DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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 An unannounced Emergency Preparedness survey was conducted 11/01/2022 through 11/04/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an	E 024	E024 1. The facility has implemented the Hill Valley Healthcare Emergency Staffing Plan. 2. All residents of the facility have the potential to be affected by this deficient practice. 3. The leadership of the facility have been provided education on the Hill Valley Healthcare Emergency Staffing Plan by the Regional Nurse Consultant. 4. The facility has adopted the Hill Valley Healthcare Emergency Staffing Plan into the Emergency Preparedness Policy/Plan and was reviewed and approved by the facility QAPI Committee. The Emergency Staffing Plan is reviewed annually during the facility assessment and on an Ad hoc basis with significant changes to the facility. 5. DOC- 1/2/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles E Phillips, Jr. TITLE: Administrator (X6) DATE: 12-21-2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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 024	Continued From page 1 emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review, the facility staff failed to develop a policy/procedure to mitigate staffing shortages in the event of an emergency utilizing an all-hazards approach. The findings included: On 11/04/2022 at 9:00 A.M., the facility's emergency preparedness program was reviewed. There was no evidence in the plan that a policy for emergency staffing strategies utilizing an all-hazards approach was developed. When asked about this, the Administrator indicated he would look into it. On 11/04/2022 at approximately 11:10 A.M., the interim Director of Nursing (DON) provided a two-page document, "Strategies to Mitigate Staffing Shortages: 09/26/2022," as well as the policy, "Emergency Procedure - Infectious Disease Threat." This policy documented, in part: "This facility has an emergency protocol for an infectious disease event." There was no evidence of a policy for emergency staffing strategies with an all-hazards approach. On 11/04/2022 at approximately 11:45 A.M., the	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 11/04/2022

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 024	Continued From page 2 Administrator was notified of findings.	E 024		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/01/22 through 11/04/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey as follows: VA00056105--Substantiated The census in this 130 certified bed facility was 74 at the time of the survey. The survey sample consisted of 34 resident reviews and 12 staff record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview, and clinical record review, the facility staff failed to ensure reasonable accommodation of needs for one Resident (Resident # 26) in a survey sample of 34 residents. The findings include: For Resident # 26, the facility staff failed to ensure the large clock on the bedroom wall was	F 558	F558 1. The facility maintenance director replaced the batteries in clock of resident #26 and adjusted the clock to the accurate time. 2. All residents of the facility have the potential of be affected by this deficient practice. The facility will conduct an audit of all resident rooms and common areas to ensure that are clocks are in good working order and time is accurate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 558	Continued From page 3 working. Resident #25's most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 9/2/2022. Resident # 26's BIMS (Brief Interview for Mental Status) Score was a 10 out of 15, indicating moderate cognitive impairment. Review of the clinical record was conducted on 11/1/2022 - 11/4/2022. During the initial tour on 11/1/2022 at 11:45 a.m., the clock in Resident # 26's room had the time of 7:22. Resident 26 was not in the room. On 11/2/2022 at 9:00 am., the clock had the time of 7:22. The second hand was not moving. Resident # 26 was sitting in the wheelchair. On 11/2/3022 at 1:55 p.m., the clock had the time of 7:22. On 11/3/2022 at 9:30 a.m., the clock had the time of 7:22. Resident # 26 was sitting in the wheelchair in the room. When asked what time it was, Resident # 26 looked and the clock and stared. On 11/3/2022 at 4:10 p.m., and on 11/4/2022 at 9:40 a.m., the clock had the time of 7:22. On 11/4/2022 at 10:00 a.m., the Maintenance Director stated he would put batteries in clocks when notified by staff members of the need. The Maintenance Director stated in this case, no maintenance request was needed. He would replace the batteries immediately upon notification. He stated he had not been informed	F 558	3. House wide Education will be provided to all staff including the Nursing, Dietary, Housekeeping, Maintenance, Therapy and Administrative Departments regarding the company policy on resident's rights and accommodation of needs. 4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness, homelike environment, privacy, and accommodation of needs and document on audit tool. Weekend supervisor/manager on duty on weekends. Rounds will be completed daily x 2 weeks, then 3 times weekly. Angel rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495235	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/04/2022
NAME OF PROVIDER OR SUPPLIER: ENVOY OF WILLIAMSBURG, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 4 that the clock was not working in Resident # 25's room. On 11/4/2022 at 10:10 a.m., an interview was conducted with the Unit Manager who stated it was very important for the clocks to function because they helped to keep the residents oriented to time. The Unit Manager stated Resident # 26 needed to know the time for meals and for smoke breaks. The Unit Manager stated the staff should notify maintenance as soon as they notice when clock is not correct. During the end of day debriefing, the facility Administrator, Director of Nursing and Corporate Nurse Consultants were informed of the issue. They stated the clocks should be accurate. No further information was provided.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583	F583 1. The facility maintenance director repaired/replaced the privacy curtain in the room for resident #43 and is now in good working order. 2. All residents of the facility have the potential to be affected by this deficient practice. The facility will conduct an audit of all resident rooms to ensure that all privacy curtains are in place and in good working order. 3. House wide Education will be provided to all staff including the Nursing, Dietary, Housekeeping, Maintenance, Therapy and Administrative Departments regarding the company policy on resident's rights and privacy. 4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 583	Continued From page 5 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility failed to maintain Resident privacy and dignity for one Resident (Resident #43) in a sample size of 34 Residents. The findings included: For Resident #43, the facility staff failed to provide the resident with a functioning privacy curtain to allow for privacy during personal care. On 11/02/2022 at 11:10 A.M., Resident #43 approached this surveyor in the hall to share a concern. Resident #43 stated that his privacy curtain wasn't working. Resident #43 stated that when staff provide care, his "roommate can see everything and I don't feel comfortable with that." Resident #43 stated that the curtain hasn't been working for "about a month and a half." This	F 583	homelike environment, privacy, and accommodation of needs and document on audit tool. Weekend Supervisor/manager on duty will complete on weekends. Rounds will be completed daily x 2 weeks, then 3 times weekly. Angel Rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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

F 583 — Continued From page 6

surveyor and Resident #43 then entered Resident #43's room. The privacy curtain was in the open position and could not be advanced on the track to close the curtain.

On 11/02/2022 at approximately 3:00 P.M., the interim Director of Nursing was notified of findings.

On 11/03/2022 at approximately 9:00 A.M., the interim DON stated that Resident #43's privacy curtain was fixed.
The DON did not dispute the findings that Resident #43's privacy curtain had not been functioning.

On 11/02/2022, Resident #43's clinical record was reviewed. According to Resident #43's quarterly Minimum Data Set with an Assessment Reference Date of 08/27/2022, the Brief Interview for Mental Status was coded as "15" out of possible "15," indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff and functional status for dressing was coded as total dependence on staff.

No further information was provided prior to exit.

