STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/7/17 through 2/9/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 84 certified bed facility was 77 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents 1 through 13) and three closed record reviews (Residents 14 through 16).	F 000		
F 252 SS=D	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252		3/8/17

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

Electronically Signed | 02/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 43 resident rooms, room 213A. Orange/light brown stains were observed on a privacy curtain and a brown substance was observed on the call bell, bed side rail, a blanket and the base of an enteral tube feeding pole (1) in 213 A. The findings include: On 2/8/17 at 4:25 p.m., a brown substance was observed on the call bell and five orange/light brown splatter stains were observed on the privacy curtain. On 2/9/17 at 8:20 a.m., an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 was asked about the process for maintaining clean privacy curtains. CNA #6 stated she inspects the privacy curtains when she pulls them out and reports any concerns to the housekeeping department. At this time, CNA #6 was asked to look at the privacy curtain in 213A. The orange/brown splatter stains remained on the privacy curtain. At this time, a brown substance was also noted on the bed side rail, a blanket in a chair and the base of a tube feeding pole. The bed side rail was positioned on one side of the tube feeding pole and the blanket in the chair was positioned on the other side of the tube feeding	F 252	1. Room 213A was deep cleaned on 02-09-17. 2. All residents have the potential to be affected. Resident rooms have been inspected and cleaning performed as needed. 3. Director of Clinical Serviced/Designee and Housekeeping Director will educate nursing and housekeeping staff on importance of maintaining a clean/homelike environment for facility residents. Executive Director/Designee will review daily in morning start-up meeting mock survey results of clean/homelike environment. Findings will be communicated to housekeeping and nursing departments. Room audits will be conducted daily x4 weeks. 4. The results will be reported to the monthly Quarterly Assurance/Performance Improvement Committee for review and discussion for no less than 2 months. Once the Quality Assurance/Performance Improvement Committee determines the problem no longer exists reviews will be conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 2	F 252		

pole. CNA #6 stated the substance on all of the objects was probably from the tube feeding. CNA #6 confirmed the stains and substance did not look homelike.

On 2/9/17 at 9:25 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the housekeeping department was responsible for cleaning resident rooms but if she saw substances/stains she would clean the objects that contained the substances/stains.

On 2/9/17 at 9:35 a.m., an interview was conducted with OSM (other staff member) #9 (the director of housekeeping [employed for three to four days]). OSM #9 stated the housekeeping department checks rooms and privacy curtains for cleanliness every day. OSM #9 stated he had already replaced a couple privacy curtains in the facility and more curtains had been ordered.

On 2/9/17 at 10:45 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of clinical services) were made aware of the above findings. ASM #1 stated daily mock survey rounds were conducted in each resident room and the mock survey rounds consisted of checking the privacy curtain, floor and other areas of the room for cleanliness. ASM #1 stated the results of the mock survey rounds were reported daily during the 9:00 a.m. morning meeting.

