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	03/30/2022

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 0600 Level of Harm - 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. 40452 Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff neglected to provide goods and services to one Resident (Resident #316) in a sample size of 32 Residents. For Resident #316, the facility staff failed to provide adequate hydration for over 24 hours after a registered nurse assessed that Resident #316 was dehydrated. Resident #316 was hospitalized and treated for significant dehydration on 01/17/2022. This is harm. The findings included: On 03/27/2022 and 03/28/2022, Resident #316's clinical record was reviewed. Resident #316's most recent Minimum Data Set with an Assessment Reference Date of 12/16/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Resident #316's medical diagnoses included but were not limited to status-post cerebrovascular accident and aphasia. A physician's order dated 11/11/2021 documented, Full code. A review of the progress noted from October 2021 through January 2022 included but were not limited to the following: Excerpts of a nurse's skilled note dated 01/12/2022 at 00:00 A.M. documented the following: Current vital signs are: Temperature: T 98.0 - Route: Forehead (non-contact) Pulse: P 82 Pulse Type: Regular Respirations: R 18 Blood pressure: BP 128/72 Position: Lying r/arm [right arm] Pain level: 0 Pain scale: Numerical. Level of consciousness noted as oriented to person Hx [history] Aphasia. Skin is warm dry. Swallowing problems are not noted [no punctuation] refusing all offers of fluids. Mood status is flat affect. (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

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	03/30/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	There was not a skilled note written on 01/13/2022 through 01/17/2022. A Medication Administration note dated 01/14/2022 at 9:18 P.M. documented, Resident not eating or taking medications. A Medication Administration note dated 01/14/2022 at 9:19 P.M. documented, Insulin not given as resident is not eating and BS [blood sugar] 150 [milligrams per deciliter]. A Medication Administration note dated 01/15/2022 at 10:31 A.M. documented, Resident would not open her mouth to take her medicine and turns head whenever offered to her, resident educated. A nurse's note written by Licensed Practical Nurse F (LPN F), agency nurse, dated 01/16/2022 at 6:14 A.M. documented, Note Text: Resident laying bed not responding to verbal stimuli. Resident has some response to physical stimuli VS [vital signs] [blood pressure] 89/64 [respirations] 18 [pulse] 68 [temperature] 97.5 BS [blood sugar] 147. Call placed to on call. Awaiting response. RN [registered nurse] on duty called to unit to assess resident. Pushing fluids. Report to oncoming shift when MD returns call to request IV to be started. Will continue to attempt oral fluid intake until further instructed. A nurse's note dated 01/16/2022 at 6:47 A.M. documented, Note Text: Continue to push fluid with minimal success. Resident able to swallow only a few times. Will continue to monitor. A Medication Administration note dated 01/16/2022 at 10:23 A.M. documented, res [resident] not swallowing md [medical doctor] made aware rp [responsible party] made aware. A nurse's note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. documented, Note Text: res [resident] not swallowing holding food and meds crushed in pudding in mouth when offered fluid via spoon res [resident] holding fluid in mouth not swallowing res awake with eyes open waving hand at times vital signs at this time 96/52 [blood pressure] 114 [pulse] 96.8 [temperature] 16 [respirations] 97% [oxygen saturation] MD [medical doctor] made aware gave orders to hold meds and insulin until 1/17/22 res [resident] is to be seen by MD [medical doctor] in the AM [morning]. A nurse's note written by Registered Nurse B (RN B) dated 01/16/2022 at 5:00 P.M. documented, Note Text: This nurse spoke with resident's [responsible party] and informed that resident was not eating, she was pocketing food and not drinking much. Her [responsible party] suggested we try ice chips to get fluid in her. A nurse's note dated 01/17/2022 at 10:09 A.M. documented, Note Text: Writer called RP [responsible party] and made aware that resident was being sent out to ED for eval [emergency department for evaluation] and treatment. Voiced understanding. Resident #316's Emergency Department (ED) medical records dated 01/17/2022 at 12:52 P.M. under the header ED Course documented, Patient presents with hypotension initial hypoxia hypoxia [sic] is improved now on 4 liters of oxygen blood pressure is normalized after 2 liters of fluid is COVID positive severe dehydration case discussed with the hospitalist soft plan will be medical admission. Under the header Clinical Impression it was documented, 1. COVID 2. Dehydration. An excerpt under the header Physical Exam documented, Unresponsive, occasional grimace due to pain. (continued on next page)