F 584 SS=D — Safe/Clean/Comfortable/Homelike Environment
CFR(s): 483.10(i)(1)-(7)

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-

Plan of Correction — F 583 / F 584

F584

1. The facility maintenance director repaired the leak and replaced the ceiling tile of resident #43 room.

2. All residents of the facility have the potential to be affected by this deficient practice. The facility will conduct an audit of all resident rooms for any missing or damaged ceiling tiles and identified concerns will be documented and repaired or replaced.

3. House wide Education will be provided to all staff including the Nursing, Dietary, Housekeeping, Maintenance, Therapy and Administrative Departments) regarding the company policy on resident's rights and clean homelike environment.

4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness, homelike environment, privacy, and accommodation of needs and document on audit tool. Weekend Supervisor/manager on duty will complete rounds on weekends. Rounds will be conducted daily x 2 weeks, then 3 x weekly. Angel Rounds audits will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 584	Continued From page 7 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview, and clinical record review, the facility staff failed to ensure a clean, comfortable homelike environment for one Resident (Resident # 26) in a survey sample of 34 residents.	F 584	reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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
F 584	Continued From page 8	F 584		

The findings include:

For Resident # 43, the facility staff failed to fix a leaking ceiling. Rain would pour into his room over his bed.

Resident # 43 was an alert and oriented resident with a BIMS (Brief Interview for Mental Status) score of 15/15 indicating no cognitive impairment. Resident # 43 was dependent of facility staff for assistance with Activities of Daily Living and wheelchair dependent for mobility.

During the Group Interview on 11/2/2022 at 1:10 p.m., Resident # 43 complained that there was a hole in the ceiling in his bedroom. He stated that when it rains, water pours over his bed. Resident # 43 stated it happened every time it rained.

Surveyor G reported that during the initial tour on 11/1/2022 at approximately 3:00 p.m., she noticed a dark stain on the ceiling tile above Resident # 43's bed.

During the end of day debriefing on 11/3/2022. the Administrator, Registered Nurse B and Corporate Nurse were informed of the issue of rain pouring into the resident's room. The Registered Nurse B stated they were aware of issues with the ceiling, and maintenance tried to fix it previously. She stated they would provide documentation that Social Services addressed the issue in the past.

On 11/4/2022, the Social Services Director presented a copy of a Social Services Note. He stated he was aware of the issue of rain pouring into Resident # 43's room and had offered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495235	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/04/2022
NAME OF PROVIDER OR SUPPLIER: ENVOY OF WILLIAMSBURG, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 another room to Resident # 43, but he declined. Review of the Social Services Progress Note revealed a note dated 1/3/2022 at 3:29 p.m. that stated: "Social Services director talked with the resident about moving rooms due to rain coming through the ceiling in his room. The resident mentioned that at this time he does not want to move rooms. Social services mentioned that he would move to 153 while his ceiling is fixed. He mentioned that he does not want to move at this time, and he is happy to stay where he is and have his bed moved toward the middle of the room so that he does not get wet. Social services will continue to monitor him at this time." The Social Services Director stated there was no more documentation about the issue, and that it had not been addressed since then. When asked if that issue of rain pouring over someone's bed for over ten months was representative of a clean comfortable home-like environment, the Social Services Director stated "no." During the end of day debriefing on 11/4/2022. the Administrator, Registered Nurse B and Corporate Nurse were informed of these concerns. The Administrator stated they would take care of it. No further information was provided.	F 584	F656 1. Resident #125 is discharged from the facility and facility is unable to make any corrective actions. 2. Residents of the facility with a diagnosis of congestive heart failure have the potential to be affected by this deficient practice. The Director of Nursing will conduct an audit of all residents with a diagnosis for CHF for comprehensive care plan addressing hydration. 3. Licensed nursing staff of the facility will be provided education on the facility policy for comprehensive care planning and specifically resident nutrition and hydration status. 4. The DON or designee will perform and audit of 3 resident care plans weekly for accurate nutrition and hydration assessment and care planning. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 1/2/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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
F 656	Continued From page 10 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 656	Continued From page 11	F 656		

care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a comprehensive hydration care plan for 1 Resident (Resident #125) in the survey sample of 34 residents.

The findings included:

For Resident #125, the facility staff failed to develop and implement a hydration care plan for a Resident with known congestive heart failure and dehydration.

Resident #125 was first admitted to the facility on 7-8-22 and discharged 7-20-22.

Resident #125 had an admission minimum data set assessment which coded the Resident with a Brief Interview of Mental Status score indicating cognitive impairment. The Resident was totally dependent on staff for activities of daily living.

Resident #125 was discharged to the hospital on 7-20-22 with a diagnosis of dehydration. The Resident's closed record was reviewed on 11-1-22. The Resident was seen by Speech therapy upon admission for documented pocketing of food, coughing, choking, and taking only drops of fluids. No care plan was developed nor implemented for dehydration during the Resident's stay.

On 11-3-22 an interview was conducted by the survey team with the Resident's physician. The physician stated that the goal was to limit fluid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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

F 656 Continued From page 12

intake to manage the Resident's congestive heart failure, while trying to relieve dehydration. The physician stated it was a balancing act between the two problems and that the Resident was still exhibiting edema in the lower extremities. Intravenous hydration was out of the question, and diuretic medications would further dehydrate the Resident. Fluids by mouth was the only intervention which could be implemented with some control.

The Administrator and Director of Nursing were notified of the missing hydration care plan at the end of day meeting on 11-2-22. On 11-3-22 at 10:30 a.m. the Administrator stated that they could not locate a hydration care plan in the clinical record for Resident #125. No further information was provided by the facility.

F 657 SS=D Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident

F 656

F 657

F657

1. Resident #50 care plan was revised to accurately reflect the care being provided to the resident. Resident #47 is discharged from the facility; no corrective actions can be made to the care plan.

2. Residents of the facility who have had a change of condition have the potential to be affected by this deficient practice. The facility will audit residents with a change on condition in the past 30 days to ensure that the care plan was revised appropriately.

3. Licensed nursing staff of the facility and IDT team members will be educated on the company policy and guidance for care plan revisions.

4. The DON or designee will audit 5 residents weekly who have had a change of condition for care plan revisions and accuracy. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.

5. DOC-1/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 657	Continued From page 13	F 657		

and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure Residents have a person-centered, comprehensive care plan that is reviewed and revised to reflect changes in condition for 2 Residents (#50 and #47) in a survey sample of 34 Residents.

The findings included:

1. For Resident #50, the facility staff failed to review and revise the care plan to include infection at the stoma site and interventions for Resident pulling at a g tube (feeding tube).

On 11/3/22 at approximately 12:00 PM Resident #50 was observed in the room, dressed in a hospital gown, resting with her eyes closed. Her tube feeding was running via enteral pump at 70 ml/hr.

On 11/3/22 a review of the clinical record revealed the following note: "10/27/2022 2:53 PM-Type: Nursing Progress Note- Resident continues on Keflex (antibiotic) for affected area around G-tube, no signs of adversity. Area cleansed and monitored as ordered. Tube patent,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 657	Continued From page 14	F 657		

flushes without any residuals observed. No complaints thus far. Will continue with current plan of care."

