STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495184	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Hall at Williamsburg Landing	5500 Williamsburg Landing Dr Williamsburg, VA 23185

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to provide supervision and ensure resident safety for two of six Residents (Resident (R)14 and R59) reviewed for elopement. As a result, R14 and R59, who had been assessed as an elopement and fall risk with moderate cognitive impairment, exited the facility without staff knowledge. R14 was found sitting in the parking of the facility next to his wheelchair with a bruised laceration under his right eye and eloped a second time. R59 also eloped from the facility two times, with one of the times being found a mile from the entrance of the facility. This had the potential to result in serious injury, harm, impairment, or death. This deficient practice resulted in the identification of Immediate Jeopardy and substandard quality of care. On 02/26/26 at 7:14 PM, the Administrator was notified that Immediate Jeopardy (IJ), which also constituted Substandard Quality of Care (SQC), was identified at F689 at a Scope and Severity (S/S) of J and began on 06/07/24 when R59 eloped from the facility. The IJ was removed on 02/27/26 at 5:15 PM, and the scope and severity was lowered to an G actual harm. Findings include:1.Review of R14's Face Sheet located in the resident's electronic medical record (EMR) under the Admission tab revealed the resident was admitted to the facility on [DATE] with diagnoses of heart failure, acute respiratory failure, abnormality of gait and a history of falls.Review of R14's Elopement assessment dated [DATE] and located in the EMR under the Assessments tab, revealed the resident was identified with wandering behavior that had occurred one to three days, was at risk for getting to a dangerous place with behaviors worsening and wandering aimlessly.Review of R14's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/22/25 did not identify the resident as exhibiting wandering behaviors. R14 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 indicating moderately impaired cognition. Review of R14's Care Plan dated 03/26/25 and located in the EMR under the Care Plan tab, revealed that the resident had been identified as exhibiting wandering behaviors. Interventions initiated included to assess for causes of wandering, record behaviors, redirect behaviors when wandering is observed, use wander guard/location monitor daily and offer periods of outside weather permitting. Review of the facility's provided investigation of R14's first elopement on 10/11/25 at 3:30 PM Utility Staff (US)3 was sitting in the parking lot located at the front entrance of the facility. US3 notified the receptionist that R14 was outside of the facility in the parking lot. The receptionist notified the nurse and campus security. Licensed Practical Nurse (LPN) 1 responded to the scene and assessed the resident. R14 had a bruise, laceration under his right eye, and no further injuries were noted. First aid was offered and emergency medical technicians (EMTs) were contacted. R14 was transferred to the hospital for further evaluation. A search of the resident's room at the time revealed his wander guard bracelet was found in his laundry bin. The Administrator met with the resident when he returned from the hospital. He was alert and recalled the events of the day. He stated, he waited until no one was looking and wanted to go outside. The receptionist was on a break at the time and did not see the resident. The Director of Nursing (DON) met with the resident separately when he returned from the hospital. He confirmed that he had intentionally removed the bracelet because it was uncomfortable. (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The root cause of the elopement was determined to stem from the resident intentionally removing this wander guard bracelet and timing his actions with intent. Upon his return, his bracelet was placed on the bottom of his wheelchair and a system has been implemented to check for the placement every shift. During an interview on 02/21/26 at 4:05 PM with LPN1 she stated that she was the nurse that was called to the front when R14 was located outside in the parking lot. She revealed that the resident rolled his wheelchair out the door to the front parking lot. She said she assessed the resident for any injury. The EMT's were contacted and transferred the resident to the hospital. She also confirmed that the resident had removed his wander guard bracelet which was found in his laundry bin in his room. She revealed the resident began exhibiting an increase in wandering and exit seeking behaviors. 2. Review of the facility's provided investigation revealed R14's second elopement of the facility was on 11/14/25 around 12:45 PM. The admission Coordinator (AC) noticed that R14 was sitting outside the facility in his wheelchair without staff supervision. She went outside and after determining the resident was not injured, she re-directed him back inside and notified the Administrator and Director of Nursing. The investigation revealed Certified Nursing Assistant (CNA)2 assisted R14 to the therapy gym in his wheelchair and informed the Physical Therapy Assistant (PTA). CNA 2 went back to the therapy gym 15 minutes later and the resident was still participating in therapy so she went back to her unit. When the resident was done with therapy PTA assisted R14 back to his wheelchair and began treating other residents. The resident left the therapy gym and turned left towards the lobby rather than right which leads to his unit. The receptionist which monitored the main entrance was on a