The facility policy titled, "Hospitality Services) documented, "Standards for routine cleaning of all interior spaces will be followed, including, but not limited to patient rooms, patient and public baths, tub and shower rooms, closets, utility rooms, offices, diet kitchens, storage spaces, TV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 3 and sitting rooms..." No further information was presented prior to exit. (1) "For the purposes of these Guidelines, enteral tube feeding (ETF) refers to the delivery of a nutritionally complete feed (containing protein or amino acids, carbohydrate +/- fiber, fat, water, minerals and vitamins) directly into the gut via a tube..." This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK49253/	F 252		
F 275 SS=D	COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS CFR(s): 483.20(b)(2)(iii) (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete a comprehensive MDS (minimum data set) assessment for one of 16 residents in the survey sample, Resident #5. The facility staff failed to complete an annual comprehensive MDS assessment for Resident #5 as was required on 1/15/17.	F 275	1. Comprehensive MDS for Resident #5 was completed on 02-09-17 2. Regional MDS Coordinator/Designee completed a 100% audit of all current residents in the facility. 3. Regional MDS Coordinator provided education to the MDS Coordinator.	3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 275	Continued From page 4 The findings include: Resident #5 was admitted to the facility on 2/4/14 with a readmission date of 9/22/16 with diagnoses that include, but were not limited to, heart failure, high blood pressure, diabetes, hyperlipidemia (high levels of lipids in the blood), dementia, asthma (breathing problems) and dysphagia (difficulty with swallowing). Resident #5's most recent MDS was a quarterly assessment with an assessment reference date of 12/14/16. Resident #5 was coded in Section C, Cognitive Patterns, as having a BIMS (brief interview of mental status) score of five out of a possible score of 15, indicating that Resident #5 was severely cognitively impaired. Review of Resident #5's clinical record revealed that a comprehensive MDS assessment had not been done since 1/15/16 and was due to be completed on 1/15/17. On 2/18/17 an interview was conducted with ASM (administrative staff member) #4, the regional MDS coordinator. ASM #4 was asked when a comprehensive MDS should be completed on a resident. ASM #4 stated, "The comprehensive MDS assessment should be completed on admission, if there is a significant change and annually." ASM #4 was asked to review Resident #5's clinical record and to determine when the last comprehensive assessment was completed and when it was due to be completed. ASM #4 reviewed Resident #5's clinical record and stated, "We missed an annual assessment; it was due to be completed on 1/15/17. It has been an unstable staff here and it just did not get done." ASM #4 was asked what the facility used as a	F 275	4. MDS Coordinator will complete a 100% audit monthly before completing monthly MDS schedule. MDS Coordinator will complete weekly audit on all new admissions comprehensive assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 275	Continued From page 5	F 275		

reference to complete the MDS assessments. ASM #4 stated, "We use the RAI (Resident Assessment Instrument) manual."

An end of day meeting was conducted on 2/8/17 at 5:15 p.m. with ASM #1, the administrator, ASM #2, the director of clinical services and ASM #6, the regional director of clinical services. The administrative staff was made aware of the above referenced concerns and a policy regarding MDS assessment completion was requested at this time.

A review of the facility policy titled "MDS" revealed, in part, the following documentation; "Policy: The facility shall conduct a comprehensive, standardized reproducible assessment of each residents (sic) functional status and need using the federally and/or state required RAI assessment as required by regulations. Procedure: A comprehensive OBRA (omnibus budget reconciliation act) RAI assessment must be completed: a) No later than 14 days after the admission date. b) Waiting 14 days after the facility has determined a significant change in the resident's condition. c) No less than once every 12 months."

No further information was provided prior to the end of the survey process.

The following instruction was obtained from the RAI manual;
Comprehensive Assessments
OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 275	Continued From page 6 change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: · Admission Assessment · Annual Assessment · Significant Change in Status Assessment · Significant Correction to Prior Comprehensive Assessment	F 275		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279		3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan from the CAA (care area assessment) section of the MDS (minimum data set) assessment for three of 16 residents in the survey sample, Residents #2, #3 and #11.	F 279	1. Regional MDS Coordinator corrected the triggered areas identified from the survey sample on 02-08-17. 2. Regional MDS Coordinator/Designee will complete 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 1. The facility staff failed to develop Resident #2's care plan for the triggered area of dehydration/fluid maintenance in Section V CAA of the admission MDS (minimum data set) assessment with an ARD of 7/25/16. 2. The facility staff failed to develop Resident #3's care plan for the triggered area of visual function in Section V CAA of the significant change in status assessment with an ARD (assessment reference date) of 1/13/17. 3. The facility staff failed to develop Resident #11's care plan for the triggered area of visual function in Section V CAA of the admission assessment with an ARD of 9/28/16. The findings include: 1. Resident #2 was admitted to the facility on 7/18/16. Resident #2's diagnoses included but were not limited to: diabetes, respiratory failure and urinary tract infection. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/6/16, coded the resident as being cognitively intact. Resident #2's most recent comprehensive MDS was an admission assessment with an ARD of 7/25/16. Section V CAA (care area assessment) section documented an "X" beside the care area of dehydration/fluid maintenance and documented the area would be care planned. Resident #2's comprehensive care plan initiated on 8/3/16 failed to document any information regarding dehydration/fluid maintenance.	F 279	audit of all comprehensive assessments and care plans in the last 60 days. 3. After all care plans are audited MDS Coordinator/Designee will audit 5% of comprehensive assessment CAA's/care plans x4 weeks. 4. Regional MDS Coordinator to complete 5% audits weekly to ensure MDS audits are being completed. MDS Coordinator will give Executive Director/Designee weekly audit to be placed in POC Book.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9	F 279		