There were no notes that the physician had seen the Resident and prescribed the antibiotic or that skin assessments had been done prior to when the infection was found. A review of the care plan did not show any updates to reflect the use of antibiotics for the infection, nor did it reflect any wound care, or updates to include observations and interventions for the stoma site infection.

On 11/3/22 at approximately 3:00 PM Employee M assisted the surveyor with viewing stoma site. Employee M stated that the resident pulls at the g tube sometimes. The stoma site and surrounding area was reddened.

A review of Resident #50's care plan dated 8/25/22 failed to reveal updates regarding the resident's G-tube site care or infection.

On 11/3/22 at approximately 11 AM an interview was conducted with the RN (registered nurse) C, who was asked the purpose of a care plan. RN C stated the care plan directs the care of the Residents. When asked how often care plans should be updated, she said, "Quarterly and with each change in condition or status of the Resident."

On 11/3/22 at approximately 4:15 PM an interview was conducted with RN C who stated, "The nurse identified the area and called the physician. Initially, the MD gave an order for a topical treatment. Then said, 'on second thought, I want to start Keflex.' The nurses should have done a change of condition form. In the Change of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 657	Continued From page 15	F 657		

Condition note, the nurse would describe the wound or any changes." RN C could not find any Change of Condition forms for Resident # 50. She also stated that "nurses should describe anytime they are assessing that area and on the weekly skin assessments."

On 11/4/22 at approximately 3:00 PM an interview was conducted with the Interim DON (director of nursing). When asked if the infection to the peg tube stoma site should be included in the care plan, she indicated that it should. She further stated this had been an ongoing problem with Resident #50 and it should be addressed in the care plan.

A review of facility document N 1015, "Plans of Care," revealed, in part: "Review and/or revise the comprehensive care plan based on changes, goals, preferences, and needs of the resident in response to current interventions after the completion of each OBRAMDS assessment except discharge assessment and as needed the interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining and maintaining the highest practical well-being physical mental and psychosocial well-being."

On 11/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident # 47 the facility staff failed to review and revise the care plan for significant weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 657	Continued From page 16 A review of the clinical record revealed that the Resident had Quarterly nutrition assessment done on 7/27/22, at which time he weighed 200.8 pounds, representing a significant weight loss. The assessment section B - Care Plan Changes read: "Recommend continue current plan of care and continue to monitor per policy.' A review of the care plan initiated 4/21/20 and most recently updated 9/7/22 failed to reveal evidence that the care plan had been reviewed or revised to reflect the July 2022 significant weight loss. On 11/3/22 at approx. 11 AM an interview was conducted with the RN (registered nurse) C who was asked the purpose of a care plan. RN C stated the care plan directs the care of the Residents. When asked how often care plans should be updated, she said, "Quarterly and with each change in condition or status of the Resident." When asked what the expectation is when interventions do not work, she stated the care plan should be revised to include different interventions. On 11/3/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
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, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658	F658 1. Residents #29 and #67 were observed to take their medications by the nurse after the concern was identified by the survey team. The staff identified Nurse M, C were provided re-education and disciplinary actions. 2. All residents of the facility have the potential to be affected by this [illegible]ent practice. An audit was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 658	Continued From page 17 by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure services that meet professional standards of practice for administering medications for 2 Residents (#29 and 67) in a survey sample of 34 Residents. The findings included: 1. For Resident #29 the facility staff left a cup containing 9 pills at the bedside unattended. On 11/3/22 at approximately 12:00 PM, Surveyor D went to Resident #29's room. Resident # 29 was not in his room, and his roommate was in bed with eyes closed. The bedside table contained a clear 30 ml (milliliter) clear plastic medication cup, containing 9 pills. Surveyor D went to the door of the room to find a nurse, but none was visible in the hall. Surveyor then waited until staff was in hall, and certified nursing assistant (CNA) B was asked to find a nurse to come to the room. At that time the Resident returned to the room and interview was conducted with the Resident. Resident #29 was asked if the pills on his table were his morning pills, and he stated that they were, and that he had forgotten to take them before he went out to smoke. He stated, "I will take them now." Resident #29 was asked to please wait for his nurse to come before taking them, and he said he would. He was asked if the nurse usually leaves the medications in the room. and he stated: "Yes she leaves them for me to take." At that time the Employee M came to the room and was asked what she saw on the bedside table. She stated she saw a cup of meds (medications). She was asked if nurses should leave medications	F 658	conducted by the director of nursing of all resident rooms of the facility and no further concerns were identified of medications being left at the bedside. 3. Licensed nursing staff will be provided education on the facility policy for medication administration and the 5 rights of medication administration. 4. IDT will conduct Angel Rounds daily and observe for medications at beside. The DON or designee will conduct medications pass observations 3 times weekly auditing that no medications are left at the bedside, and accurate documentation of administration in the EMAR. Results of the weekly audits/observations will be reported monthly to the QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 658	Continued From page 18	F 658		

unattended at the bedside. When told the Resident had just arrived back to the room after being outside smoking, she said the meds should not be left in the room. When asked what could happen if medications are left unattended, she stated someone else could take them. When asked if she knows how many pills should be in the cup for the resident's morning meds, she said she did not. When asked if other residents wander throughout the facility, she stated they do. She stated some Residents who have dementia sometimes wander. A review of the as worked schedule revealed that Employee M was the nurse who passed the medications that morning.

The nursing standard per the Lippincott Website (https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration):

"Rights of Medication Administration"
"1. Right patient -Check the name on the order and the patient. Use 2 identifiers.
2. Right medication - Check the medication label. Check the order.
3. Right dose - Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route - Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route.
5. Right time - Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given.
6. Right documentation - Document administration AFTER giving the ordered medication. Chart the time, route, and any other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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
F 658	Continued From page 19	F 658		

specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason - Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use.
8. Right response - Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize?"

On 11/3/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #67, the facility staff failed to document a medication left at the bedside, and then documented document the administration of a narcotic medication which the staff did not observe the Resident to swallow/take.

On 11/2/22 at 9:09 AM, a medication administration observation was made with LPN (licensed practical nurse) C. LPN C prepared Resident #67's medications, which included but were not limited to Tylenol Extra Strength 650 mg (milligrams). LPN C entered the room, sat the cup of pills on the bedside table, inquired about Resident #67's pain, and then stepped back into the hall to the medication cart to retrieve Oxycodone 5 mg tablet. LPN C then re-entered Resident #67's room and sat the medication cup containing the Oxycodone on the over bed. LPN C exited the room. LPN C did not observe Resident #67 to take any of his medications.

Upon returning to the medication cart, LPN C was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 658	Continued From page 20	F 658		

asked by Surveyor C if her normal practice is to leave medications at the bedside. LPN C said, "No, I give them to him, and it takes him some time to take them." Surveyor C then asked how the nurse knows if the resident took the medicine. LPN C said, "He will tell me. I will go back in there and check too." LPN C signed off on medications in the computer.