scheduled break. When the resident was questioned, he acknowledged that the receptionist was not there and he stated that he wanted to go outside after his exercise.During an interview with the PTA on 02/27/26 at 12:00 PM, he stated after R14 was finished with therapy he got him back in this wheelchair and let him return on his own The PTA revealed he was not aware that the resident was a wanderer and he said he didn't remember him having a wander guard bracelet on. 3. Review of R59s Face Sheet located in the EMR under the admission tab reveled R59 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, schizophrenia disorder, anxiety, delusional disorders, post-traumatic stress disorder (PTSD), abnormality of gait and mobility. The resident was discharged from the facility on 11/07/24.Review of R59's quarterly MDS dated [DATE] located in the EMR under the MDS tab revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment.Review of R59's Care Plan dated 12/02/19, located in the EMR under the Care Plan tab, revealed the resident had the potential for falls and wandering behavior. Interventions in place were to keep the resident safe, keep side doors on unit locked, observe and monitor resident for wandering behavior, re-direct resident, monitor for placement of wander guard bracelet on wrist and offer 1:1 (one on one) staff when indicated. Review of a Wandering/Elopement Risk Assessment located in the EMR under the Assessment tab dated 12/02/19, revealed the resident was identified with no wandering behaviors at the present, had a history of wandering behaviors, was cognitively impaired, a recent change in medications to decrease behaviors and a hx (history) of wandering behavior to find family or pet. The resident scored a six out of a range of zero to nine. The decision was made to add an elopement deterrent device, develop an elopement care plan and refer to therapy.Review of the facility's investigation dated 12/14/23 and provided by the facility revealed that R59 eloped from the facility to the parking lot but remained within the staff's sight. Staff immediately brought the resident to safety inside the facility. Review of the five-day report dated 12/19/23, revealed that the morning of 12/14/23, the resident's daughter took her out for a car ride to look at Christmas lights. They left at 4:00 AM and returned around 7:00AM. Upon her return, there was an attempt to get her to eat but she was fixated on finding her daughter. This led to her elopement to the parking lot. She was in constant sight of facility staff and never more than 10 feet ahead. Staff remained with her, provided her walker and a coat for continued safety. Immediate interventions included medications to address anxiety. 4.Review of the facility's Incident/Accident Investigation provided by the facility revealed on 06/07/24, R59 eloped from the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility a second time. She was found at the security gate which was a mile from the entrance of the facility. She was in a resident's personal car who resided in the independent living. The resident stated, I am going home, I don't want to get out (of car), I don't know you. My daughter won't come up here again. I don't think she will. Are you going to call her? This kind lady was going to take me home. I don't think I'll ever see her again. After my daughter left, she (kind lady) can come back and pick me up. I don't think I can get out. I'm so tired, I don't know if I can go to the bathroom. Included in the investigation, revealed LPN3 indicated that staff alerted her while she was at the front reception desk that R59 was sitting in someone's vehicle at the Security guard gate. When LPN arrived the security the guard was talking with resident who was sitting in the passenger's seat of the independent resident's car. LPN3 introduced herself to the resident. R59 told LPN3 she didn't know her but she knew her daughter. R59 was taken back to the front of the facility. Staff assisted the resident back inside the facility and was taken to her room. The resident exhibited physical aggression toward staff when her vital signs were attempted. The daughter was notified of the incident and returned to the facility. Review of the follow up report submitted by the Administrator revealed that on 06/07/24, at approximately 4:00 PM, R59 was picked up on campus by an independent resident and taken to the guard house after she appeared to be lost. Staff were alerted by security staff who came to the guardhouse and brought the resident back to her room. LPN3 helped with getting the resident back to her room while working with staff. In speaking with various team members from the 3:00 PM to 11:00 PM shift and collecting statements from staff, it was suspected the resident followed a family or staff member out the side hall door closest to the guard house and main road on campus. Her comments upon return were that she was going home since her daughter won't come to the facility. She has a diagnosis of PTSD, schizoaffective disorder, and delusional disorder. As part of the investigation, a review of the statements by staff at the time of the incident revealed staff did not see the resident leave the facility. There was no time frame for when the last time the resident was observed. During an interview on 02/26/26 at 4:30 PM LPN2 she indicated that she was working the day R59 eloped from the facility but she did not remember the events around the incident. She stated that the resident had on a wander guard bracelet and was always trying to remove it. She considered the resident alert and oriented. She was not aware where the resident went or where she was found. Other staff involved in the incident