PRINTED: 06/07/2022 FORM APPROVED OMB NO. 0938-0391

	ND DI AN OF CORRECTION IDENTIFICATION NUMBER		I	PLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		495402	B. WING _	B. WING		05/19/2022	
NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG				STREET ADDRESS, CITY, STATE, ZIP COD 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000			
F 883 SS=D	survey was conducte The facility was in sul CFR Part 483.73, Re Care Facilities. No e complaints were inve INITIAL COMMENTS An unannounced Me survey was conducte Corrections are requi CFR Part 483 Federa requirements. The Li survey/report will follo investigated during th The census in this 22 at the time of the surv consisted of 17 reside Influenza and Pneum CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influen policies and procedur (i) Before offering the each resident or the re	dicare/Medicaid standard d 5/17/22 through 5/19/22. red for compliance with 42 al Long Term Care fe Safety Code ow. No complaints were le survey. certified bed facility was 16 rey. The survey sample ent reviews. ococcal Immunizations (2) and pneumococcal za. The facility must develop res to ensure that- influenza immunization, resident's representative regarding the benefits and of the immunization;	F 8			7/1/22	
	immunization Octobe annually, unless the i contraindicated or the immunized during this (iii) The resident or the	r 1 through March 31 mmunization is medically e resident has already been					
I ARODATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Electronically Signed 06/01/2022

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

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WINDSORMEADE OF WILLIAMSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188		1 03/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 883	documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider immunization or did immunization due to refusal. §483.80(d)(2) Pneu must develop policion that- (i) Before offering the immunization, each representative receivenefits and potential immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unless medically contrained already been immunication that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider pneumococcal immunication or residential immunication im	redical record includes indicates, at a minimum, the at or resident's representative ation regarding the benefits ffects of influenza at either received the influenza not receive the influenza of medical contraindications or mococcal disease. The facility are and procedures to ensure the pneumococcal resident or the resident's resident or the resident's resident or the resident has inized; the resident's representative to refuse immunization; and redical record includes indicates, at a minimum, the at or resident's representative ation regarding the benefits ffects of pneumococcal at either received the unization or did not receive mmunization due to medical	F 88	3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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WINDSOR	MEADE OF WILLIAMED	UDC		3900 WINDSOR HALL DRIVE			
WINDSOR	MEADE OF WILLIAMSB	URG		WILLIAMSBURG, VA 23188			
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F 883	Continued From page	e 2	F 88	33			
	and facility document failed to provide an ir	dents reviewed for influenza		1. 1 resident, #16 was identif receiving an influenza vaccinat flu season. The vaccine had be and requested by the resident, facility failed to administer the vordered. The vaccine is not ab given at this time, as it is out of designated influenza season from	ion during een offered however, vaccine as ole to be f the		
	The facility staff failed immunization for Res	•		October-March. Resident #16: was reviewed for other potentia immunizations to be administer	□s record al		
	for Resident #16 and dated 2/1/22 which re was offered the flu va one [flu vaccine]". A p 2/7/22 read, "Afluria p prefilled syringe 0.5 r intramuscularly one t There was no documbeing administered. An interview was con Preventionist who acfor Resident #16 and facility policy on influer requested and receiver Review of the facility	ime only for flu prevention". entation of the flu vaccine ducted with the Infection cessed the clinical records verified the findings. A enza immunization was		documentation is necessary for pneumococcal vaccine, to which does not have any proof of vact this time. Facility will seek clarithis vaccine to ensure administ occurred and/or offer and administ vaccine to the resident. 2. All residents residing in the household have the potential to affected by not having received having appropriate documental current vaccination status. A 10 will be completed of all resident influenza and pneumococcal vato determine if there are any ot residents who have been affected.	r the ch facility ccination at fication on tration has inister the e facility to be d or not tion of 00% audit t s accinations ther		
