed staff (RN/LPN) on the following process : New admissions/ re admissions: • Newly admitted or re-admitted residents, regardless of their vaccination status will have a series of two viral COVID-19 test, immediately and if negative, again in 5-7 days after admission. • Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative.	

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F 880	Continued From page 13 §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, clinical record review, and facility documentation review, the facility staff failed to maintain infection control practices in accordance with the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommendations to prevent the spread of COVID-19 for 1 resident, Resident #107, in a survey sample of 14 residents. The findings included: For Resident #107, the facility staff failed to quarantine and implement transmission based precautions following her readmission to the facility from a hospital stay. Resident #107 left the facility on 4/27/22, was admitted to a local hospital, and was re-admitted back to the facility on 5/1/22. Resident #107 is unvaccinated for COVID-19. On 5/4/22, Resident #107 was observed resting quietly in bed in her assigned room. There was no indication that Resident #107 was on transmission-based precautions (TBP) such as signage or the availability of personal protective equipment (PPE). On 5/4/22, at approximately 2:30 PM, a staff	F 880	The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. • Initiate transmission based precautions based on CDC guidance, including PPE –N95 or higher respirator, eye protection, gown and gloves • If the resident develops symptoms, notify the MD, and initiate COVID-19 viral test as soon as possible Residents who are up to date with all recommended COVID-19 vaccines and residents within 90 days of a COVID-19 infection do not need to be placed in quarantine. Center may consider quarantine for a resident who is moderately to severely immunocompromised, by 5/9/2022. 4. DCS/Designee will monitor admissions/re-admissions during the daily clinical review to ensure guidance followed for Covid-19 5 x weekly for 4 weeks, then weekly for 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with	

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F 880	Continued From page 14 interview was conducted with the facility Infection Preventionist (IP) who confirmed Resident #107 had just been re-admitted from the hospital on 5/1/22 and was not placed on TBP. The IP stated the facility follows current CDC (Centers for Disease Control and Prevention) recommendations for residents who are readmitted to the facility following hospitalization. A facility policy was requested and received. On 5/4/22, at approximately 9:00 PM, in the course of an interview that was conducted by Surveyor C, the IP stated, "For re-admissions, when an admission comes, we monitor for symptoms...if [the resident] is unvaccinated, we offer the vaccine, we don't quarantine them...". Review of the facility's policy entitled, "COVID-19--Pandemic Plan", revised on 3/11/2022, subheading, "Emergency Procedure--Pandemic COVID-19...The following procedure should be utilized in the event of a Pandemic COVID 19 outbreak in the community", item 13 on page 2 read, "New admissions/re-admissions: ...Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative....Initiate transmission based precautions based on CDC guidance, including PPE--N95 or higher respirator, eye protection, gown, and gloves". On page 9 of the same facility policy, subheading, "Re-opening Centers", read, "1. Centers will follow Federal and State guidelines for	F 880	quarterly monitoring by the Regional Director of Clinical Services / designee.	5/9/22

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F 880	Continued From page 15	F 880		

re-opening". On page 16 of the same facility policy, subheading, "Resident Outings--Leave of Absence", item 2 read, "Residents who leave the center for 24 hours or longer should be managed as a new admission/re-admission. Please refer to the 'Managing New Admissions/Re-Admissions' section of this plan". There was no section entitled "Managing New Admissions/Re-Admissions" nor any further reference found in any other part of the policy regarding the management of residents re-admitted to the facility.

Per CDC guidance, updated on February 2, 2022, entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", page 1, "Key Points...Even as nursing homes resume normal practices, they must sustain core IPC [infection prevention and control] practices and remain vigilant for SARS-CoV2 infection among residents and HCP [healthcare personnel] in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death".

Page 6 of the same CDC document, subheading "New Admissions and Residents who Leave the Facility--Create a Plan for Managing New Admissions and Readmissions", item 2 read, "In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission" and "Guidance addressing recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection [located on page 6]"

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F 880	Continued From page 16 which reads, "...HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)". The Facility Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 880		
{F 886} SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	{F 886}	1. Resident #107 was tested on 5/5/2022 with negative results. Resident #107 will be retested on 5/12/2022. Resident #107 placed on Transmission Based Precautions on 5/5/2022. The Infection Preventionist Nurse retested employees (LPN B and CNA B) with no test results on 5/05/2022, Employees (LPN B and CNA B) were negative. 2. A review of new admissions within the past 2 weeks will be completed by the DCS/ designee to ensure that they were tested for Covid-19 immediately upon admission and if negative, again in 5-7 days after admission. Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms).	