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	03/30/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/29/2022 at 9:40 A.M., Certified Nursing Assistant F (CNA F) was interviewed. CNA F confirmed she had taken care of Resident #316. When asked about Resident #316's eating and drinking, CNA F stated that Resident #316 was eating and drinking at first. CNA F then stated that at one point Resident #316 wouldn't eat but would hold a cup and drink fluids. CNA F stated that then [at some point] Resident #316 wouldn't take anything [food or fluids]. On 03/29/2022 at 10:20 A.M., Registered Nurse B (RN B) was interviewed. When asked about Resident #316's eating and drinking, RN B stated that Resident #316 refused to eat and often refused her drinks, too. When asked about the process if a Resident refuses to eat and drink fluids, RN B stated We inform the doctor. RN B also stated that [Resident #316] would drink some but not enough and that's why she went to the hospital. When asked how fluid intake is monitored, RN B stated We don't track I and O [meaning intake and output] unless there is a doctor's order. When asked about the process if a Resident is not drinking adequate amount of fluids, RN B indicated she would notify the physician because of the need to send them out [to the hospital]. RN B also stated that she would obtain vital signs. RN B did not mention assessment for dehydration. On 03/29/2022 at 11:50 A.M., the Director of Nursing (DON) was interviewed. This surveyor and the DON reviewed the nurse's note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the expectation of the nurse at that time, the DON stated they have a policy that if the nurse cannot get in touch with the physician, they are to call the administrator or the nurse on call. When asked who the RN was referencing in the note, the DON stated she would find out. When asked about the expectation of the RN, the DON stated she would expect the RN to assess and document findings. The DON also stated that based on the RN's assessment findings, she could've sent [Resident #316] out [to the hospital]. This surveyor and the DON reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked about the expectation of the nurse at that time, the DON stated the nurse should ask the physician if [Resident #316] can be sent out [to the hospital]. When asked about monitoring for adequate hydration, the DON stated the nurse should check skin turgor [elasticity] and mucous membranes. The DON also stated that the nurse should ask the aides how many cc's [cubic centimeters meaning milliliters] intake the Resident has had. The DON also stated that output should also be measured. On 03/29/2022 at 2:25 P.M., LPN G was interviewed. The surveyor and LPN G reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked why she called the physician about [Resident #316], LPN G stated that [Resident #316 was not swallowing and was concerned because her blood pressure was low and her pulse was up. LPN G stated that [Resident #316] I know she was dehydrated because she wasn't drinking anything or swallowing. LPN G also stated that she thought the physician would send her out but he didn't [send her out]. When asked if she felt she had other options, LPN G stated, I did not. LPN G verified the on-call physician was [Employee L]. On 03/29/2022 at approximately 3:00 P.M., the DON provided the name of the RN referenced in the note dated 01/16/2022 at 6:14 A.M. as (RN C). (continued on next page)