On 11/2/22 at 10:28 AM, a clinical record review of Resident #67's chart was conducted. There were no orders for self-administration of medications. Surveyor C observed the medication administration record and progress notes of Resident #67. LPN C had failed to make any documentation regarding the Tylenol 650 mg, to indicate that it was provided, refused, etc. LPN C documented the Administration of all of the other medications, including the Oxycodone HCL, which she did not observe the Resident take/swallow. It is unknown if the Resident took the medications, sat them aside, etc.

On 11/3/22, LPN C was asked about the importance of ensuring Residents receive/take the medications as ordered. She stated, "Evidently they need it because the doctor ordered it." When asked what she is to do if a Resident doesn't take a medication, LPN C said, "I let the doctor know, because if it causes a side effect, they may want to revisit/re-evaluate." LPN C was asked when she is to document the medications are provided to a Resident, she said, "Immediately after I give them."

On 11/4/22 at 9:17 AM, an interview was conducted with LPN B. LPN B had been observed at the side of a Resident, watching him take his pills one by one. Upon exiting the room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 658	Continued From page 21 LPN B was asked why she watched him take the pills versus leaving them on the table. LPN B said, "To make sure they take them." LPN B was to identify the risk of leaving a medication at the bedside. LPN B said, "They may not take it or someone else could take them." When asked about the documentation regarding administration of medications, LPN B said, "I document it as soon as I am done with that Resident, before I move on to the next one." A review of the facility's medication administration policy revealed, in part: "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones...27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." On 11/2/22, during an end of day meeting, the facility Administration and corporate staff were made aware of the above findings. The Corporate Clinical Director confirmed the facility's standard of nursing practice is Lippincott. The facility's Corporate Clinical Director was asked about the administration of medication. She stated, "Make sure it is the right Resident, right medication, right dose, they are in the proper position, you have adequate fluid and document." When asked about observing the Resident to	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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

F 658

Continued From page 22

take the pills, the Corporate Clinical Director said, "We are to watch them take the medicine, unless they are self-administering medications." The facility staff and corporate staff confirmed that they have no Residents who currently self-administer medications. When asked what is expected if a Resident doesn't want to take the medication while the nurse is in the room, the corporate nurse said, "I have to take it back out and waste it." The facility staff confirmed that the practice of leaving medications at the bedside presents the opportunity for medications to be abused, misused, kept for later use, etc.

No additional information was provided.

Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices, General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions."

On 11/4/22, during the end of day meeting the facility Administration and Corporate staff were again made aware of the above findings.

No additional information was provided.

F 661 SS=D

Discharge Summary
CFR(s): 483.21(c)(2)(i)-(iv)

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

F 658

F 661

F661

1. Resident #125 is discharged from the facility; no corrective actions can be made.

2. All residents with anticipated discharge from the facility have the potential to be affected by this deficient practice. An audit will be conducted by the Social Services Director of all planned discharges for the past 30 days ensuring all residents were provided a discharge summary.

3. The facility IDT will be educated on the facility policy for discharge planning including the discharge summary and recapitulation of stay requirements.

4. The Social Services Director will audit all planned discharges weekly to ensure that the discharge summary is open and monitor the completion prior to resident discharge from the facility. Results of the weekly audits will be submitted to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.

5. DOC- 1/2/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 661	Continued From page 23 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a discharge summary to include recapitulation of stay for 1 resident (Resident #125) in the survey sample of 34 residents. The findings included: For Resident #125, the facility staff failed to complete a recapitulation (discharge summary) of care, upon discharge from the facility. Resident #125 was first admitted to the facility on	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 661	Continued From page 24 7-8-22 and discharged 7-20-22. Resident #125 had an admission minimum data set assessment which coded the Resident with a Brief Interview of Mental Status score indicating cognitive impairment. The Resident was totally dependent on staff for activities of daily living. Resident #125 was discharged to the hospital on 7-20-22. The Resident's closed record was reviewed on 11-1-22. No discharge summary or recapitulation of stay was included in the closed record. The Administrator and Director of Nursing were notified of the missing discharge summary at the end of day meeting on 11-2-22. On 11-3-22 at 10:30 a.m. the Administrator stated that they could not locate a discharge summary in the clinical record for Resident #125. No further information was provided by the facility.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure Residents received care in a	F 684	F684 1. Resident #50 Gastrostomy Tube was replaced by a physician on a scheduled outpatient procedure on 11/14/22. 2. All residents of the facility who receive medications, hydration, or nutrition by Gastrostomy tube have the potential to be affected by this deficient practice. 3. Licensed nursing staff of the facility will be provided education on the facility policy on replacement of the Gastrostomy tube and timeliness of following physician orders. 4. The DON or designee will audit 3 residents weekly to ensure that have gastrostomy tubes to ensure there are no orders not being followed timely. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 684	Continued From page 25 manner to promote highest level of wellbeing, in keeping with professional standards of care, for 1 Resident (#50) in a survey sample of 34 Residents. The findings included: For Resident #50, the facility staff failed to ensure peg tube replacement was done in a timely manner. It was ordered on 8/24/22 and by end of survey 11/4/22, the tube was not yet replaced. On 11/2/22 a review of the clinical record was conducted the following are excerpts from the progress notes: "8/21/2022 5:38 PM - Type: Nursing Progress Note resident sent to ER (emergency room) for peg tube replacement per on call NP (nurse practitioner) order. No s/s (signs/symptoms) of distress noted. Mother made aware of resident's condition." "8/24/2022 2:57 PM-Type: Nursing Progress Note -Writer faxed referral to [MD info redacted] GI (gastrointestinal) for Peg Replacement." "9/22/2022 12:21 PM - Chart reviewed. Resident with history of peg tube displacement in 2021 and recent return to hospital for possible displacement again. Hospital returned resident with no actions performed with peg tube and confirmed placement at that time." "9/30/2022 3:39 PM -Type: Nursing Progress Note Text: 10/6/22 @ (at) 10am Peg Replacement w/ [MD name redacted] @ [Hospital name, address, and phone number redacted] Stretcher Transportation Set Through	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 684	Continued From page 26	F 684		

[Transportation information redacted]."

"10/6/2022 6:29 PM -Writer received call from Doctor's office will have to reschedule Peg Replacement due to not having the size resident needed. Will call to reschedule when comes in."

On 11/3/22 an interview was conducted with RN (registered nurse) C who stated that she was not aware that the Resident had not been seen for the G Tube replacement ordered on 8/24/22. She stated that she would look into it and find out if the doctor had gotten the right size peg tube.

On 11/4/22 during the end of day meeting, RN C was interviewed and when asked what the facility expectation was for carrying out orders. She stated they should be carried out in a timely manner. When asked if Resident #50's PEG tube was replaced in a timely manner, she stated that it was not. She stated that the facility should have followed up more closely with the hospital or the specialist's office to see if an alternative hospital or arrangement could be made.

A review of the facility policy, "Physician Orders," revealed, in part: "The center will ensure that physician orders are appropriately and timely documented in the medical record. Information received from the referring facility or agency is to be reviewed and verified with the position transcribed on the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that a physician sign and date orders during or as soon as practicable after per after it is provided to maintain an accurate medical record."

