

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Windsormeade of Williamsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 Windsor Hall Drive Williamsburg, VA 23188	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and staff interviews, the facility staff failed to ensure that expired medications were not accessible for administration. The findings included: On 4/17/26 at approximately 11:35 AM, an inspection of the medication room was completed with Registered Nurse (RN) #1. Inside the refrigerator, among other medications available for administration, a bottle of Lorazepam Concentrate 2mg/ml was identified in the locked box. The Lorazepam bottle was filled on 01/17/2024 and had an expiration date of 01/2026. RN #1 stated that the direct care nurses notify the Director of Nursing (DON) of medications that need to be removed, and it was the DON who was responsible for destroying discontinued medication. On 4/17/26 at approximately 6:15 p.m., a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Regional Nursing Consultant, and Administrator-in-Training staff. The above information was provided, and the facility's staff were offered the opportunity to present information. The DON stated that the expired medication in the refrigerator had been brought to her attention today.		

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and staff interviews, the facility's staff failed to maintain dignity during wound care for 1 of 21 residents (Resident #20) in the survey sample. The findings included: Resident #20 was originally admitted to the facility 4/03/26. The residents' diagnoses included Type 2 diabetes mellitus without complications, and Muscle weakness, generalized. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/07/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #20's cognitive abilities for daily decision making were intact. The April 2026 Physician Order Summary (POS) Reads: Cleanse sacrum with normal saline (NS). Pat dry. Apply Medi honey to wound bed. Apply Calcium Alginate to wound bed. Cover with a foam dressing daily and as needed (PRN) if it becomes soiled. one time a day. On 04/17/2026 at approximately 10:25 am, during the initial tour, Resident #20 mentioned that he had a wound on his sacrum related to falling at home. Permission was received from the resident to observe wound care. On 04/17/26 at approximately 1:35 pm, wound care observation was conducted with Licensed Practical Nurse #1. No issues were observed involving wound care except when the wound care was completed, LPN #1 was observed dating and initialing the resident's dressing once it was placed on his sacrum. On 04/17/2026 at approximately 4:23 pm, a brief interview was conducted with LPN #1 concerning the wound care observation. LPN #1 said she will initial and date the resident's dressing before placing the dressing on his sacrum due to dignity. On 4/17/26 at approximately 5:45 PM, a final interview was conducted with the Administrator, the Director of Nursing (DON), the Regional Director of Operations, the Regional Nursing Consultant, and the Administrator-in-Training staff. The above information was provided, and the facility's staff were offered the opportunity to present information but no other information was presented.		

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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** Based on observations, staff interviews, and a review of the clinical record, the facility staff failed to adhere to professional standards during medication administration for 1 of 21 residents in the survey sample (Resident #16). The findings included: Resident #16 was admitted to the facility on [DATE]. The resident's current diagnoses included anemia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/7/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 14 out of 15. This indicated that Resident # 16's cognitive abilities for daily decision-making were intact. The Physician's Order Summary had an order dated 4/1/26, for Ferrous Sulfate Oral Tablet 27 MG. Give 1 tablet by mouth once daily for anemia. On 4/17/26 at 9:54 AM, a medication administration observation was conducted with Registered Nurse (RN) #1. RN #1 assisted the resident in accepting 8 pills, including the Ferrous Sulfate. The resident took small sips with the pill until they had all been swallowed. The resident was not instructed to or encouraged to consume the full glass of water. An interview was conducted with RN #1 at approximately 10:10 AM regarding the amount of water Resident #16 consumed during the medication administration task. RN #1 stated that the resident had a diagnosis of heart failure; therefore, consumption of 8 ounces of water was not encouraged. RN #1 further stated that the physician didn't order fluid restrictions, but she believed it was a necessary intervention. On 4/17/26 at approximately 5:45 PM, a final interview was conducted with the Administrator, the Director of Nursing (DON), the Regional Director of Operations, the Regional Nursing Consultant, and the Administrator-in-Training