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	495402	A. BUILDING _____ B. WING _____	05/19/2022

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WINDSORMEADE OF WILLIAMSBURG	3900 WINDSOR HALL DRIVE WILLIAMSBURG, VA 23188

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/17/22 through 5/19/22. 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 5/17/22 through 5/19/22. 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 22 certified bed facility was 16 at the time of the survey. The survey sample consisted of 17 resident reviews.	F 000		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		7/1/22

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

Electronically Signed | 06/01/2022

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F 883	Continued From page 1 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 2 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an influenza vaccine for 1 resident out of 5 residents reviewed for influenza immunization. The findings included: The facility staff failed to provide influenza immunization for Resident #16. On 5/18/22, clinical record review was performed for Resident #16 and revealed a progress noted dated 2/1/22 which read, "...she [Resident #16] was offered the flu vaccine and agreed to that one [flu vaccine]". A physician's order dated 2/7/22 read, "Afluria preservative free suspension prefilled syringe 0.5 ml...inject 0.5 ml intramuscularly one time only for flu prevention". There was no documentation of the flu vaccine being administered. An interview was conducted with the Infection Preventionist who accessed the clinical records for Resident #16 and verified the findings. A facility policy on influenza immunization was requested and received. Review of the facility policy revised 4/1/22 and entitled, "Influenza and Pneumonia Vaccine", subheading "Policy", read: "To establish and maintain an infection control program designed to minimize the risk of developing and transmission of the influenza and pnemonia virus". The Facility Administrator and Director of Nursing were updated and verified the findings. No further information was provided.	F 883	1. 1 resident, #16 was identified as not receiving an influenza vaccination during flu season. The vaccine had been offered and requested by the resident, however, facility failed to administer the vaccine as ordered. The vaccine is not able to be given at this time, as it is out of the designated influenza season from October-March. Resident #16□s record was reviewed for other potential immunizations to be administered, and documentation is necessary for the pneumococcal vaccine, to which facility does not have any proof of vaccination at this time. Facility will seek clarification on this vaccine to ensure administration has occurred and/or offer and administer the vaccine to the resident. 2. All residents residing in the facility household have the potential to be affected by not having received or not having appropriate documentation of current vaccination status. A 100% audit will be completed of all resident□s influenza and pneumococcal vaccinations to determine if there are any other residents who have been affected. 3. The facility policy on Influenza and Pneumococcal Vaccine will be reviewed and revised with necessary changes to ensure compliance. The facility nurses will be re-educated on the revised policy and any changes made to prevent errors in administering vaccines and/or documentation of vaccination status. WindsorMeade clinical leadership team	

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F 883	Continued From page 3	F 883	will utilize VIIS to clarify vaccination status, obtain PCP records of vaccination for new admissions when possible, and ensure physician orders are followed through if the resident requests vaccines to be administered. 4. The DON/Clinical Leader/designee will perform weekly audits for 8 weeks of all new admissions immunization status to ensure adequate documentation of previous vaccines and to ensure any requests for vaccines are carried out by physician orders. Team member performing the audit will also ensure documentation on the medication administration record and onto the immunization record in the facilities electronic medical record. This audit will continue on a monthly basis after the initial 8 weeks of weekly audits, and all audits will be reported quarterly through the QAPI process. 5. The corrective actions will be completed by 7/1/2022.	
F 886 SS=E	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	F 886		7/1/22

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F 886	Continued From page 4	F 886		

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.

§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.

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F 886	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 conducts COVID-19 testing for all residents in	F 886	1. Resident # 168 & Resident #170 were found to not have received a second COVID test 5-7 days following admission as recommended in the updated guidelines from the CDC entitled “Interim Infection Prevention and Control 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 currently for these 2 residents. Both of these residents remain in the facility household, however, the residents are not exhibiting symptoms of 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 (greater than) 24 hours that remain in the window to receive their second COVID-19 test will be tested per	

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F 886	Continued From page 6 accordance with CDC (Centers for Disease Control and Prevention) recommendations. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "we test all new admits within 1-2 hours after arrival, if the result is negative, then it is business as usual, we don't have to quarantine them and we do not test them any further". The IP verified the findings for Resident #168. The IP provided a copy of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, and confirmed it was utilized in facility's COVID-19 policies and practices. The IP was asked to review page 4 of the previously referenced CDC document, subheading, "Testing", item 3, which read, "Newly-admitted residents and residents who have left the facility for (greater than) 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission". Following her review, the IP stated, "This [lack of follow-up testing] has been an oversight, a second test should have been performed, I am correcting our protocols right now". On 5/18/22, during the end of day meeting, the Facility Administrator and Director of Nursing were made aware of the findings. 2. For Resident #170, the facility staff failed to conduct a second COVID-19 test following her admission to the facility.	F 886	recommendations. 3. The Infection Preventionist received authorization from the physician to enter a Standing order that will be entered for each new admission in the EMR for a second COVID test to be obtained 5-7 days post admission. The facility nurses will be re-educated on the updated testing procedures for new admissions and residents out of the facility greater than 24 hours. 4. The Infection Preventionist and/or designee will perform an audit on 10% of all admissions monthly to ensure that the standing orders are entered for the COVID-19 testing. The team member performing the audit will also ensure that the COVID-19 testing is performed and documented in the medical record. Monthly ongoing audits will be conducted and reported quarterly through the QAPI process. 5. The corrective actions will be completed by 7/1/22.	

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F 886	Continued From page 7	F 886		

On 5/18/22, a clinical record review was conducted and revealed facility staff performed and documented a negative COVID-19 test for Resident #170 on 4/29/22, the date of admission to the facility. There was no evidence of any further COVID-19 testing for Resident #170.

On 5/18/22 at approximately 2:30 PM, an interview was conducted with the facility Infection Preventionist (IP) who confirmed the facility conducts COVID-19 testing for all residents in accordance with CDC (Centers for Disease Control and Prevention) recommendations. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "we test all new admits within 1-2 hours after arrival, if the result is negative, then it is business as usual, we don't have to quarantine them and we do not test them any further". The IP verified the findings for Resident #170.

The IP provided a copy of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, and confirmed it was utilized in facility's COVID-19 policies and practices. The IP was asked to review page 4 of the previously referenced CDC document, subheading, "Testing", item 3, which read, "Newly-admitted residents and residents who have left the facility for (greater than) 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission". Following her review, the IP stated, "This [lack of follow-up testing] has been an oversight, a second test should have been

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F 886	Continued From page 8 performed, I am correcting our protocols right now". On 5/18/22, during the end of day meeting, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 886		