On 2/8/17 at 2:41 p.m., an interview was conducted with ASM (administrative staff member) #4 (the regional MDS coordinator). ASM #4 stated the current facility MDS coordinator was new to the role of head MDS coordinator. ASM #4 was asked what should be done when a care area on the MDS assessment triggered and facility staff coded the area as would be care planned. ASM #4 stated, "Once you say you are going to care plan then you should." ASM #4 stated she prints out the CAAs and starts the care planning process. ASM #4 was asked to review Resident #2's MDS assessment and care plan. ASM #4 stated she did not see dehydration/fluid maintenance documented on the resident's care plan. ASM #4 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual.

On 2/8/17 at 3:30 p.m., ASM #4 presented Resident #2's revised care plan that included documentation regarding dehydration/fluid maintenance. ASM #4 stated she had just updated the care plan.

On 2/8/17 at 5:25 p.m., ASM #1 (the administrator), ASM #2 (the director of clinical services) and ASM #6 (the regional director of clinical services) were made aware of the above findings.

The facility policy titled, "Plans of Care" documented, "An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on an as needed basis..."

The CMS RAI manual documented the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10	F 279		

"Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."

No further information was presented prior to exit.

2. Resident #3 was admitted to the facility on 5/25/16. Resident #3's diagnoses included but were not limited to: diabetes, muscle weakness and high blood pressure. Resident #3's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/13/17, coded the resident's cognition as severely impaired. Section V (CAA) documented an "X" beside the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11	F 279		

care area of visual function and documented the area would be care planned. Resident #3's comprehensive care plan initiated on 9/14/16 failed to document any information regarding visual function.

On 2/8/17 at 2:41 p.m., an interview was conducted with ASM (administrative staff member) #4 (the regional MDS coordinator). ASM #4 stated the current facility MDS coordinator was new to the role of head MDS coordinator. ASM #4 was asked what should be done when a care area on the MDS assessment triggered and facility staff coded the area would be care planned. ASM #4 stated, "Once you say you are going to care plan then you should." ASM #4 stated she prints out the CAAs and starts the care planning process. ASM #4 was asked to review Resident #3's MDS assessment and care plan. ASM #4 stated she did not see visual function documented on the resident's care plan. ASM #4 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual.

On 2/8/17 at 3:30 p.m. ASM #4 presented Resident #3's revised care plan that included documentation regarding visual function. ASM #4 stated she had just updated the care plan.

On 2/8/17 at 5:25 p.m., ASM #1 (the administrator), ASM #2 (the director of clinical services) and ASM #6 (the regional director of clinical services) were made aware of the above findings.

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12	F 279		

3. Resident #11 was admitted to the facility on 9/21/16. Resident #11's diagnoses included but were not limited to: diabetes, muscle weakness and heart disease. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/16/16, coded the resident as being cognitively intact.

Resident #11's most recent comprehensive MDS was an admission assessment with an ARD of 9/28/16. Section V (CAA) documented an "X" beside the care area of visual function and documented the area would be care planned. Resident 11's comprehensive care plan initiated on 10/3/16 failed to document any information regarding visual function.

On 2/8/17 at 2:41 p.m., an interview was conducted with ASM (administrative staff member) #4 (the regional MDS coordinator). ASM #4 stated the current facility MDS coordinator was new to the role of head MDS coordinator. ASM #4 was asked what should be done when a care area on the MDS assessment triggered and facility staff coded the area would be care planned. ASM #4 stated, "Once you say you are going to care plan then you should." ASM #4 stated she prints out the CAAs and starts the care planning process. ASM #4 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual.