were not available for interview. During an observation and interview on 02/26/26 at 11:20 AM the DON and Registered Nurse (RN)5 and the Director of Nursing (DON) demonstrated the alarm using the wheelchair for R14 with the bracelet attached. As the wheelchair passed though the sensor outside of the door of the nurses station, the audible alarm sounded. The sound of the alarm was not as loud as the alarm for the call bells. When the alarm is triggered, it is also reflected on a monitor located at the nurses station and another monitor further down the hallway next to a second station. RN5 stated that sometimes if there is a lot of noise around the nurses station, the alarm is hard to hear. An elevator was observed to the left of the nurses station before you exit the unit. A resident unit is located upstairs and downstairs for the basement. Following the hallway in the basement from the elevator door, a second wander bracelet alarm was present. There was no staff present in the area at the time of the observation. The hallway leads to a stairway with an unlocked exit door that leads to outside. Further down the hallway, a second unlocked door leads to a loading dock and ramp leading to the outside of the facility. Review of the facility's policy titled, Resident Elopement revised on 02/26, revealed; Williamsburg Landing shall take immediate action to ensure the safe return of residents who are reported as unaccounted for or missing.An elopement is defined as any instance where a resident has wandered away from his/her residence without staff knowledge, out of staff visual sight, and is incapable of finding his/her way back home. This is a serious situation requiring an immediate, coordinated response.any resident assessed as high elopement risk will be added to the Elopement Risk Binder.Upon discovery of a missing resident, immediate attempts shall be made to determine where the resident was last seen and what the resident was wearing. This deficient practice resulted in the identification of Immediate (continued on next page)

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	495184	A. Building B. Wing	02/27/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Jeopardy and substandard quality of care. On 02/26/26 at 7:14 PM, the Administrator was notified that Immediate Jeopardy (IJ), which also constituted Substandard Quality of Care (SQC), was identified at F689 at a Scope and Severity (S/S) of J and began on 6/7/24 when R59 eloped from the facility.On 02/27/26 the facility provided a Removal Plan that was accepted at 1:34 AM.The removal plan indicated the following:R59 was discharged from the facility on 11/07/24 and R14 still remains in the facility.On 02/26/26 the Administrator provided education to the Director of Nursing (DON), Director of Social Services, the Minimum Data Set Coordinator (MDSC) for the risk of wandering. Assessments were recorded in resident's medical record. No additional residents were identified to be at risk for wandering. There are currently four residents who were identified to have a wander guard. On 02/26/26 the Administrator checked all external and lobby doors within the health and rehabilitation center to ensure that all doors were secured or had a wander guard system in place. On 02/26/26 the facility immediately placed a staff member to continuously supervise and monitor the lobby area outside of the health and rehab center lobby, elevator, and unsecured areas. The facility will maintain supervision of this area until a wander guard is placed to ensure no access to an unsupervised area. On 02/26/26 the Administrator, DON, Director of Social Services, MDSC, ADON and the Medical Records Coordinator provided in-service education to all staff present to the wandering resident policy and wander guard protocol to include identification of residents at risk of wandering, the wander guard system and the newly placed monitoring system of the lobby leading to other doors, in secured areas and the elevator. All incoming shifts of nurses, certified nursing assistants and Health and Rehabilitation center administrative staff, dining, activities, maintenance and therapy staff who are scheduled to work within the Health and Rehabilitation and living center will receive in-service education to the wander guard system including the newly identified target areas (elevator and lobby) including newly hired staff including unscheduled and contracted staff on an ongoing basis prior their next shift of the health and rehabilitation center. The Administrator or DON will be responsible for the implantation of the removal plan. The facility will conduct an impromptu Quality Assurance Performance Improvement (QAPI) committee meeting on 02/27/26 to include the Medical Director through in person or google meet attendance to review the facilities plan of correction and removal of immediate jeopardy. The Administrator, DON, Security Guard, or nursing supervisor will inspect the wander guard system for proper function and all exterior doors five times per times four weeks, then three times per week times four weeks, then weekly there after in all areas of the Health and Rehabilitation Center to ensure substantial compliance is maintained. This plan of correction will be monitored and reviewed by the Quality Assurance plan for six months to ensure ongoing substantial compliance is met, amending the plan of correction to maintain compliance as needed. The date of compliance is implemented on 02/27/26. The survey team validated the implementation of the removal plan through observations, staff interviews, and record reviews. The IJ was removed on 02/27/26 at 5:15 PM, and the scope and severity was lowered to an G actual harm.