	subheading "Policy", maintain an infection minimize the risk of d of the influenza and p	read: "To establish and control program designed to eveloping and transmission onemonia virus". rator and Director of Nursing rified the findings. No further		3. The facility policy on Influe Pneumococcal Vaccine will be and revised with necessary characteristic compliance. The facility be re-educated on the revised any changes made to prevent administering vaccines and/or documentation of vaccination s WindsorMeade clinical leaders	reviewed anges to nurses will policy and errors in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
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	COVID-19 Testing-ReCFR(s): 483.80 (h)(1)	esidents & Staff I-(6)	F 8	will utilize VIIS to clarify vaccinate status, obtain PCP records of vactors for new admissions when possible ensure physician orders are followed through if the resident requests to be administered. 4. The DON/Clinical Leader/dewill perform weekly audits for 8 vall new admissions immunization ensure adequate documentation previous vaccines and to ensure requests for vaccines are carried physician orders. Team member performing the audit will also endocumentation on the medication administration record and onto the immunization record in the facility electronic medical record. This accontinue on a monthly basis after initial 8 weeks of weekly audits, audits will be reported quarterly the QAPI process. 5. The corrective actions will be completed by 7/1/2022.	accination ble, and bwed vaccines esignee weeks of n status to n of e any d out by r sure in he ties audit will er the and all through	7/1/22	
	must test residents are individuals providing and volunteers, for Co for all residents and faindividuals providing and volunteers, the L' §483.80 (h)((1) Condo	services under arrangement TC facility must:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 886	this paragraph diagraph COVID-19 in the factors in this paragraph with consistent with COV suspected exposure (iv) The criteria for casymptomatic indiviparagraph, such as COVID-19 in a cour (v) The response tin (vi) Other factors sphelp identify and pretransmission of COV \$483.80 (h)((2) Con is consistent with cuconducting COVID-\$483.80 (h)((3) For (i) Document that the results of each staff (ii) Document in the was offered, complet to the resident's test each test. §483.80 (h)((4) Upo individual specified symptoms consistent with COVID-19 in the conducting COVID-19 in the resident's test each test.	of any individual specified in mosed with sility; nof any individual specified in symptoms (ID-19 or with known or to COVID-19; conducting testing of duals specified in this the positivity rate of sity; ne for test results; and ecified by the Secretary that event the (ID-19). Iduct testing in a manner that rrent standards of practice for 19 tests; each instance of testing: sting was completed and the test; and resident records that testing sted (as appropriate ting status), and the results of the identification of an in this paragraph with	F	386			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	x			(X5) COMPLETION DATE
S483.80 (h)((5) Have residents and staff, in services under arran refuse testing or are S483.80 (h)((6) When the services due to contact state and local health departments, such as obtain processing test result This REQUIREMENT by: Based on clinical regard facility documentated to conduct CO with the Centers for IPrevention (CDC) guild Residents #168 and Residents reviewed the sting. The findings included the second Conduct a second Conduct a second Conduct and reveal and documented and reveal and documented and Resident #168 on 5/8 the facility. There was COVID-19 testing for the second conducted and reveal and second conducted and reveal and documented and Resident #168 on 5/8 the facility. There was COVID-19 testing for the second conducted and reveal and second conducted and reveal and documented and Resident #168 on 5/8 the facility. There was COVID-19 testing for the second conducted and reveal and second conducted and reveal and documented and reveal and do	e procedures for addressing including individuals providing gement and volunteers, who unable to be tested. In necessary, such as in testing supply shortages, artments to assist in testing ining testing supplies or its. It is not met as evidenced cord review, staff interview, tation review, the facility staff VID-19 testing in accordance Disease Control and addance for 2 Residents, #170, in a sample of 3 for new admission COVID-19 desired. It is not met as evidenced cord review, staff interview, tation review, the facility staff vID-19 testing in accordance Disease Control and addance for 2 Residents, #170, in a sample of 3 for new admission COVID-19 desired. It is not met as evidenced cordance Disease Control and addance for 2 Residents, #170, in a sample of 3 for new admission COVID-19 desired. It is not met as evidence of a sample of 3 for new admission to confirmed the facility Infection to confirmed the facility Infection to confirmed the facility	F	386	found to not have received a second COVID test 5-7 days following admission as recommended in the updated guidelines from the CDC entitled "Interinfection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Home posted February 2, 2022. The facility is out of the window to perform the COVID-19 testing currently for these 2 residents. Both of these residents remain the facility household, however, the residents are not exhibiting symptoms COVID-19, and do not meet criteria for testing at this time. 2. All facility new admissions since February 2022 were affected, as this second COVID-19 testing was not performed on any new admissions to the facility household. All newly admitted residents, and those that leave the facility for the country of the country admitted residents, and those that leave the facility window to receive their second	on im s" ain of	