On 2/9/17 at 9:50 a.m., ASM #4 reviewed Resident #11's MDS assessment and care plan. ASM #4 stated visual function was not documented on the care plan. ASM #4 stated she would update the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 On 2/9/17 at 10:45 a.m., ASM #1 (the administrator) and ASM #2 (the director of clinical services) were made aware of the above findings. No further information was presented prior to exit.	F 279		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide services and treatments to prevent pressure ulcers for one of 16 residents in the survey sample, Resident #10. The facility staff failed to apply cushion boots on Resident #10's heels as ordered by the physician	F 314	1. Resident is utilizing preventive measures as ordered by physician. Cushion boots on while in bed was added to the Kardex. 2. Residents that reside in the facility have the potential to be affected by failure to implement	3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 on 2/7/17. The findings include: Resident #10 was admitted to the facility on 1/10/17 with diagnoses that included, but were not limited to; cancer, reflux, Alzheimer's, manic depressive disorder, bipolar disorder and pain. Resident #10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/27/17. Resident #10 was coded on Section C, Cognitive Patterns, as having a BIMS (brief interview of mental status) score of "00" (zero) out of a possible score of 15, indicating that Resident #10 was severely cognitively impaired. On 2/7/17 at approximately 1:30 p.m. a review of Resident #10's clinical record was conducted and revealed, in part, the following written physician order dated 2/7/17 and was signed by the physician on 2/7/17: "Cushion boots to be worn while in bed. Indication: boggy heels." Resident #10 was observed on 2/7/17 at 5:00 p.m. sitting on the side of her bed in her nightgown and was not wearing the cushion heels on her feet as ordered by the physician. Resident #10 was observed on 2/8/17 at 8:30 a.m. lying in the bed. ASM (administrative staff member) #3, the assistant director of clinical services, was in the room talking to Resident #10. This surveyor asked Resident #10 if we could look at her feet. Resident #10 agreed and ASM #3 pulled back the covers to reveal Resident #10's feet, there were no cushion boots on Resident #10's feet. ASM #3 inspected Resident	F 314	preventive measure. An audit was completed for residents with safety devices and no deficiencies were noted. 3. Residents with pressure ulcers reviewed to ensure nursing measures in place are being followed. Director of Clinical Services/Designee will educate nursing staff on the policy of pressure ulcer prevention, nursing measures and the policy for transcribing physician orders,documentation on the 24 Hr. Report Sheet and use of the Kardex. Director of Clinical Services/Designee will audit residents with pressure ulcers daily to ensure nursing measures are in place x4 weeks. 4. The results will be reported to the monthly Quarterly Assurance/Performance Committee for review and discussion for no less than 2 months. Once the Quality Assurance/Performance Improvement committee determines the problem no longer exists reviews will be conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15	F 314		

#10's heels and there were no concerns of skin breakdown. ASM #3 reviewed Resident #10's clinical record and stated that Resident #10 should have had the boots on her feet. ASM #3 was asked how the aides would know to apply the boots on Resident #10's feet. ASM #3 stated, "We keep a kardex (a card-filing system that allows quick reference to the particular needs of each patient) at the desk." ASM #3 was asked whether or not the cushion boots were on the kardex. ASM #3 pulled out Resident #10's kardex and stated that the boots were not on there. ASM #3 further stated, "Between the order being written yesterday morning and the morning meeting the kardex should be updated." ASM #3 was asked whether or not the cushion boots were on the TAR (treatment administration record). ASM #3 reviewed Resident #10's TAR and stated, "They (the cushion boots) are not on the TAR. ASM #3 was asked where else the cushion boots would be documented to alert the staff. ASM #3 stated that they should be included on the 24 hour report. A review of the 24 hour report dated 2/7/17 did not contain any reference to Resident #10 requiring cushion boots on her heels. ASM #3 was asked what should have happened so that Resident #10 received the cushion boots when ordered. ASM #3 stated, "The nurse who received the order should have made sure that the order was initiated. The nurse that was working is PRN (as needed) and does not work very often." An attempt was made to speak to the nurse that received the order and this surveyor was unable to reach her by phone.