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{F 886}	Continued From page 17 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, and clinical record review the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for one Resident (Resident #107) in a survey sample of 14	{F 886}	Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. Follow up based on findings. The COVID vaccine records were reviewed by the DCS to identify employees not vaccinated or not up to date with recommended vaccines who requiring routine testing based on county Transmission rates and vaccination status. Follow up based on findings. 3. DCS/designee will educate all licensed staff (RN/LPN) on the following process : New admissions/ re admissions: • Newly admitted or re-admitted residents, regardless of their vaccination status will have a series of two viral COVID-19 test, immediately and if negative, again in 5-7 days after admission. • Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10	

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{F 886}	Continued From page 18 Residents and failed to record the results of COVID testing for two staff (LPN B and CNA B). The findings included: 1. For Resident #107, who was unvaccinated, the facility staff failed to conduct COVID-19 testing upon her readmission to the facility, following a hospitalization. On 5/4/22, a clinical record review of Resident #107's chart was conducted. This review revealed that Resident #107 had not received any vaccinations for COVID-19, she had refused. On 4/27/22, Resident #107 was discharged to the hospital. On 5/1/22, Resident #107 was readmitted to the facility. The entire clinical record was reviewed, to include but not limited to: progress notes, results tab for labs, miscellaneous tab, medication administration records and treatment administration records. There was evidence of Resident #107 being tested for COVID-19 upon her admission to the hospital on 4/27/22 but there was no evidence of any other COVID testing upon her readmission to the facility. On 5/4/22 at 8:49 PM, an interview was conducted with the facility Infection Preventionist (IP). The IP was asked when COVID testing is conducted. She stated that they test according to their pandemic plan. When asked for specific instances that Residents would be tested she said, "If symptomatic or a potential exposure". The IP was asked, what about admissions or readmissions. The IP said, "When an admission comes we monitor them for symptoms but don't	{F 886}	days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. • Initiate transmission based precautions based on CDC guidance, including PPE – N95 or higher respirator, eye protection, gown and gloves • If the resident develops symptoms, notify the MD, and initiate COVID-19 viral test as soon as possible Residents who are up to date with all recommended COVID-19 vaccines and residents within 90 days of a COVID-19 infection do not need to be placed in quarantine. Center may consider quarantine for a resident who is moderately to severely immunocompromised, by 5/9/2022 DCS/Designee will educate all licensed staff (RN/LPN) on proper completion of the staff testing form to include documentation of results.	

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{F 886}	Continued From page 19 test". The Infection Preventionist confirmed the facility follows all recommendations from the CDC (Centers for Disease Control and Prevention). Review of the facility policy titled, "Covid-19 Pandemic Plan", with a revision date of 3/11/22, was conducted. This policy read on page 2, "13. New admissions/re-admissions: Newly admitted or re-admitted residents, regardless of their vaccination status will have a series of two viral COVID-19 test, immediately and if negative, again in 5-7 days after admission". The CDC gives the guidance to nursing facilities in their document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes". This was reviewed and it read, "Newly-admitted residents and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection; immediately and, if negative, again 5-7 days after their admission". On 5/5/22, during an end of day meeting, the facility Administrator, Director of Nursing and corporate staff were made aware of the findings. Following the end of day meeting, the facility staff submitted a document indicating they had held an ad hoc quality assurance meeting on 5/5/22 at 12 noon. This document indicated the following: "Reason for Ad Hoc Meeting: New Admissions-Re-admissions testing/Quarantine, Analysis (Root Cause Analysis) Re-admits not being tested and quarantined per Pandemic Plan". Included in the documents provided was evidence that a physician order was obtained on 5/5/22 at 3:48 PM, for Resident #107 to have	{F 886}	4. DCS/Designee will monitor admissions/re-admissions during the daily clinical review to ensure guidance followed for Covid-19 5 x weekly for 4 weeks, then weekly for 4 weeks. DCS/Designee will monitor the test results documents 5 x weekly for 4 weeks then weekly for 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	5/9/22

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{F 886}	Continued From page 20 COVID testing. There was also evidence that a rapid COVID-19 test had been performed on 5/5/22, which resulted as negative for Resident #107. No further information was provided. 2. The facility staff failed to record the results of COVID-19 testing of 2 staff members who were not up-to-date with COVID vaccinations during routine testing. The facility provided staff vaccination matrix indicated CNA B and LPN B had not received any booster doses of the COVID-19 vaccination and therefore were not considered up-to-date with COVID immunizations and were subjected to routine testing. On 5/4/22, a review was conducted with LPN B, the nurse who manages the COVID testing of staff. Surveyor B sat with LPN B and reviewed the COVID testing that had been conducted from 4/23/22-5/4/22. Upon review, it was noted that on 4/25/22, LPN B had been tested for COVID-19 but no result of the test was recorded. On 4/29/22, CNA B had been tested for COVID-19 and no result of the test was noted on the form. LPN B and the facility Administrator were shown the test results and asked what the results of the tests for LPN B and CNA B were. LPN B stated that she knew both were negative because she was the subject of one of the tests and was the one conducting the test for CNA B. However, she agreed that the results were not noted and should have been.	{F 886}		

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{F 886}	Continued From page 21	{F 886}		

A review of the facility policy titled, "COVID-19 Pandemic Plan" was conducted. This policy on pages 11-12 read, "Expanded Screening Testing of Asymptomatic Staff: Test all staff who are not up to date with the recommended COVID-19 vaccine doses based on the extent of the virus in the community, using the community transmission level available from the CDC....Documentation: Expanded Screening Testing of Staff includes: community transmission level, testing frequency, date the community transmission rate was collected, date staff testing, testing results".