On 11/4/22 during the end of day meeting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 684	Continued From page 27 Administrator was made aware of the concerns and no further information was provided.	F 684	F692	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure Residents maintains acceptable parameters of nutrition to maintain body weight and prevent unplanned weight loss for 1 Resident (#47) in a survey sample of 34 Residents. The findings included:	F 692	1. Resident #47 is discharged from the facility; no corrective actions can be made. 2. All residents of the facility have the potential to be affected by this deficient practice. An audit was conducted for all active residents' weights for any significant weight changes. Notification of the physician and responsible party will be notified. 3. Licensed nursing staff of the facility will be provided education on the facility weight loss policy and procedure and identification of change of condition. 4. The DON or designee will audit resident weights weekly to identify any residents with weight changes have been addressed. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring on compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 692	Continued From page 28	F 692		

Continued From page 28

For Resident #47, the facility staff failed to provide proper nutrition to prevent an unplanned weight loss of 37 lbs. in the 6 months from 5/9/22 till 11/4/22.

On 11/2/22 at 12:15 PM Resident # 47 was observed in bed asleep, with a food tray untouched on the bedside table.

On 11/3/22 at approximately 9:40 AM, Resident # 47 was observed in bed with eyes closed. The breakfast tray was on the bedside table, with approximately all drink containers empty and about half of his breakfast still untouched.

On the afternoon of 11/3/22 a clinical record review was conducted, and it was found that Resident #47 was not care planned for desired weight loss. Resident #47 had continuous weight loss from 5/9/22 - 9/27/22. The weights were:

9/27/2022 175.2 Lbs. (pounds)
9/21/2022 181.6 Lbs.
9/20/2022 181.6 Lbs.
9/14/2022 181.8 Lbs.
9/7/2022 185.6 Lbs.
9/6/2022 185.6 Lbs.
8/31/2022 199.0 Lbs.
8/31/2022 199.0 Lbs.
8/31/2022 204.0 Lbs.
8/1/2022 200.0 Lbs.
7/5/2022 200.8 Lbs.
6/1/2022 208.0 Lbs.
5/9/2022 207.8 Lbs.

On 11/4/22 at 11:41 AM surveyor accompanied the CNA (certified nursing assistant) B to obtain a current weight on Resident #47. His weight was 169.9 lbs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 692	Continued From page 29	F 692		

A review of the clinical record revealed that the Resident had a Quarterly nutrition assessment done on 7/27/22, at which time he weighed 200.8 lbs. The assessment section B - Care Plan Changes read: "Recommend continue current plan of care and continue to monitor per policy.'

A review of the care plan revealed: "[Resident name redacted] is at risk for nutrition problems related to disease process AEB sig. weight loss, poor PO intake, and PMH: pneumonia, sepsis, dementia, DM2, bipolar, anxiety, seizures, gingivitis, MDD, Date Initiated: 04/21/2020 Revision on: 09/07/2022 ... [Resident name redacted] will minimize the risk of nutrition problems through review date. Date Initiated: 01/29/2020. Target Date: 11/01/2022 ...Will maintain weight +/- 5% of CBW through the next review date. Date Initiated: 09/07/2022 Target Date: 11/01/2022
Will consume adequate energy of >/= 50% of all meals to promote adequate nutritional status through the next review date. Date Initiated: 09/07/2022 ...Monitor intake and record q meal. Date Initiated: 01/29/2020 Monitor/record weights and report sig wt. changes to MD PRN. Date Initiated: 01/29/2020. Provide diet as ordered. Date Initiated: 01/29/2020. Provide supplements as ordered Date Initiated: 09/07/2022 ...RD (registered dietician) to evaluate and make diet change recommendations PRN."

On 11/3/22 during the end of day meeting, an interview was conducted with the RN (registered nurse) C, who stated that it was her expectation that the intervention of supplements should have come sooner than 9/7/22, by which time, the Resident had lost 22 lbs. She stated that it was also her expectation that the nursing staff report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 11/04/2022

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

F 692 Continued From page 30

the weight loss to the physician as well. When asked why there was a gap in the nutrition assessments, RN C stated there had been staffing challenges, including the dietician.

On 11/3/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
BB

Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure 2 residents (Resident #26 and #3) in a survey sample of 34 residents received oxygen services in a manner to prevent the spread of infection.

Findings included:

1. For Resident # 26, the oxygen tubing was not dated.

Resident # 26 was admitted to the facility with the diagnoses of, but not limited to, Chronic

F695

1. Residents #26 and #3 oxygen and tracheostomy supplies were immediately replaced and dated.
2. All residents of the facility who use respiratory supplies have the potential to be affected by this deficient practice. An audit of all resident rooms was completed checking for dating and storage of respiratory supplies.
3. Licensed Nursing staff of the facility will be educated on the facility policy for Respiratory Equipment Change Policy.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 Obstructive Pulmonary Disease and Chronic Respiratory Failure. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 9/2/2022. The MDS coded Resident # 26 as requiring oxygen therapy. Review of the clinical record was conducted on 11/1/2022 - 11/4/2022. During the initial tour on 11/1/2022 at 12:20 PM, an oxygen concentrator was located on the right side of the bed in Resident #26's room. The oxygen tubing and bag connected to an oxygen concentrator were not labeled and dated. On 11/2/2022 at 9:15 AM, closer inspection of the tubing connected to the concentrator revealed a date of "10-19"written in a black marker on the tubing near the end connected to the concentrator. Certified Nursing Assistant B came into Resident # 26's room while the surveyor was still there. Certified Nursing Assistant B stated she was filling in as the Central Supply Clerk. During an interview on 11/2/22 at 9:20 AM, Certified Nursing Assistant B stated she was new at that job and did not know to place the date on the tubing. She stated she had changed the oxygen tubing but did not put a label on the actual tubing. When asked about the 10-19 date on the end of the tubing on the concentrator, the Certified Nursing Assistant B stated she must have missed that one. She also stated the oxygen tubing should be changed weekly. On 11/2/2022 at 9:25 AM, LPN (Licensed	F 695	4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for oxygen and trach supplies being properly stored and dated. Weekend supervisor/manager on duty will complete rounds on weekends. Rounds will be completed daily x 2 weeks, then 3 x weekly. Angel rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 695	Continued From page 32	F 695		

Practical Nurse) B and Surveyor E observed Resident # 26's oxygen equipment. LPN B stated there should have been a date on the oxygen tubing and concentrator. LPN B stated the facility staff should change the oxygen tubing weekly and staff should check the date on the tubing prior to using it, making sure it has not been in use longer than a week due to potential for infection control problems.

Review of the Physicians Orders revealed the following orders for oxygen therapy:
"9/9/2022 for Oxygen at 2 Liters per minute via nasal cannula every shift."

Review of the facility policy, "Oxygen Therapy," Effective Date: 11/30/2014 Revision Date: 8/28/2017 revealed, in part: "Label tubing and humidifier with date and time." The policy did not state how often the tubing should be changed.