The Cartain State of Contract	SUMMARY STREACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR SANSON (h)((5) Have residents and staff, it services under arranterfuse testing or are services under arranterfuse testing or are services due to contact state and local health departments, such as obtain processing test result This REQUIREMENT by: Based on clinical regarded to conduct CO with the Centers for I Prevention (CDC) guilded to conduct CO with the Centers for I Prevention (CDC) guilded Residents #168 and Residents reviewed testing. The findings included the facility of the facility. There was COVID-19 testing for the formal preventionist (IP) who reventionist (IP) who residents (IP) who re	DENTIFICATION NUMBER: 495402 DIVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 §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 clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 2 Residents, Residents #168 and #170, in a sample of 3 Residents reviewed for new admission COVID-19	A BUILDII 495402 DVIDER OR SUPPLIER IEADE OF WILLIAMSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 §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 clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 2 Residents, Residents #168 and #170, in a sample of 3 Residents reviewed for new admission COVID-19 testing. The findings included: 1. For Resident #168, the facility staff failed to conduct a second COVID-19 test following her admission to the facility. On 5/18/22, a clinical record review was conducted and revealed facility staff performed and documented a negative COVID-19 test for Resident #168 on 5/9/22, the date of admission to the facility. There was no evidence of any further COVID-19 testing for Resident #168. On 5/18/22 at approximately 2:30 PM, an interview was conducted with the facility Infection Preventionist (IP) who confirmed the facility	DENTIFICATION NUMBER: 495402 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 §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 clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 2 Residents, Residents #168 and #170, in a sample of 3 Residents reviewed for new admission COVID-19 testing. The findings included: 1. For Resident #168, the facility staff failed to conduct a second COVID-19 test following her admission to the facility. On 5/18/22, a clinical record review was conducted and revealed facility staff performed and documented a negative COVID-19 test for Resident #168 on 5/9/22, the date of admission to the facility. There was no evidence of any further COVID-19 testing for Resident #168. On 5/18/22 at approximately 2:30 PM, an interview was conducted with the facility Infection Preventionist (IP) who confirmed the facility	DOUDER OR SUPPLIER ### A BUILDING ### BUILDING ### A BUILDING ### BUILDING ### A BUILDING ### BUI	A BUILDING A STREET ADDRESS, CITY, STATE, ZIP CODE 3900 WINDSOR HALL DRIVE WILLIAMSBURG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 \$483.80 (h)(6) 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 supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Center for Disease Control and Prevention (CDC) guidance for 2 Residents, Residents #168 and #170, in a sample of 3 Residents reviewed for new admission COVID-19 testing. On 5/18/22, a clinical record review was conducted and revealed facility staff failed to conduct a second COVID-19 test following her admission to the facility. The findings included: 1. Resident #168, the facility staff failed to conduct a second COVID-19 test following her admission to the facility. The findings included: 1. Resident #168, the facility staff failed to conduct a second COVID-19 test for Resident #168, the facility staff failed to conduct a second COVID-19 test for Resident #168. The findings included: 1. Resident #168 & Resident #170 were found to not have received a second COVID test 5-7 days following admission as recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes' posted February 2, 2022. The facility is out of the window to perform the COVID-19 testing out of the second 2. All facility new admissions to the facility. There was no evidence of any further COVID-19 testing on any further COVID

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				39	900 WINDSOR HALL DRIVE		
WINDSOR	MEADE OF WILLIAMS	BURG		V	VILLIAMSBURG, VA 23188		
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F 886	Continued From pag	ge 6	F 8	386			
	accordance with CD	C (Centers for Disease			recommendations.		