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	495184	A. Building B. Wing	02/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure the dish machine wash and rinse temperature was at the proper temperature to sanitize the dishes. This had the potential to affect 44 of 44 skilled nursing residents who consumed food from the kitchen. Findings include:During an observation on 02/26/26 at 12:25 PM, revealed the dishwasher wash and rinse cycle's temperature was registering 158 degrees Fahrenheit (F) for the wash cycle and 150 degrees F for the rinse cycle from the gauge on the dish machine. A second temperature monitor mounted on the wall and connected to the dish machine registered the wash cycle at 155 degrees F and 188.8 degrees F for the rinse cycle. The monitor is designed to alert staff for any temperatures that are out of range. There had been no alerts on the monitor. Due to the discrepancy, the Executive Chef (EC) used an internal thermometer inside the machine to check water temperature. The internal thermometer registered 151.4 degrees F. A second rack was sent through the machine using the internal thermometer which registered 158 degrees F. Another thermometer was used to test the water inside the well of the machine, it registered 165 degrees F. The EC verified the water temperatures were not reaching the proper temperature. The three-compartment sink would be used in the interim. During an observation on 02/27/26 at 10:00 AM revealed several representatives from Ecolabs working on the dish machine. According to the Executive Chef, when the machine was turned on earlier in the morning, he heard a loud pop and lost all power to the machine. During an interview on 02/27/26 at approximately 10:30 AM, the EC stated that he was unable to locate previous temperature logs for the dish machine. It was the responsibility of the Sous Chef to monitor and record the water temperatures of the dish machine for all three meals of the day. He verified that he was unable to validate the logs since he could not locate any of the copies. The Sous Chef was not available and was not presently on the schedule according to the EC. Review of the facility policy titled, Standard Operating Procedure (SOP): Dish Machine Operation, not dated, revealed. 1. Purpose to ensure the dish machine operates safely and consistently within required sanitation standards by verifying proper setup, monitoring temperatures and pressures, and protecting the booster heater from overload.3. The Back of the House ([NAME]) Supervisor ensures the dish machine is set up correctly and that all temperature and pressure readings are recorded. All ware-washing staff follow this SOP and report any deviations immediately.4.3 Temperature Monitoring, monitor the temperature gauges located on the front of the machine throughout service. If the wash temperature drops to 170 degrees or below, immediately: stop washing dishes, initiate a 7-minute pause to allow the machine to recover, recheck temperatures before resuming operation. 4.4 If temperatures do not return to required levels after the recovery period: notify the supervisor, submit a maintenance request, switch to manual ware-washing procedures if required by policy. 5. Documentation: All temperature and PSI readings must be logged at setup and monitored throughout the shift; any deviations must be documented on the ware-washing log.

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	495184	A. Building B. Wing	02/27/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, interview, and facility policy review, the facility failed to ensure residents were protected from potential abuse for one of one resident (Resident (R) 56) reviewed for an injury of unknown origin. R56 was discovered on the floor with signs and symptoms of pain and was emergently transferred to the hospital for further evaluation. There were no witnesses to the incident, and the resident did not explain the reason he was on the floor and in pain. The facility's failure to identify the incident as an injury of unknown origin caused the resident to be a possible victim of abuse.Findings include: Review of R56's printed Face Sheet, provided by the Administrator, revealed R56 was admitted to the facility's on 12/21/23 with diagnoses including dementia and weakness.Review of R56's printed admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/23, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. Review of a printed Incident/Accident Report, dated 01/03/24, provided by the Administrator, revealed R56 was observed lying on the floor. Upon assessment resident complained of pain in right leg. Unable to perform active range of motion without pain. First responder [Social Services Director (SSD)] approached nurse to inform resident observed lying on the floor.During an interview on 02/25/26 at 1:34 PM, the SSD stated she arrived at the unit shortly after residents finished breakfast. The SSD stated that as she approached the entrance to the dining room, she observed R56 lying on the floor in a lateral position groaning and grimacing in pain. The SSD stated she visually inspected the resident for bleeding and attempted to ask if he was okay, but the resident responded only with a groan. The SSD stated there were no other people in the area, so she then left the resident and went and located a nurse. The SSD stated she returned to the location with the nurse where R56 remained lying on the floor.During an interview on 02/25/26 at 6:00 PM, the Executive [NAME] President/Chief Operating Officer (ExVPCOO) stated that (surveyors) were not allowed to view incident/risk management reports, statements, or