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	03/30/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/29/2022 at 4:00 P.M., Employee L, the on-call physician, was interviewed. When asked about the process of being the on-call physician, the on-call physician indicated he does not take notes on the calls he receives and he does not have access to the clinical record. The on-call physician stated he relies on the nurse's report. When asked about [Resident #316]'s status on 01/16/2022, the on-call physician stated he did not remember [Resident #316]. This surveyor and the on-call physician reviewed the nurse's note written by LPN G dated 01/16/2022 at 12:49 P.M. When asked if he would want to send [Resident #316] to the emergency department for evaluation based on the note, the on-call physician stated No because it sounded like a chronic problem. The on-call physician indicated that unless the Resident was lethargic or choking on food or aspirating, he would not send the Resident out but have the primary provider address it in the morning. When asked about the hydration status, the on-call physician stated that It could've been dehydration; I might have thought about that. The on-call physician stated that he sent a message to the nurse practitioner to evaluate [Resident #316] the following day [Monday morning]. This surveyor and the on-call physician reviewed the note written on 01/16/2022 at 6:14 A.M. The on-call physician stated he wasn't aware [Resident #316] not responding to verbal stimuli. The on-call physician indicated that [LPN G] did not convey that information. On 03/29/2022 at 4:55 P.M., an interview with RN C was conducted. RN C verified she was the RN referenced in the note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the events indicated in the note, RN C stated that [LPN F] asked her to look at [Resident #316] at approximately 6:30 A.M. [on 01/16/2022]. RN C stated that [Resident #316] had dry lips, dry mucous membranes, and poor skin turgor. RN C stated that Resident #316 looked dehydrated to me. RN C stated she told [LPN F] she was unsure he would even be able to get an IV [intravenous catheter] in her because she was dehydrated. RN C stated she told LPN F that if he couldn't get an IV into her, they would have to send her out [to the hospital]. RN C stated that LPN F called the physician and left a message. When asked if she had documented her assessment findings, RN C stated no. RN C indicated that she had her own assignment and was not working as a supervisor. On 03/30/2022 at 9:30 A.M., a follow-up interview with RN C was conducted. When asked about Resident #316's level of consciousness at the time of her assessment on the early morning of 01/16/2022, RN C stated that Resident #316 was at her [level of consciousness] baseline but she definitely needed an intervention because she was dehydrated. RN C also stated that she wished she had gone back to check on [Resident #316] and followed up. A review of the Physician orders for January 2022 revealed there were no orders for an IV to be started. The facility staff provided a copy of their policy entitled, Abuse, Neglect, Exploitation & Misappropriation. An excerpt under the header Definitions documented the following: Neglect is the failure of the center and its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: Failure to provide adequate nutrition and fluids. On 03/30/2022 at approximately 3:30 P.M., the administrator and DON were notified of findings. The administrator stated they had no further information or documentation to submit.

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	03/30/2022

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 - 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** 40452 Based on staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care according to professional standards of practice for one Resident (Resident #316) in a sample size of 32 Residents. For Resident #316, the facility staff failed to: 1) convey Resident #316's dehydration status to the on-call physician 2) document assessment findings 3) address the dehydration status in a timely fashion after a registered nurse assessed that Resident #316 was dehydrated which resulted in hospitalization and treatment for significant dehydration. This is harm. The findings included: On 03/27/2022 and 03/28/2022, Resident #316's clinical record was reviewed. Resident #316's most recent Minimum Data Set with an Assessment Reference Date of 12/16/2021 was coded as a quarterly assessment. Cognitive Skills for Daily Decision-Making were coded as severely impaired. Resident #316's medical diagnoses included but were not limited to status-post cerebrovascular accident and aphasia. A physician's order dated 11/11/2021 documented, Full code. A review of the progress noted from October 2021 through January 2022 included but were not limited to the following: Excerpts of a nurse's skilled note dated 01/12/2022 at 00:00 A.M. documented the following: Current vital signs are: Temperature: T 98.0 - Route: Forehead (non-contact) Pulse: P 82 Pulse Type: Regular Respirations: R 18 Blood pressure: BP 128/72 Position: Lying r/arm [right arm] Pain level: 0 Pain scale: Numerical. Level of consciousness noted as oriented to person Hx [history] Aphasia. Skin is warm dry. Swallowing problems are not noted [no punctuation] refusing all offers of fluids. Mood status is flat affect. There was not a skilled note written on 01/13/2022 through 01/17/2022. A Medication Administration note dated 01/14/2022 at 9:18 P.M. documented, Resident not eating or taking medications. A Medication Administration note dated 01/14/2022 at 9:19 P.M. documented, Insulin not given as resident is not eating and BS [blood sugar] 150 [milligrams per deciliter]. A Medication Administration note dated 01/15/2022 at 10:31 A.M. documented, Resident would not open her mouth to take her medicine and turns head whenever offered to her, resident educated. (continued on next page)