On 2/8/17 at approximately 9:00 a.m. an interview was conducted with CNA (certified nursing assistant) #1, the CNA assigned to Resident #10. CNA #1 was asked how she was made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 any changes in care for the residents. CNA #1 stated, "The nurses make us aware when we come onto the floor." CNA #1 was asked if she reviewed the kardex, CNA #1 stated, "Not usually, I haven't looked at it for a long time." An end of day meeting was conducted on 2/8/17 at 5:15 p.m. with ASM #1, the administrator, ASM #2, the director of clinical services and ASM #6, the regional director of clinical services. The administrative staff was made aware of the above referenced concerns and a policy regarding orders and initiating pressure ulcer preventative measures was requested at this time. On 2/9/17 at approximately 9:00 a.m. ASM #2, the director of clinical services, presented a document titled "Pressure Ulcer Prevention at a Glance" which documented, in part, the following; "Use heel/elbow protectors as appropriate." ASM #2 stated that they did not have a specific policy regarding preventative measures for pressure ulcers.	F 314		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or	F 323		3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide safety interventions for one of 16 residents in the survey sample, Resident #10. The facility staff failed to place non-skid socks on Resident #10's feet as ordered by her physician on 1/23/17 to prevent falls. The findings include: Resident #10 was admitted to the facility on 1/10/17 with diagnoses that included, but were not limited to; cancer, reflux, Alzheimer's, manic depressive disorder, bipolar disorder and pain. Resident #10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/27/17. Resident #10 was coded on Section C, Cognitive Patterns, as having a BIMS (brief interview of mental status) score of "00" (zero) out of a	F 323	1. Non-skid socks were applied to resident #10 during survey. 2. Director of Clinical Services/Designee conducted an audit on all residents that have been identified at risk for safety have safety interventions in place and used appropriately. 3. Director of Clinical Services/Designee will educate nursing staff on Fall Intervention Policy and the use of the Kardex. Director of Clinical Services/Designee will review daily in Clinical Start-Up meeting any resident that had a fall to ensure a safety intervention has been implemented. Will also conduct a safety audit weekly on each unit to ensure safety measures are in place x4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 possible score of 15, indicating that Resident #10 was severely cognitively impaired. A review of Resident #10's clinical record revealed, in part, a written physician order dated 1/23/17 at 0900 (9:00 a.m.) that documented, "Resident to wear non-skid socks at all times. Dx (diagnosis) fall risk." Resident #10 was observed on 2/7/17 at 5:00 p.m. sitting on the side of her bed in her nightgown and was not wearing non-skid socks on her feet as ordered by the physician. Resident #10 was observed on 2/8/17 at 8:30 a.m. lying in the bed. ASM (administrative staff member) #3, the assistant director of clinical services, was in the room talking to Resident #10. This surveyor asked Resident #10 if we could look at her feet. Resident #10 agreed and ASM #3 pulled back the covers to reveal Resident #10's feet, there were no non-skid socks on Resident #10's feet. ASM #3 reviewed Resident #10's clinical record and stated that Resident #10 should have had the non -skid socks on her feet. ASM #3 was asked how the aides would know to apply the non-skid socks on Resident #10's feet. ASM #3 stated, "We keep a kardex (a card-filing system that allows quick reference to the particular needs of each patient) at the desk." ASM #3 was asked whether or not the non-skid socks were on the kardex. ASM #3 pulled out Resident #10's kardex and stated that the non-skid socks were listed on the kardex. A review of Resident #10's "nurse tech information kardex" revealed in part the following documentation; "Special considerations; non-skid socks."	F 323	4. The results will be reported to the monthly Quality Assurance/Performance Improvement Committee for review and discussion for no less than 2 months. Once the Quality Assurance/Performance Improvement Committee determines the problem no longer exists reviews will be conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323		

A review of Resident #10's TAR (treatment administration record) did not reveal that non-skid socks were included.

