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	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Post Acute & Rehabilitation	1235 S Mount Vernon Avenue 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to maintain the professional standards of medication and treatment administration in nursing practice for one Resident (Residents #63) in a survey sample of 27 Residents. For Resident #63, the facility staff failed to administer treatments and pain medications for a dependent Resident with wounds and pain. The findings included: Resident #63's diagnoses included; Osteomyelitis right ankle and foot with amputation, acute and chronic respiratory failure with continuous oxygen use, chronic pain syndrome, anxiety and PTSD, foot drop, and hypothyroidism. Resident #63's most recent MDS (minimum data set) was coded as a quarterly assessment. Resident #63 was coded as having a BIMS (brief interview of mental status) score of 15 out of a possible 15, or no cognitive impairment. Resident #63 was also coded as requiring extensive to total dependence on one to two staff members to perform activities of daily living, such as hygiene, transferring, and bed mobility. The resident was coded as incontinent of bowel and bladder. On 4-16-24 at 12:00 noon, Resident #63 was observed in bed, with the head of the bed slightly elevated, during the initial tour of the facility, th resident was interviewed during this time. The resident stated that her legs and arms itching all the time, and that she would like to have some medicated cream to help that. She was observed to be scratching her thighs while speaking to the surveyor. The resident continued to state that she was in pain most of the time, and needed more pain medication daily. The resident's physician orders were reviewed and reveal orders for wound treatments, and pain medication administration for chronic pain treatment. Those orders were for the following; Treatments; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Ordered 1-11-24 foam border gauze to sacrum wound every day at 9:00 a.m. 2. Ordered 1-11-24 xeroform dressing to right foot every day at 9:00 a.m. 3. Ordered 1-15-24 Collagen sheet to sacrum every day at 9:00 a.m. 4. Ordered 1-20-24 Betadine left posterior knee every day at 9:00 a.m. Medications; 1. Ordered 1-24-24 Fentanyl patch 72 hour 25 mcg (micrograms) per hour change every 3 days for pain. 2. Ordered 1-26-24, discontinued 2-7-24, Hydromorphone 4 mg (milligrams) give 1/2 tablet every 6 hours as needed for pain. 3. Ordered 2-8-24 Hydromorphone 2 mg (milligrams) give 1/2 tablet every 8 hours as needed for pain. 4. Ordered 3-22-24 Hydromorphone 2 mg give 1/2 tablet 2 times per day at 6:00 a.m., and 6:00 p.m. for chronic pain syndrome. 5. Ordered 3-22-24 Methocarbamol 500 mg two times per day at 10:00 a.m., and 10:00 p.m. for chronic pain syndrome. 6. Ordered 4-9-24 Percocet 10-325 mg 1 tablet per day at 1:00 p.m. for chronic pain, one hour prior to physical or occupational therapy. The Medication and Treatment Administration Records (MAR/TAR) were reviewed for February and April 2024, and revealed the absence of nursing signatures indicating that the treatments and medications were omitted on multiple occasions. Those follow; Treatments; (13 opportunities) Foam border - 2-8-24, 2-19-24. Xeroform - 2-6-24, 2-8-24, 2-10-24, 2-13-24, 2-15-24, 2-16-24. Collagen - 2-8-24, 2-19-24, 2-24-24. Betadine - 2-8-24, 2-19-24. Medications; (8 opportunities) 1. Fentanyl patch - 4-3-24, 4-9-24. 2. Hydromorphone 2 mg (milligrams) give 1/2 tablet at 6:00 a.m., and 6:00 p.m. - 4-7-24 both doses, 4-8-24 both doses. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Methacarbamol - 4-7-24 at 10:00 p.m. 4. Percocet - 4-11-24 Nursing medication administration notes do not indicate why the treatments and medications were not administered. Nurses on the nursing unit were asked if treatments and medications were administered on the dates in question and the responses were if it's not documented, it's not done. Guidance for the administration of medications is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov Insulin must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses as ordered to decide proper dosing needed. Do not discontinue medication without seeking a doctor's help. Stopping narcotic pain medications may increase the risk of precipitous withdrawal which can be life threatening. The nursing facility stated [NAME] as their nursing standard. [NAME] stated all medications must be administered per the physician's order. Resident #63's care plan was reviewed and revealed a care plan for chronic pain and wound treatments that instructed to administer medications and treatments as ordered by the physician. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the treatments and medications had been omitted, nor that the doctor was made aware of the omissions. On 4-18-24 at 5:30 p.m., the DON and Administrator were interviewed and stated that they had been unaware that treatments and medications had not been given, nor that the doctor and family were not notified of them being omitted by staff. On 4-19-24 at approximately 10:00 a.m., at the end of day debrief, the Corporate Director of Operations and DON were again made aware of the failure of staff to administer treatments and medications as ordered. No further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41450 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to store medication in a secure location for 1 resident, Resident #61, out of a survey sample of 27 residents. The findings included: For Resident #61, facility staff failed to store prescribed antifungal powder in a secure location to ensure only authorized persons had access to the medication. On 4/16/24 at approximately 2:45 PM, Surveyor B observed a 3 ounce bottle which read, Antifungal Powder with Miconazole Nitrate 2%, expiration date 01/2025, with a prescription label from an outside provider attached to the bottle with Resident #61's name, date of birth, and prescriber/pharmacy information. The bottle was located on top of Resident #61's bedside table next to the head of his bed. On 4/16/24 at 2:50 PM, an interview was conducted with Resident #61 who stated, My wife brought that [referencing the bottle of antifungal powder] in the other day, it has been there [referencing his bedside table] a couple of days, I don't know if it is being used or not, the nurses put some kind of powder on me each day but that's all I know. On 4/16/24 at 3:00 PM, an interview was conducted with RN B, who also identified himself as the Unit Manager. RN B observed the medication at Resident #61's bedside, picked it up to remove it, and stated, I am not sure how this [medication] got there [bedside table] but I am going to look into it. RN B stated, Staff have been in here several times today, someone should have seen it, removed it, and locked it up, that is both my expectation and facility policy. A facility policy was requested and received. Review of the facility policy, Medication Storage, read, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. On 4/17/24 at approximately 10:15 AM, the Facility Administrator was updated on the findings. No further information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41450 Based on observation, staff interview, and facility policy review, the facility staff failed to properly store, label and date food items, and clean the floors in 2 out of 4 refrigerators/freezers located within the facility's main kitchen. The findings included: 1. Facility staff failed to label and date food items located within the vegetable and meat freezers. On 4/17/24 at approximately 2:00 PM, an interview and kitchen tour was conducted with the Dietary Manager (DM). A partial bag of crinkle-cut french fries, which had been previously opened, was observed in the vegetable freezer, however the bag was not labeled or dated. A partial bag of round meat patties, which had been previously opened, was observed in the meat freezer, however the bag was not labeled or dated. The DM stated, These bags should be labeled and dated, I will dispose of these things right now. The DM also stated, Labels are needed to identify food items so that potential food allergans can be identified before serving it to people and dating food lets us know when it may no longer be safe to serve. 2. Facility staff failed to ensure the floors in the beverage refrigerator and the walk-in refrigerator, located within the facility kitchen, was free from dirt and debris. On 4/16/24 at approximately 1:00 PM, an interview and kitchen tour was conducted with the DM. Observations of the beverage refrigerator and the walk-in refrigerator revealed dirt and debris, including food/beverage spillage, located on the bottom/floor of the refrigerators. The DM stated, It is dirty and not acceptable, I will be sure that it gets cleaned up. On 4/17/24 at approximately 2:15 PM, the Facility Administrator was informed of the findings. A facility policy was requested and received. The facility policy titled, Receiving and Storage of Food, dated 10/1/21, Policy: Foods shall be received and stored in a manner that complies with safe food handling practices, Item 1, read, Food Services, or other designated staff, will maintain clean food storage areas at all times and Item 8 read, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). The facility policy titled, Refrigerators and Freezers, dated 10/1/21, Policy: The facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines, Item 10, read, Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. No additional information was provided.