staff. The above information was provided, and the facility's staff were offered the opportunity to present information. The DON stated that 8 ounces of water is the professional standard when administering Ferrous Sulfate to aid in dissolving the medication and help prevent constipation. Take tablets or capsules with a full glass of water (8 ounces or 240 milliliters) unless otherwise directed by your doctor. Do not lie down for at least 10 minutes after taking your tablet or capsule dose. (ferrous sulfate 325 mg (65 mg iron) tablet Kaiser Permanente)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and a review of the clinical record, the facility staff failed to ensure activities of daily living (ADL) care was provided for 1 of 21 residents (Resident 2) in the survey sample. The findings included: Resident #2 was admitted to the facility on [DATE]. The residents' current diagnoses included lumbar compression fractures. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/26/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 13 out of 15. This indicated that Resident # 2's cognitive abilities for daily decision-making were intact. In section GG0130 (Functional Abilities), the resident was coded as requiring supervision or touching assistance with eating, partial/moderate assistance with oral hygiene and personal hygiene, substantial/maximal assistance with shower/bathe and upper body dressing, and dependent with lower body dressing, putting on/taking off footwear, and toileting hygiene. On 4/16/26 at approximately 1:20 PM and again on 4/17/26, Resident #2 was visited in his room. He was on contact precautions, and the room door was closed most of the time. The resident's fingernails were observed to be approximately 2 inches above the fingertips, brownish, and some of them had broken, irregular edges. Resident #2 stated that he didn't have his nail clippers with him, but when he returned to his townhouse, he would cut them. The resident further stated that he didn't like having long fingernails because they get caught on all kinds of things. On 4/17/26 at approximately 6:15 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Regional Nursing Consultant, and Administrator-in-Training. The above information was provided, and the facility's staff were offered the opportunity to present information. The DON stated that the resident wouldn't be returning to a townhouse. She stated that the staff would provide the necessary fingernail care		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to provide respiratory care consistent with professional standards of practice for 1 Resident (#18) in a survey sample of 21 Residents. The findings included: Resident #18. The facility staff failed to ensure the oxygen concentrator tubing and the humidification bottle attached to the oxygen concentrator were changed according to physician order for Resident #18. Resident #18 was originally admitted to the facility 4/6/26. The resident's diagnoses included chronic kidney disease, anxiety disorder, type 2 diabetes mellitus without complications, and essential hypertension. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/13/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #18's cognitive abilities for daily decision making were intact. On 4/17/26 at 12:05 PM during an observation tour of Resident #18's room, it was observed that the oxygen concentrator tubing read: dispose and replace on 4/16/26 and the humidification bottle attached to the oxygen concentrator for Resident #18 was dated 3/25/26. On 4/17/26 at 12:10 PM an interview was conducted with the Director of Nursing (DON). The DON stated that the oxygen concentrator tubing should have been changed on 4/16/26. The DON also stated that the humidifier bottle does not need to be changed and she is not sure why the bottle has a date on it. The DON further stated that the nurses just write the date on the bottle. A review of the Physician Order Summary with a start date of 04/07/2026 read: Change all respiratory tubing weekly (O2, nebulizers) every evening shift every Tue. The Facility's Respiratory Assessment Policy with a revised date of 4/1/23 read: V. Maintenance: A. The oxygen cannula, tubing and humidifier bottle are changed every week or as needed and should be dated and labeled on day of change. The weekly change is documented on the TAR. On 4/17/26 at approximately 6:15 p.m., a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Regional Nursing Consultant, and Administrator-in-Training staff. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family and staff interviews, and a review of the clinical record, the facility staff failed to ensure that the hospice plan of care coordinated with the facility's plan of care and to provide symptom management for 2 of 21 residents (Resident #7 and #10) in the survey sample. The findings included:1. The facility's staff failed to have Resident #7's visit schedule and notes available.Resident #7 was admitted to the facility on [DATE]. The resident's current diagnoses included Alzheimer's disease, TIAs, and urinary retention. The admission significant change annual quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 01/23/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 12 out of 15. This indicated that Resident #7's cognitive abilities for daily decision-making were moderately impaired.A review of resident #7's clinical record failed to reveal hospice visit notes or a schedule of disciplines to support the resident and family. A review of the facility's care plan meeting documentation also failed to reveal that a member of the hospice agency participated. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 4/17/26 at approximately 2:40 PM. CNA #1 stated that she was never informed when or what time to expect the hospice CNA to arrive, and she proceeded with caring for the resident as if there was no hospice support. On 4/17/26 at approximately 2:50 PM, an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated that she didn't have a schedule for who or when the hospice agency would visit, but she could attest that after visits with Resident #7, the hospice representative always stopped by and provided the nurse with an oral report.On 4/17/26 at approximately 4:30 PM, hospice documentation that had been faxed to the facility at 4:00 PM on 4/17/26 was provided to the survey team. On 4/17/26 at approximately 6:15 p.m., a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Regional Nursing Consultant, and Administrator-in-Training staff. The above information was provided, and the facility's staff were offered the opportunity to present information. They had no comments and voiced no concerns regarding the above information. 2. The facility's staff failed to assess and manage the symptoms for Resident #10.Resident #10 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 02/26/2026, coded the resident as unable to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long-term and short-term memory problems, as well as severe impairment for daily decision making. In section GG0130, the resident was coded as dependent with all activities of daily living.On 4/17/26 at approximately 11:14 AM, the resident could be heard from the hallway making loud sounds. The sounds were so severe that the spouse had to leave the resident's room to speak with a caller. The sounds lasted approximately 45 minutes, and no staff came to the residents' aid. LPN #1 was observed at the distal end of the corridor; she was alerted to the resident's status. LPN #1 instructed the spouse not to hesitate to notify staff if she notices any change in the resident. LPN #1 administered 2mg of Lorazepam to the resident, which calmed him within 10 minutes. The spouse and the companion left after the resident quieted and appeared relaxed. On 4/17/26 at approximately 6:15 p.m., a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Operations, Regional Nursing Consultant, and Administrator-in-Training staff. The above information was provided. The above information was provided, and the facility's staff were offered the opportunity to present information. They had no comments and voiced no concerns regarding the above information.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and family and staff interviews, the facility staff failed to ensure that the essential equipment for 1 of 21 residents (Resident #15) in the survey sample was operational. The findings included: Resident #15 was admitted to the facility on [DATE]. The residents' current diagnoses included. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 01/19/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident # 15's cognitive abilities for daily decision-making were intact. In section GG0130, the resident was coded as requiring partial/moderate assistance with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear; supervision or touch assistance with upper body dressing; and is independent with eating, oral hygiene, and personal hygiene. On 4/17/26 at approximately 12:20 AM, an interview was conducted with the resident and his spouse. The spouse stated that the resident's bed had not been functioning properly for 2 weeks and that he still could not raise or lower the bed. An interview was conducted with Certified Nursing Assistant (CNA) #1 at 3:29 PM. CNA #1 stated that the resident had experienced problems with his bed, but it had been repaired 3 days ago. CNA #1 was unaware of the concerns the spouse spoke of on 4/17/26. On 4/17/26 at approximately 6:15 p.m., a final interview was conducted with the Administrator, the Director of Nursing (DON), the Regional Director of Operations, the Regional Nursing Consultant, and the Administrator-in-Training staff. The above information was provided, and the facility's staff were offered the opportunity to present information. The DON said the resident bed had not been operating properly, but it had been repaired. The DON also stated that today's concern was secondary to user error: the electrical portion was separating, preventing activation when the controls were pressed, and that a simple fix would prevent further problems.		