		ion) recommendations. The					
		the facility's protocol for			3. The Infection Preventionist received		
		ed residents for COVID-19			authorization from the physician to ente	er a	
	and she stated, "we	test all new admits within 1-2			Standing order that will be entered for		
	hours after arrival, if	the result is negative, then it			each new admission in the EMR for a		
	is business as usual	, we don't have to quarantine			second COVID test to be obtained 5-7		
	them and we do not			days post admission. The facility nurse			
	verified the findings			will be re-educated on the updated test	ing		
					procedures for new admissions and		
	The IP provided a co			residents out of the facility greater than	1 24		
	entitled, "Interim Infe			hours.			
	Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2,				4. The Infection Preventionist and/or		
		d it was utilized in facility's			designee will perform an audit on 10%	of	
		and practices. The IP was			all admissions monthly to ensure that t		
		e 4 of the previously			standing orders are entered for the	10	
	referenced CDC doc				COVID-19 testing. The team member		
		nich read, "Newly-admitted			performing the audit will also ensure th	at	
		ents who have left the facility			the COVID-19 testing is performed and		
	for (greater than) 24	hours, regardless of			documented in the medical record.		
	vaccination status, s			Monthly ongoing audits will be conduct	.ed		
	viral tests for SARS-			and reported quarterly through the QAI	기		
	and, if negative, aga			process.			
		ng her review, the IP stated,					
	_	up testing] has been an					
	•	test should have been			5. The corrective actions will be		
	now".	recting our protocols right			completed by 7/1/22.		
		he end of day meeting, the					
	-	r and Director of Nursing					
	were made aware of	r tne findings.					
		0, the facility staff failed to OVID-19 test following her					
	admission to the fac						

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F 886	On 5/18/22, a clinical conducted and revea and documented a ne Resident #170 on 4/2 to the facility. There we further COVID-19 tes On 5/18/22 at approxinterview was conducted Preventionist (IP) who conducts COVID-19 to accordance with CDC Control and Prevention IP was asked about the testing newly admitted and she stated, "we thours after arrival, if the is business as usual, them and we do not the verified the findings for the residue of the state of the	record review was led facility staff performed egative COVID-19 test for 19/22, the date of admission was no evidence of any ting for Resident #170. Imately 2:30 PM, an ested with the facility Infection of confirmed the facility esting for all residents in C (Centers for Disease on) recommendations. The he facility's protocol for d residents for COVID-19 est all new admits within 1-2 he result is negative, then it we don't have to quarantine est them any further". The IP	FE		:NCY)		
	entitled, "Interim Infect Recommendations to Spread in Nursing Ho 2022, and confirmed COVID-19 policies are asked to review page referenced CDC docu "Testing", item 3, which residents and resident for (greater than) 24 livaccination status, showiral tests for SARS-C and, if negative, again admission". Following	ction Prevention and Control Prevent SARS-CoV-2 pmes", updated February 2, it was utilized in facility's and practices. The IP was 4 of the previously ument, subheading, ch read, "Newly-admitted ats who have left the facility mours, regardless of would have a series of two CoV2 infection; immediately a 5-7 days after their by her review, the IP stated, p testing] has been an					

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F 886	performed, I am corre now".	ecting our protocols right e end of day meeting, the and Director of Nursing the findings.	F 88	36			