During the end of day debriefing on 11/3/2022, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of these concerns. The Corporate Nurse Consultant stated the oxygen tubing should be changed weekly and dated.

No further information was provided.

2. For Resident #3, facility staff failed to label and date the oxygen tubing.

During initial tour on 11/1/22 at approximately 1:45 PM, Surveyor C observed Resident #3 with oxygen being administered via tracheostomy collar. There was no label or date on the oxygen tubing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 695	Continued From page 33	F 695		

On 11/2/22, Resident #3's oxygen tubing was observed again and found to be without label or date. An interview was conducted with the Director of Nursing (DON) who stated, "Oxygen tubing should be labeled and dated and also changed weekly, or if it becomes visibly dirty, in order to prevent infections."

Review of Resident #3's clinical record revealed a physician's order that read, "Oxygen at 2 LPM [liters per minute] by trach collar."

The Facility Administrator was informed of the findings on 11/3/22. No further information was provided.

F 760 SS=D Residents are Free of Significant Med Errors
CFR(s): 483.45(f)(2)

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
SS

Based on interview, clinical record review, and facility documentation review, the facility staff failed to ensure Residents were free from significant medication error for 2 Residents (#29 and #67) in a survey sample of 34 Residents.

The findings included:

1. For Resident #29, the facility staff signed off giving an Invega Trinza injection 2 times in one month; the injection is ordered for every 3 months.

F 760 (Plan of Correction)

F760

1. Residents #29 and #67 medication errors were addressed by the facility and the MD was notified of the errors. No adverse effects were noted.
2. All residents of the facility have the potential to be affected by this deficient practice. An audit was conducted by the director of nursing of all resident rooms of the facility and no further concerns were identified of medications being left at the bedside.
3. Licensed Nursing staff of the facility will be educated on the facility policy for medication administration, accurate documentation in the MAR, medications being left at bedside, and reporting of medication errors.
4. The DON or designee will conduct medications pass observations 3 times weekly auditing that no medications are left at the bedside, and accurate documentation of administration in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 760	Continued From page 34 On 11/3/22 at 12:00 pm, Resident #29 was lying in the bed in a hospital gown. She was awake; however, she declined to speak with the surveyor. On the afternoon of 11/3/22 a review of the Residents clinical record revealed the following order: "Invega Trinza Intramuscular Suspension Prefilled Syringe 819 MG [milligram] / 2.63ML [milliliters] Inject 2.63 milliliter intramuscularly every 3 months every 3 month(s) starting on the 22nd for 84 day(s) related to PARANOID SCHIZOPHRENIA (F20.0) Give injection 28-30 days after last injection of Invega Sustena.-Start Date10/22/2022 1145 AM." A review of the MAR (Medication Administration Record) revealed that the "check mark" indicating that the medication had been given was present on 10/22/22 and 10/31/22. On 10/23/22 - 10/31/22 the nurses had used the code for medications being held or refused. On 11/4/22 at approximately 12:55 PM, an interview was conducted with the DON (director of nursing) and the Unit manager who signed off the medication on 10/31/22. The unit manager stated that she signed off the medication in error. She stated she should have signed it off as held. The DON was asked what it means when the check mark appears on the MAR, and she stated it means the medication was administered. A review of the progress notes revealed the notes written by the nurse who signed off on giving the injection on 10/22/22, describing the injection site with the time date, and patient reaction.	F 760	EMAR. Results of the weekly audits/observations will be reported monthly to the QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 760	Continued From page 35	F 760		

Continued From page 35

The unit manager did not write a note in the progress notes to document site of administration. When asked why, she stated that she had not given the injection on 10/31/22. She stated she only checked the box because she knew it had been given. She stated she realizes now she should have signed it off as held or not given, and put in a note that stated that it had already been given on the 22nd. However, the facility provided no pharmacy receipts or proof that only 1 injection was received and given by facility.

On 11/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.
2. For Resident #67, the facility staff left a narcotic medication at the bedside and did not observe the Resident take the medication.

On 11/2/22 at 9:09 AM, a medication administration observation was made with LPN (licensed practical nurse) C. LPN C prepared Resident #67's medications, which included but were not limited to Tylenol Extra Strength 650 mg (milligrams). LPN C entered the room, sat the cup of pills on the bedside table, inquired about Resident #67's pain, and then stepped back into the hall to the medication cart to retrieve Oxycodone 5 mg tablet. LPN C then re-entered Resident #67's room and sat the medication cup containing the Oxycodone on the over bed. LPN C exited the room. LPN C did not observe Resident #67 to take any of his medications.

Upon returning to the medication cart, LPN C was asked by Surveyor C if her normal practice is to leave medications at the bedside. LPN C said,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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
F 760	Continued From page 36	F 760		

"No, I give them to him, and it takes him some time to take them." Surveyor C then asked how the nurse knows if the resident took the medicine. LPN C said, "He will tell me. I will go back in there and check too." LPN C signed off on medications in the computer.

On 11/2/22 at 10:28 AM, a clinical record review of Resident #67's chart was conducted. There were no orders for self-administration of medications. Surveyor C observed the medication administration record and progress notes of Resident #67. LPN C had failed to make any documentation regarding the Tylenol 650 mg, to indicate that it was provided, refused, etc. LPN C documented the Administration of all of the other medications, including the Oxycodone HCL, which she did not observe the Resident take/swallow. It is unknown if the Resident took the medications, sat them aside, etc.

On 11/3/22, LPN C was asked about the importance of ensuring Residents receive/take the medications as ordered. She stated, "Evidently they need it because the doctor ordered it." When asked what she is to do if a Resident doesn't take a medication, LPN C said, "I let the doctor know, because if it causes a side effect, they may want to revisit/re-evaluate." LPN C was asked when she is to document the medications are provided to a Resident, she said, "Immediately after I give them."

On 11/4/22 at 9:17 AM, an interview was conducted with LPN B. LPN B had been observed at the side of a Resident, watching him take his pills one by one. Upon exiting the room LPN B was asked why she watched him take the pills versus leaving them on the table. LPN B

F 760

Continued From page 37

said, "To make sure they take them." LPN B was to identify the risk of leaving a medication at the bedside. LPN B said, "They may not take it or someone else could take them." When asked about the documentation regarding administration of medications, LPN B said, "I document it as soon as I am done with that Resident, before I move on to the next one."

Review of the facility's medication administration policy was conducted. This policy read, "...27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely..."

On 11/2/22, during an end of day meeting the facility Administration and corporate staff were made aware of the above findings.

No additional information was provided.

F 806 SS=D

Resident Allergies, Preferences, Substitutes
CFR(s): 483.60(d)(4)(5)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;

§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record

F 806

F806

1. Resident Identifier #29 has received meal preferences, with attention given to resident allergies, since this deficient practice was identified during the survey.

2. All residents of the facility have the potential to be affected by this deficient practice. An audit of all residents and their meal preferences, with attention given to resident allergies, will be completed by the Dietary Manager.