investigation documents. The ExVPCOO did not provide any credible evidence that the facility identified the incident as an injury of unknown origin and possible abuse. On 02/25/26, the Administrator provided a written statement that provided no credible evidence the incident was identified as an injury of unknown origin and/or possible abuse. An attempt was made to contact the former Administrator and was unsuccessful. Review of the facility's policy titled, Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, approved 12/2025 revealed, .The facility will not tolerate abuse.DEFINITIONS: Abuse- includes.injuries of unknown source.Injury of Uknown Source-An injury is classified as an 'Injury of Unknown Source' when both the following are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular time, or the incidence of injuries over time.3. Prevention & Identification. Facility's procedures will include: .e. The identification of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.Review of the facility's policy titled, Abuse, revised 10/2025 revealed .'Abuse' is defined.as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.'Injuries of unknown source' - An injury should be classified as an 'injury of unknown source' when ALL of the following criteria are met: The source of the injury was not observed by any person; and the resident could not explain the source of injury; and the injury is suspicious because of: The extent of the injury, or the location of the injury.or the number of injuries observed at one particular point in time, or the incidence of injuries over time.'Serious Bodily Injury' means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surgery, hospitalization, or physical rehabilitation.Identification. 1. Staff will be educated on observation and reporting importing information about resident care, condition, or behavior. Staff are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as injuries of unknown etiology, occurrences, patterns, and trends that may constitute abuse.a. Physical Abuse. i. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking.iii. Examples of injuries that could indicate abuse include but are not limited to: 1. Injuries that are non-accidental or unexplained; 2. Fractures, sprains, or dislocations; .j. Injuries of Unknown Source. i. Injuries of Unknown Source that meet the criteria for reporting may include but are not limited to: 1. Unobserved/Unexplained fractures, sprains, or dislocations.13. Unobserved/unexplained injury requiring transfer to a hospital for examination and/or treatment .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, staff interview, and facility policy review, the facility failed to implement its policies and procedures related to abuse, neglect, and injuries of unknown origin. The facility failed to report an injury of unknown injury and failed to complete an investigation related to an injury for one Resident (Resident (R) 56) of one resident reviewed for potential abuse and neglect out of a total sample of 14 residents. R56 was found on the floor with no witnesses and sustained a right hip fracture requiring surgical repair. This had the potential for abuse as the injury was not reported or investigated. (Cross Reference F609 and F610)Findings include: Review of R56's printed Face Sheet, provided by the Administrator, revealed R56 was admitted to the facility's skilled nursing unit on 12/21/23 with diagnoses including dementia and weakness.Review of R56's printed admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/23, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment. Review of a printed Incident/Accident Report, dated 01/03/24, provided by the Administrator, revealed R56 was observed lying on the floor. Upon assessment resident complained of pain in right leg. Unable to perform active range of motion without pain. First responder [Social Services Director (SSD)] approached nurse to inform resident observed lying on the floor. R56 was transferred to the hospital following the incident where he was found on the floor (unwitnessed) and subsequently underwent a right partial hip replacement due to a fracture. On 02/25/26, the Administrator provided a written statement composed by the Executive [NAME] President/Chief Operating Officer (ExVPCOO) and Chief Clinical Officer (CCO) of Independent Living Health Services indicating that the former Administrator did not complete a facility reportable incident within 24 hours because he believed the fracture was related to a fall and not an injury of unknown origin.An attempt was made to contact the former Administrator and was unsuccessful. Review of the facility's policy titled Abuse Prevention Program revealed that injuries of unknown origin must be reported, investigated, and managed in accordance with facility procedures and regulatory requirements.