On 2/8/17 at approximately 9:00 a.m. an interview was conducted with CNA (certified nursing assistant) #1, the CNA assigned to Resident #10. CNA #1 was asked whether Resident #10 should be wearing non-skid socks. CNA #1 stated, "This is the first time I have learned that the non-skid socks should be applied to (name of Resident #10's) feet. CNA #1 was shown the kardex and asked whether or not she referred to the kardex for "special instructions" regarding the residents, CNA #1 stated, "Not usually, I haven't for a long time."

A review of Resident #10's comprehensive care plan dated 1/10/17 revealed, in part, the following documentation; "Focus: The resident has the potential for injury r/t (related to) immobility, cognition deficit, communication deficit, total dependent and hx (history) of falls decrease (sic) functional mobility. Date initiated 1/23/2017. Interventions: Non-skid socks as indicated. Date initiated 2/23/17."

An end of day meeting was conducted on 2/8/17 at 5:15 p.m. with ASM #1, the administrator, ASM #2, the director of clinical services and ASM #6, the regional director of clinical services. The administrative staff was made aware of the above referenced concerns and a policy regarding initiation of fall preventative devices was requested at this time..

On 2/9/17 at approximately 9:00 a.m. ASM #2, the director of clinical services, presented a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 document titled "Falls Prevention at a Glance" which documented, in part, the following; "5. Discuss restraints, alarms and other devices as appropriate." ASM #2 stated that she did not have a policy specific to the order of or the utilization of fall preventive devices. No further information was provided prior to the end of the survey process.	F 323		
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2) (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure timely physician visits for one of 16 residents in the survey sample, Resident #9. The facility staff failed to ensure that Resident #9 was seen by a physician within 60 days between, 10/26/16 and 1/9/17, a period of 75 days. The findings include: Resident #9 was admitted to the facility on 3/25/15 with a readmission date of 6/25/16 with	F 387	1. Physician saw resident #5 on 01-25-17. 2. Director of Clinical Services/Designee conducted an audit on all residents to ensure all residents were seen by Physician/NP per policy. 3. Director of Clinical services/Designee will educate nursing staff and medical records staff on Physicians Visits Policy. Director of Clinical	3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 21 diagnoses that included, but were not limited to; drug induced acute dystonia *(movement disorder in which a person's muscles contract uncontrollably. The contraction causes the affected body part to twist involuntarily, resulting in repetitive movements or abnormal postures), dysphagia (difficulty with swallowing) and anemia (low red blood cell count). Resident #9's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 1/9/17. Resident #9 was coded on the MDS as having a BIMS (brief interview for mental status) score of 15 out of 15. The MDS manual documents that a score of 15 indicates that the resident's cognition is intact. A review of Resident #9's clinical record did not reveal a physician visit between 10/26/16 and 1/9/17, a total of 75 days. On 2/8/17 at 3:35 p.m. an interview was conducted with OSM (other staff member) #1, medical records. OSM #1 was asked how often a physician was required to see a resident in the facility. OSM #1 stated, "The physician sees the resident every 30 days at the time of admission for three months, then he sees them every 60 days." OSM #1 was asked how she ensured that the physician visits were being conducted as required. OSM #1 stated, "I audit the charts every month and do a list going by the last note to determine when they (the residents) should be seen. I started this process in January 2017." OSM #1 was asked to review Resident #9's clinical record and asked when Resident #9 was seen by a physician between 10/26/16 and 1/9/17. OSM #1 stated, "Our new doctor started	F 387	Services/Designee will audit 3 resident medical records on each unit to ensure Physician/NP visits are completed per facility policy x4 weeks. 