3. Education on the topic of resident meal preferences, with attention given to resident allergies, will be given to all dietary staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ___ B. WING ___	C 11/04/2022

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
F 806	Continued From page 38 review, and facility documentation review, the facility staff failed to ensure Residents receive food that accommodates allergies and intolerance and preferences for 1 Resident (#29) in a survey sample of 34 Residents. The findings included: For Resident #29 the facility staff failed to honor preferences of food choices when available. On 11/3/22 at approximately 1225 pm, Resident #29 was in the room talking with surveyor and the lunch tray arrived. Resident #29 opened the lid and found that he was given chicken and Brussel sprouts instead of the grilled cheese sandwiches he requested. Resident #29 became angry and began cursing in frustration, and he yelled, "They always just give me whatever! It does not matter what I choose they give me whatever they want to. I'm sick and tired of this (expletive). Dogs and cats in the street eat better than I do I'm sick and tired of this mess." CNA (certified nursing assistant) B heard him yelling and came to see what the problem was. the CNA told the Resident he would return his tray to the kitchen and get him what he had requested. Resident #29 said "Why do they keep on doing this to me?" CNA B was asked if this happens frequently, and he responded, "Yes it does happen a lot." On 11/4/22 at approximately 9:00 AM, Resident #29 was interviewed, and he stated "They did it again last night, I didn't choose what they sent me. I was just so mad; I just didn't eat. I sent it back. It's no use arguing with them. They give me what they want me to have." On 11/4/22 at approximately 9:52 AM an interview	F 806	4. The results of the Dietary Manager's observations and audit of resident meal preferences, with attention given to resident allergies, will be discussed in morning stand-up for 1 month or until there are no further issues with resident meal preferences and allergies. Resident meal preferences and allergies will be discussed in monthly QAPI for 3 months or until resident meal preference issues have been resolved. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 806	Continued From page 39 was conducted with the dietary manager, who stated that she had only been working at the facility for 5 weeks and was having issues with staff and ordering. She also stated she tries to get around to the residents and make sure they have what they need and prefer. She stated that she blamed the staff on the tray line because "They are supposed to be looking at the tickets." She was asked about Resident #29, and she stated that she was unaware he was having difficulty, and would go and see him personally. She explained that the procedure was for the dietician was to collect the data on preferences and allergies and intolerances, and this information would be put into the system. A review of the policy , "Dining and Food Preferences," revealed, in part: "Policy Statement: Individual dining, food, and beverage preferences are identified for all residents/patients ...The diet requisition form will notify the dining services department of food allergies upon admission and prior to any meals being served. 2. Dining services director or designee will interview resident or resident representative to complete food preference interview within 48 hours of admission. 3. The food preference interview will be entered into the medical record. 4. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system. 5. The registered dietitian/nutritionist or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional contact for the residents that do not consume certain foods or food groups. 6. Dining services	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 806	Continued From page 40 Director or other clinically qualified nutrition professional or designee, will enter the information pertinent to the individual meal plan into the plan of care. 7. The individual tray assembly ticket will identify all food items appropriate for the resident/Patient based on diet order, allergies and intolerances and preferences. 8. Upon meal service any rivers resident, patient with expressed or observed refusal of food and or beverage will be offered an alternate selection of comparable nutritional value. 9. Alternate meal and/or beverage selection will be provided in a timely manner." On 11/4/22 during the end of day meeting, the Administrator was made aware of the concerns, and no further information was provided.	F 806	F808 1. Resident Identifier #8 has received a therapeutic diet since this deficient practice was identified during the survey. 2. All residents of the facility have the potential to be affected by this deficient practice. An audit of all resident's therapeutic diets will be completed by the Dietary Manager. 3. Education will be provided to the Nursing, Dietary, Therapy and Administrative Departments on resident therapeutic diets. 4. The results of the Dietary Manager's observations and audit of resident's therapeutic diets will be discussed in morning stand-up for 1 month or until there are no further issues with resident's therapeutic diets. Resident therapeutic diets will be discussed in the monthly QAPI for 3 months or until resident therapeutic diet issues have been resolved. 5. DOC- 1/2/23	
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, clinical record review, and facility documentation review, the facility staff failed to provide a therapeutic diet as ordered for one Resident (Resident #8) in a survey sample of 34 Residents.	F 808		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 41 The findings included: The facility failed to provide Resident #8 with large portions, as directed on the care plan. On 11/1/22 at approximately 1:30 PM, during an interview with Resident #8, he indicated that frequently, more times than not, he doesn't receive the large portions as he is supposed to. The Resident said, "I can only survive if I can get the unclaimed trays in the hall." On 11/2/22 at 01:27 PM, Resident #8 was visited in his room. The Resident's lunch tray was observed. The meal ticket said, "large portions/no salt/no sugar/extra veggies." The tray had one piece of meat and normal portion size of carrots and creamed potatoes. CNA (certified nursing assistant) C entered the room and was asked to look at his tray. When asked if the amount of food on Resident #8's tray was the same amounts as other residents received, CNA C confirmed that the portion sizes were the same as for other Residents, and were not larger. The CNA was then shown the meal ticket and left the room without any offers to contact the kitchen for resolution. On 11/3/22 at 1:43 PM, Resident #8 was visited in his room. Resident #8 reported that for breakfast, "My ticket says no bacon and no dessert, and I got both. I had a sweet roll and got no sausage." For lunch he received one slice of pizza, but the Resident reported he called the dietary manager "and she fixed me extra pizza." On 11/2/22, a clinical record review was conducted. Resident #8's care plan read, "[Resident #8's name redacted] has nutritional	F 808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 808	Continued From page 42	F 808		

problem or potential nutritional problem r/t [related to] showing non-compliance w/ CCHO [consistent carbohydrate] diet order and PMH [past medical history]: DM2 [type 2 diabetes], anemia, adult FTT [failure to thrive], schizoaffective disorder, morbid obesity, delusional disorders. Consumes meals slowly at times ...Provide and serve diet as ordered, Provide, serve diet as ordered. Monitor intake and record q [every] meal, RD [registered dietician] to evaluate and make diet change recommendations PRN [as needed]."

On 11/4/22 at 9:52 AM, an interview was conducted with Employee G, the dietary manager. Employee G reported to the survey team that she had only been working at the facility for 5 weeks. Employee G was told of the instances the survey team had observed Resident #8 not getting the diet as indicated on his meal ticket. Employee G said, "Everyone knows [Resident #8's name redacted] gets double portions. I blame the people doing the trays. They aren't reading the ticket." The dietary manager reported on-going concerns with the dietary staff not having attention to detail and that she has provided disciplinary action and spoken with her supervisor about her concerns.

The dietary manager, Employee G, confirmed the facility has no policy regarding the tray line process.