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	03/30/2022

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 - Actual harm Residents Affected - Few	A nurse's note written by Licensed Practical Nurse F (LPN F), agency nurse, dated 01/16/2022 at 6:14 A.M. documented, Note Text: Resident laying bed not responding to verbal stimuli. Resident has some response to physical stimuli VS [vital signs] [blood pressure] 89/64 [respirations] 18 [pulse] 68 [temperature] 97.5 BS [blood sugar] 147. Call placed to on call. Awaiting response. RN [registered nurse] on duty called to unit to assess resident. Pushing fluids. Report to oncoming shift when MD returns call to request IV to be started. Will continue to attempt oral fluid intake until further instructed. A nurse's note dated 01/16/2022 at 6:47 A.M. documented, Note Text: Continue to push fluid with minimal success. Resident able to swallow only a few times. Will continue to monitor. A Medication Administration note dated 01/16/2022 at 10:23 A.M. documented, res [resident] not swallowing md [medical doctor] made aware rp [responsible party] made aware. A nurse's note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. documented, Note Text: res [resident] not swallowing holding food and meds crushed in pudding in mouth when offered fluid via spoon res [resident] holding fluid in mouth not swallowing res awake with eyes open waving hand at times vital signs at this time 96/52 [blood pressure] 114 [pulse] 96.8 [temperature] 16 [respirations] 97% [oxygen saturation] MD [medical doctor] made aware gave orders to hold meds and insulin until 1/17/22 res [resident] is to be seen by MD [medical doctor] in the AM [morning]. A nurse's note written by Registered Nurse B (RN B) dated 01/16/2022 at 5:00 P.M. documented, Note Text: This nurse spoke with resident's [responsible party] and informed that resident was not eating, she was pocketing food and not drinking much. Her [responsible party] suggested we try ice chips to get fluid in her. A nurse's note dated 01/17/2022 at 10:09 A.M. documented, Note Text: Writer called RP [responsible party] and made aware that resident was being sent out to ED for eval [emergency department for evaluation] and treatment. Voiced understanding. Resident #316's Emergency Department (ED) medical records dated 01/17/2022 at 12:52 P.M. under the header ED Course documented, Patient presents with hypotension initial hypoxia hypoxia [sic] is improved now on 4 liters of oxygen blood pressure is normalized after 2 liters of fluid is COVID positive severe dehydration case discussed with the hospitalist soft plan will be medical admission. Under the header Clinical Impression it was documented, 1. COVID 2. Dehydration. An excerpt under the header Physical Exam documented, Unresponsive, occasional grimace due to pain. On 03/29/2022 at 9:40 A.M., Certified Nursing Assistant F (CNA F) was interviewed. CNA F confirmed she had taken care of Resident #316. When asked about Resident #316's eating and drinking, CNA F stated that Resident #316 was eating and drinking at first. CNA F then stated that at one point Resident #316 wouldn't eat but would hold a cup and drink fluids. CNA F stated that then [at some point] Resident #316 wouldn't take anything [food or fluids]. (continued on next page)

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	03/30/2022

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 - Actual harm Residents Affected - Few	On 03/29/2022 at 10:20 A.M., Registered Nurse B (RN B) was interviewed. When asked about Resident #316's eating and drinking, RN B stated that Resident #316 refused to eat and often refused her drinks, too. When asked about the process if a Resident refuses to eat and drink fluids, RN B stated We inform the doctor. RN B also stated that [Resident #316] would drink some but not enough and that's why she went to the hospital. When asked how fluid intake is monitored, RN B stated We don't track I and O [meaning intake and output] unless there is a doctor's order. When asked about the process if a Resident is not drinking adequate amount of fluids, RN B indicated she would notify the physician because of the need to send them out [to the hospital]. RN B also stated that she would obtain vital signs. RN B did not mention assessment for dehydration. On 03/29/2022 at 11:50 A.M., the Director of Nursing (DON) was interviewed. This surveyor and the DON reviewed the nurse's note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the expectation of the nurse at that time, the DON stated they have a policy that if the nurse cannot get in touch with the physician, they are to call the administrator or the nurse on call. When asked who the RN was referencing in the note, the DON stated she would find out. When asked about the expectation of the RN, the DON stated she would expect the RN to assess and document findings. The DON also stated that based on the RN's assessment findings, she could've sent [Resident #316] out [to the hospital]. This surveyor and the DON reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked about the expectation of the nurse at that time, the DON stated the nurse should ask the physician if [Resident #316] can be sent out [to the hospital]. When asked about monitoring for adequate hydration, the DON stated the nurse should check skin turgor [elasticity] and mucous membranes. The DON also stated that the nurse should ask the aides how many cc's [cubic centimeters meaning milliliters] intake the Resident has had. The DON also stated that output should also be measured. On 03/29/2022 at 2:25 P.M., LPN G was interviewed. The surveyor and LPN G reviewed the note written by Licensed Practical Nurse G (LPN G) dated 01/16/2022 at 12:49 P.M. When asked why she called the physician about [Resident #316], LPN G stated that she was told in report that [Resident #316 was not swallowing and she observed herself that [Resident #316 was not swallowing and was concerned because her blood pressure was low and her pulse was up. LPN G stated that [Resident #316] I know she was dehydrated because she wasn't drinking anything or swallowing. LPN G also stated that she thought the physician would send her out but he didn't [send her out]. When asked if she felt she had other options, LPN G stated, I did not. LPN G verified the on-call physician was [Employee L]. On 03/29/2022 at approximately 3:00 P.M., the DON provided the name of the RN referenced in the note dated 01/16/2022 at 6:14 A.M. as (RN C). (continued on next page)