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that an injury of unknown origin was reported to the State Survey Agency (SSA) immediately but not later than two hours for one of one resident (Resident (R) 56) reviewed for injuries of unknown origin out of 14 sampled residents. This failure placed the resident and other residents who are discovered to have an injury of unknown origin at risk of sustaining injuries that could have been caused by abuse. (Cross Reference: (F600, F607, and F610)Findings include: Review of R56's printed Face Sheet, provided by the Administrator, revealed R56 was admitted to the facility on [DATE] with diagnoses including dementia and weakness.Record review of a printed Incident/Accident Report, dated 01/03/24, provided by the Administrator, revealed R56 was observed lying on the floor and complained of right leg pain. The report indicated the incident was unwitnessed and R56 was not interviewed about the incident. On 02/25/26, the Administrator provided a written statement composed by the Executive [NAME] President/Chief Operating Officer (ExVPCOO) and Chief Clinical Officer (CCO) of Independent Living Health Services indicating that the former Administrator did not report to the SSA the incident where R56 was discovered on the floor, in pain, and emergently transferred to the hospital for medical intervention as an injury of unknown origin. An attempt was made to interview the former Administrator and was unsuccessful.Review of the facility's policy titled, Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, approved 12/2025 revealed, .It is the facility's policy to investigate all.injuries of unknown source.Facility staff must immediately report all such allegations to the Administrator. The Administrator will immediately.notify the applicable local and state agencies in accordance with the procedures in this policy.6. Initial Reports. a. Timing. All allegations of Abuse.Injuries of Unknown Source.must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported.immediately, but not later than 2 hours after the allegation is made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495184	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Hall at Williamsburg Landing	5500 Williamsburg Landing Dr Williamsburg, VA 23185

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure an injury of unknown origin that required an emergent hospital transfer was investigated to determine if the incident was a result of abuse for one of one resident (Resident (R) 56) reviewed for injuries of unknown origin out of 14 sampled residents. The facility's failure to investigate R56's injury of unknown origin to determine if the injury was sustained because of abuse placed the resident at risk of being a victim of potential abuse. (Cross Reference: F600, F607 and F609). Findings include: Review of R56's printed Face Sheet, provided by the Administrator, revealed R56 was admitted to the facility on [DATE] with diagnoses including dementia and weakness.Review of a printed Incident/Accident Report dated 01/03/24, provided by the Administrator, revealed R56 was observed lying on the floor and complained of right leg pain. The report indicated the incident was unwitnessed. During an interview on 02/24/26 at 6:33 PM, the Day Shift Supervisor (DSS) stated she was informed by the Social Services Director (SSD) that a resident (R56) was discovered on the floor. The DSS also stated that she was responsible for doing a follow-up investigation of any incident/risk management reports that were completed. The DSS further stated she interviewed the assigned nurse and two certified nurse assistants (CNAs) assigned to the unit on the day of the incident, and all reported they did not witness the fall. However continued interview revealed no other interviews were conducted and it was not determined what led to the resident being discovered lying on the floor in pain and then emergently transferred to the hospital. On 02/25/26, Executive [NAME] President/Chief Operating Officer (ExVPCOO) provided no credible evidence to the inspectors that a thorough investigation had been completed when R56 was discovered on the floor and could not explain the incident. During an interview on 02/25/26 at 6:00 PM, the Chief Clinical Officer (CCO) stated that surveyors were not permitted to review incident/risk management reports, staff statements, or investigative documentation. The CCO provided no credible evidence to the inspectors that a thorough investigation had been completed after R56 was discovered lying on the floor, in pain, and then emergently transferred to the hospital for medical intervention. An attempt was made to contact the former Administrator and was unsuccessful. Review of the facility's policy titled, Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, approved 12/2025 revealed, .The facility will not tolerate abuse.It is the facility's policy to investigate all allegations, suspicions, and incidents of abuse.and injuries of unknown source.The Administrator will immediately begin an investigation.DEFINITIONS: Abuse- includes.injuries of unknown source.Injury of Uknown Source-An injury is classified as an 'Injury of Unknown Source' when both the following are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular time, or the incidence of injuries over time.7. Investigate. Once the Administrator and DON [Director of Nursing] are notified, an investigation of the allegation or suspicion will be conducted. a.The investigation must be completed within five working days from the alleged occurrence. b.The person investigating the incident should generally take the following actions: I. Interview the resident., and all witnesses.II. If there are no direct witnesses, then the interviews may be expanded.For Injuries of Uknown Source, the investigation will generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well. III. obtain written statements from the resident, if possible, the accused, and each witness. IV. Obtain all medical reports and statements from physicians and/or hospitals, if applicable. Review the resident's records.8. Reach a Conclusion. After completion of the investigation, all of the evidence should be analyzed, and the Administrator (or his/her designee) will make a determination regarding whether the allegation or suspicion is substantiated, and, for Injuries of Unknown Source, a determination regarding the probable source of the injury.