The facility policy, "Meal Distribution," revealed: "All meals will be assembled in accordance with the individual's diet order, plan of care, and preferences... 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 808	Continued From page 43 A review of the policy, "Therapeutic Diets," revealed: "Definitions: therapeutic diet is defined as a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition.... 3. Diets are prepared in accordance with the guidelines in the approved Diet Manual and individualized plan of care." On 11/3/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate Staff were made aware of the above findings. No further information was provided.	F 808	F810 1. Resident Identifier #69 has received adaptive dietary equipment/utensils since this deficient was identified during the survey. 2. All residents of the facility have the potential to be affected by this deficient practice. An audit of all residents needing adaptive dietary equipment/utensils will be completed by the Dietary Manager. An in-service on the topic of adaptive dietary equipment/utensils will be given to all dietary staff. continued on next page	
F 810 SS=E	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, Resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide adaptive equipment/utensils for one Resident (Resident #69) in a survey sample of 34 Residents. The findings included: On 11/1/22, during a Resident interview, Resident #69 reported that she was unable to eat her	F 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 810	Continued From page 44 lunch. She stated: "The utensils were too heavy, and I dropped them in the floor." When asked if she was offered more food and given the proper utensils, the Resident reported "No." Resident #69 said she was unable to each her lunch meal because they gave her "heavy"/weighted utensils which she dropped due to the weight, and it left her with no means to eat her food, Resident #69 reported the same thing happened the day before and she told her therapist. On 11/2/22 at 11:42 AM, Resident #69's meal tray was observed after it had been delivered to her room. The Resident had been provided a built-up and weighted fork. Surveyor C asked Employee H, the occupational therapist, to accompany her to the room. Employee H reported that Resident #69 has "neuropathy in her hands and she needs built-up utensils [larger handles] but not weighted utensils." Employee H confirmed that Resident #69 had been given a weighted fork. Employee H then notified Employee J, the therapy manager, who was going to return the fork to the kitchen for the correct one. Resident #69 reported that she had requested a cheeseburger for lunch, because "I just wanted something I could pick up and eat with my hands." On 11/2/22 at 12:01 PM, Resident #69 was visited in her room again and the meal tray had been removed. When questioned, Resident #69 said she was told "When they finish with the other side of the building, they will fix me something, or if not, it is ok, I will order something out like I usually do or wait until dinner." Resident #69 went on to say, "When you are served that mess, they don't know how to cook or just don't care."	F 810	3. Education will be provided to the Nursing, Dietary, Therapy and Administrative Departments on adaptive equipment and the specific needs of the residents of the home. 4. The results of the Dietary Manager's observations and audit of adaptive dietary equipment/utensils will be discussed in morning stand-up for 1 month or until there are no further issues with adaptive dietary equipment/utensils. Adaptive dietary equipment/utensils will be discussed in the monthly QAPI for 3 months or until adaptive dietary equipment/utensil issues have been resolved. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 810	Continued From page 45	F 810		

On 11/3/22 at 1:27 PM, Resident #69 was visited in her room. Resident #69's lunch tray was still in front of her, and she reported she didn't eat the salad because "I couldn't' get the dressing open." Her tray was observed to have a slice of pizza and a full leaf of lettuce, not a tossed salad as indicated on the meal ticket. An unopened packet of salad dressing was on the tray.

On 11/2/22, a clinical record review was conducted. Resident #69's care plan read, "[Resident #69's name redacted] has nutritional problem or potential nutritional problem...", the interventions included: "Monitor/document/report PRN any s/sx (signs/symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals., Monitor/record/report to MD [doctor] PRN [as needed] s/sx [signs and symptoms] of malnutrition:, Provide, serve diet as ordered. Monitor intake and record q [every] meal, RD [registered dietician] to evaluate and make diet change recommendations PRN."

Review of the facility policy titled, "Assistive Devices," revealed, in part: "Appropriate assistive devices/utensils will be provided as indicated in the individualized plan of care. 2. The assistive device/utensil requests will be entered into the individual resident profile in the menu management system for provision with each meal and snack. 3. The nursing staff, therapy staff, or their designee will ensure that all assistive devices/utensils are returned to the dining services department for proper ware washing following each use. 4. The interdisciplinary team will review the need for assistive devices/utensils

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 810	Continued From page 46	F 810		

quarterly or as indicated by the condition of the resident/patient."

On 11/3/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings.

On 11/4/22 at 9 AM, Resident #69 was visited in her room. Her breakfast tray was at the bedside and contained a regular fork and knife. The meal ticket read, "built up utensils."

On 11/4/22 at 9:17 AM, an interview was conducted with CNA B. CNA B confirmed that Resident #69 had received regular/standard utensils. CNA B said, "She usually gets the utensils with larger handles so it is easier to hold, I don't know why she didn't get them today."

On 11/4/22 at 9:52 AM, an interview was conducted with Employee G, the dietary manager. Employee G confirmed she was aware that Resident #69 uses the built-up utensils and said, "I replaced hers with the foam ones." When Employee G was made aware that consistently throughout the survey, Resident #69 had not received the correct utensils, she said, "It scares me when I leave, I will personally make sure she gets them. Even if I am not here, I can call back to the staff, I'm worried about them when I'm not here."

On 11/4/22, during an end of day meeting the facility Administration and Corporate staff were again made aware that Resident #69 received the incorrect utensils for breakfast this morning.

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 11/04/2022

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
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to provide required training for 5 staff members (Staff 8, Staff 9, Staff 10, Staff 11, Staff 12) in a sample size of 6 staff members. The findings included: The facility staff failed to provide abuse prevention and dementia care training for 5 staff members (Staff 8, Staff 9, Staff 10, Staff 11, Staff 12). On 11/02/2022 at approximately 1:45 P.M., the training logs for 5 staff members (Staff 8, Staff 9, Staff 10, Staff 11, Staff 12) were reviewed. There was no evidence of abuse prevention and dementia care training in the transcripts. At approximately 3:00 P.M., the Administrator and	F 943	F943 1. Facility HR director provided required education for abuse and dementia for the survey identified employees. 2. All residents of the facility have the potential to be affected by this deficient practice. HR Director to conduct a facility wide audit of current employees abuse and neglect training, and dementia training. 3. All staff of the facility will be provided education on the facility policy for abuse and neglect and the required dementia training. 4. The Human Resources Director will audit all new hires weekly for the required Abuse and Neglect Training and required dementia training. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. DOC- 1/2/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ____ B. WING ____	C 11/04/2022

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
F 943	Continued From page 48	F 943		

interim Director of Nursing were notified.

On 11/04/2022, the facility staff provided evidence of onboarding education for 5 staff members (Staff 8, Staff 9, Staff 10, Staff 11, Staff 12). A review of the documents revealed the following:

Staff 8, a certified nursing assistant (CNA) with a hire date of 09/06/2022, did not receive dementia care training.
Staff 9, a CNA with a hire date of 07/05/2022, did not receive abuse prevention nor dementia care training.
Staff 10, a licensed practical nurse (LPN), with a hire date of 09/17/2019, did not receive abuse prevention nor dementia care training.
Staff 11, an LPN, with a hire date of 11/17/2020, did not receive abuse prevention nor dementia care training.
Staff 12, a registered nurse (RN), with a hire date of 06/22/2022, did not receive abuse prevention nor dementia care training.

On 11/04/2022 at approximately 11:15 A.M., the Administrator was notified of findings.