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	03/30/2022

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 - Actual harm Residents Affected - Few	On 03/29/2022 at 4:00 P.M., Employee L, the on-call physician, was interviewed. When asked about the process of being the on-call physician, the on-call physician indicated he does not take notes on the calls he receives and he does not have access to the clinical record. The on-call physician stated he relies on the nurse's report. When asked about [Resident #316]'s status on 01/16/2022, the on-call physician stated he did not remember [Resident #316]. This surveyor and the on-call physician reviewed the nurse's note written by LPN G dated 01/16/2022 at 12:49 P.M. When asked if he would want to send [Resident #316] to the emergency department for evaluation based on the note, the on-call physician stated No because it sounded like a chronic problem. The on-call physician indicated that unless the Resident was lethargic or choking on food or aspirating, he would not send the Resident out but have the primary provider address it in the morning. When asked about the hydration status, the on-call physician stated that It could've been dehydration; I might have thought about that. The on-call physician stated that he sent a message to the nurse practitioner to evaluate [Resident #316] the following day [Monday morning]. This surveyor and the on-call physician reviewed the note written on 01/16/2022 at 6:14 A.M. The on-call physician stated he wasn't aware [Resident #316] not responding to verbal stimuli. The on-call physician indicated that the nurse did not convey that information. On 03/29/2022 at 4:55 P.M., an interview with RN C was conducted. RN C verified she was the RN referenced in the note written by LPN F dated 01/16/2022 at 6:14 A.M. When asked about the events indicated in the note, RN C stated that [LPN F] asked her to look at [Resident #316] at approximately 6:30 A. M. [on 01/16/2022]. RN C stated that [Resident #316] had dry lips, dry mucous membranes, and poor skin turgor. RN C stated that Resident #316 looked dehydrated to me. RN C stated she told [LPN F] she was unsure he would even be able to get an IV [intravenous catheter] in her because she was dehydrated. RN C stated she told LPN F that if he couldn't get an IV into her, they would have to send her out [to the hospital]. RN C stated that LPN F called the physician and left a message. When asked if she had documented her assessment findings, RN C stated no. RN C indicated that she had her own assignment and was not working as a supervisor. On 03/30/2022 at 9:30 A.M., a follow-up interview with RN C was conducted. When asked about Resident #316's level of consciousness at the time of her assessment on the early morning of 01/16/2022, RN C stated that Resident #316 was at her [level of consciousness] baseline but she definitely needed an intervention because she was dehydrated. RN C also stated that she wished she had gone back to check on [Resident #316] and followed up. A review of the Physician orders for January 2022 revealed there were no orders for an IV to be started. According to Fundamentals of Nursing by [NAME] & [NAME], Eighth Edition, 2013, page 217 under the header, Documentation Data, it was documented, Data documentation is the last part of a complete assessment. The timely, thorough, and accurate documentation of facts is required in recording patient data. If you do not record an assessment finding or problem interpretation, it is lost and unavailable to anyone else caring for the patient. If information is not specific, the reader is left with only general impressions. Observing and recording patient status are legal and professional responsibilities. The Nurse Practice Acts in all states and the American Nurses Association Nursing's Social Policy Statement (2010) require accurate data collection and recording as independent functions essential to the role of the professional nurse. In Chapter 34 entitled, Communication on page 316, an excerpt documented, Research indicates that effective communication between health care providers and other members of the health care team ensures patient safety and promotes optimal patient outcomes. (continued on next page)

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	03/30/2022

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 - Actual harm Residents Affected - Few	On 03/30/2022 at approximately 3:30 P.M., the administrator and DON were notified of findings. The administrator stated they had no further information or documentation to submit.