4. The results will be reported to the monthly Quality Assurance/Quality Improvement Committee for review and discussion for no less than 2 months. Once Quality Assurance/Performance Improvement Committee determines the problem no longer exists reviews will be conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 387	Continued From page 22 in December 2016 and the prior doctor left at the beginning of December. (Name of Resident #9) just got missed in the transition." An end of day meeting was conducted on 2/8/17 at 5:15 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of clinical services and ASM #6, the regional director of clinical services. The administrative staff was made aware of the above referenced concerns and a policy regarding physician visits was requested. On 2/9/17 at approximately 9:00 a.m. ASM #2, the director of clinical services, presented a facility policy titled "Physician's Visit Monitoring" which documented, in part, the following; "Policy: The facility will make every effort to assure that physician's visits to residents conform to applicable State and Federal law, i.e. (for example), every 30 days for the first 90 days and at least every 60 days thereafter, regardless of the resident's level of care. Procedure: 1. The Medical Record Designee will monitor physician visits for timeliness by: a) using the physician's visit log. e. Perform visit monitoring monthly at the beginning of each month." No further information was provided prior to the end of the survey process. * This information was obtained from the following website; http://www.webmd.com/brain/dystonia-causes-types-symptoms-and-treatments	F 387		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		3/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23 LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 514	1. The diagnostic test result was removed from Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 24 the facility staff failed to maintain a complete and accurate clinical record for one of 16 residents in the survey sample, Resident #9. The facility staff filed another resident's diagnostic result in Resident #9's clinical record. The findings include; Resident #9 was admitted to the facility on 3/25/15 with a readmission date of 6/25/16 with diagnoses that included, but were not limited to; drug induced acute dystonia *(movement disorder in which a person's muscles contract uncontrollably. The contraction causes the affected body part to twist involuntarily, resulting in repetitive movements or abnormal postures), dysphagia (difficulty with swallowing) and anemia (low red blood cell count). Resident #9's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 1/9/17. Resident #9 was coded on the MDS as having a BIMS (brief interview for mental status) score of 15 out of 15. The MDS manual documents that a score of 15 indicates that the resident's cognition is intact. A review of Resident #9's clinical record revealed, in part, a radiology report that provided the X-Ray results for another resident in the facility filed in Resident #9's medical chart at the nurses station. On 2/7/17 at 2:15 p.m. an interview was conducted with RN (registered nurse) #5, the clinical coordinator. RN #5 was asked to review Resident #9's medical chart at the nurse's station, specifically diagnostic results filed in the chart.	F 514	#9 medical record and filed in the correct medical record. 2. Medical Records /Designee will conduct a 100% resident clinical record audit to ensure proper documentation is in the resident medical record. 3. Director of Clinical Services/Designee provided education on the facility policy regarding filing dictated progress notes, lab test results, etc. are in the correct residents' clinical record. Director of Clinical Services/Designee will audit 3 resident's clinical chart on each unit to ensure resident's medical record contain the correct records x4 weeks. 4. The results will be reported to the monthly Quality Assurance/Performance Improvement Committee for review and discussion for no less than 2 months. Once the Quality Assurance/Performance Improvement Committee determines the problem no longer exists reviews will be conducted on a random basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25	F 514		

RN #5 stated that the radiology report had another residents' name on it and did not belong in Resident #9's record. RN #5 further stated that the radiology result had been filed incorrectly. RN #5 was asked who was responsible for filing the radiology results. RN #5 stated, "The nursing staff puts the results received from laboratory tests or radiology tests into the chart after the physician is notified of the results."

An end of day meeting was conducted on 2/8/17 at 5:15 p.m. with ASM (administrative staff member) #1, the administrator, ASM #2, the director of clinical services and ASM #6, the regional director of clinical services. The administrative staff was made aware of the above referenced concerns and a policy regarding maintaining a complete medical record was requested.

A review of the facility policy titled "Clinical/Medical Records revealed, in part, the following documentation; "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care."

No further information was provided prior to the end of the survey process.

* This information was obtained from the following website; http://www.webmd.com/brain/dystonia-causes-typ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 26 es-symptoms-and-treatments	F 514		