On 5/4/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the findings. The Administrator stated they had implemented a new system and each day would review the testing occurrences from the previous day and would review the forms to ensure they were complete, to include test results and would have another person sign off as having reviewed it.

On 5/5/22, following the end of day meeting, the facility staff presented the survey team with evidence that an ad hoc quality assurance and performance improvement meeting had been held on 5/4/22 at 3:50 PM. The reason for the meeting was noted as "completion of the POC [point of care] testing forms with signatures results". The analysis/root cause analysis was noted as "oversight in completing forms, follow-up and follow through, a checker 2nd final reviewer of forms".

Also included in the documents submitted was evidence of LPN B being tested for COVID-19 on

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{F 886}	Continued From page 22 5/5/22, with a negative result. No further information was received.	{F 886}		
{F 888} SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and	{F 888}	1. The Employee Vaccination Matrix has been updated to reflect current employees and their current vaccination status. 2. Quality review conducted by the Director of Clinical Services/ designee of F888 Employee Vaccination Matrix to ensure the matrix is current with employees and their current vaccination status 3. The Vice President of Operations assumed the role of Interim Executive Director on 05/06/2022 and re-implemented the process for completing the F888 Matrix. 4. The Executive Director/ Director of Clinical Services/ designee to conduct quality monitoring to ensure that all staff members are included on the vaccination tracking system, staff will be listed on the Vaccination Matrix.	

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	495235	A. BUILDING _____ B. WING _____	R-C 05/05/2022

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 888}	Continued From page 23 (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely	{F 888}	Matrix will include Proof of Vaccination or Exemption provided to Infection Preventionist, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks then weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	5/9/22

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{F 888}	Continued From page 24	{F 888}		

documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

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Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed to have an accurate system to track the immunization status of all facility employees affecting five employees (Employee J, Employee K, CNA C, CNA D and LPN E) in a survey sample of 18 employees reviewed.

The findings included:

On 5/4/22, the facility staff provided the survey team with a copy of the staff vaccination matrix. Review of this matrix revealed LPN E was noted as being fully vaccinated, boosted and granted a non-medical exemption.

The as-worked schedule for 4/23/22 and 5/4/22, were requested and received. A listing of all new hires since 4/23/22, was also requested and received.

The above noted documents were used to check that all facility employees were included on the staff vaccination matrix. This review revealed that two employees, Employee J and CNA C were not listed on the staff vaccination matrix.

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On the morning of 5/5/22, a video call was held with Surveyor C and the facility staff which included, the facility Administrator, LPN B and the facility Infection Preventionist. LPN B was asked to show the evidence she had on file for Employee J, CNA C and LPN E, with regards to COVID-19 immunizations. LPN B had a copy of the COVID-19 immunization cards which indicated both Employee J and CNA C had received two doses of a multi-dose vaccination series vaccine and no booster doses. For LPN E, the vaccination card revealed she had received 2 doses of a multi-dose vaccine series and well as a booster shot/dose.

During this same call, the facility Administrator access the staff vaccination log and confirmed that he was not able to find either employee [Employee J and CNA C] on the log. He went on to say that Employee J had severed employment with the facility and was removed from the log but just recently started working to pick-up weekend shifts and "She wasn't added back in". The Administrator stated that he reviews and updates the form at least weekly to ensure all staff are captured on the form. When asked about LPN E, he acknowledged that she was listed as being fully vaccinated and boosted but also as having had an approved non-medical exemption. He indicated he would have to look into that.

The facility Administrator also confirmed that the information listed on the staff vaccination matrix is what is used to determine the staff's vaccination status, and is then used to report to NHSN (National Health Safety Network). When asked if the staff vaccination matrix not being complete could affect the accuracy of the information being reported to NHSN, he said, "I

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would have put them on there before we did our reporting on Friday".

On the afternoon of 5/5/22, the facility Administrator provided the survey team with an additional spreadsheet they use to track staff vaccinations and lists the date of the immunizations. This document was used to compare to the staff vaccination matrix submitted to the survey team on 5/4/22. A sample of employees was selected and reviewed. The findings were as follows:
1. CNA D was noted on the staff vaccination matrix as being completely vaccinated but not boosted. Review of the additional spreadsheet provided 5/5/22, noted CNA D with 3 vaccines doses which would indicate the CNA was boosted.

2. Employee K was noted on the staff vaccination matrix as being completely vaccinated but not having received a booster dose for COVID-19. Review of the additional spreadsheet revealed Employee K had received a booster dose on 4/20/22.

On 5/5/22, during the end of day meeting, the facility Administrator and Director of Nursing were made aware of the concern that the staff vaccination matrix/tracking system in use is not complete and accurate.

No additional information was received.