STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 11/13/17 through 11/15/17. Three complaints were investigated during the survey. 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 111 certified bed facility was 100 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #17 and #24) and 6 closed record reviews (Residents #18 through #23).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		12/22/17

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

Electronically Signed | 12/06/2017

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.

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician when orders were not completed for three out of 24 residents in the survey sample, Resident #4, Resident #14 and Resident #11. 1. The facility staff failed to notify the physician when restorative nursing services were not provided to Resident #4 as ordered by the physician on 9/20/17.	F 157	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 157	Continued From page 2 2. The facility staff failed to notify the physician when the restorative nursing program was not initiated as ordered for Resident #14. 3. The facility staff failed to notify the physician that Resident #11did not receive restorative nursing services as ordered. The findings include: 1. Resident #4 was admitted to the facility on 4/3/15 and readmitted on 7/5/17 with diagnoses that included but were not limited to: stroke, diabetes, elevated cholesterol, depression and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/16/17 coded Resident #4 as having scored a 15 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. Review of Resident #4's care plan initiated on 7/5/17 and revised on 9/29/17 documented, "Focus. SAFETY: Potential for injury r/t (related to) - Decreased mobility...Gait/balance problems. Interventions. Restorative nursing exercise program as written." Review of the physician's orders dated and signed on 9/20/17 documented, "Restorative Nursing Program initated (sic) to address UE (upper extremity) strength and w/c (wheelchair)	F 157	1. Resident # 4'□s attending physician has been notified of resident'□s restorative nursing not having been carried out. Resident # 4 has been screened by Center'□s rehabilitation staff and evaluated by the restorative nurse to determine appropriate nursing restorative program. There were no other changes in this resident□s prescribed plan of care. Resident #4 is receiving range of motion and locomotion restorative nursing programs. Resident # 14□'s attending physician has been notified of resident□'s restorative nursing program not being initiated. Resident # 14 has been screened by Center□'s rehabilitation staff and evaluated by the restorative nurse to determine appropriate nursing restorative program. There were no other changes in this resident'□s prescribed plan of care. Resident #14 is receiving range of motion and ambulation restorative nursing program. Resident #11'□s physician was notified that restorative nursing program was not implemented. Resident # 11 has been screened by Center□'s rehabilitation staff and evaluated by the restorative nurse to determine appropriate nursing restorative program. There were no other changes in this resident'□s prescribed plan of care. Resident #11 is receiving range of motion and ambulation restorative nursing program.	

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F 157	Continued From page 3 tolerance for 6 days per week for 90 days." Review of the clinical record for Resident #4 did not evidence documentation of restorative nursing services being provided or any notification to the physician the order for restorative nursing had not been carried out. An interview was conducted on 11/14/17 at 11:35 a.m. with LPN (licensed practical nurse) #7, the unit manager. When asked who provided restorative nursing services to the residents, LPN #7 stated, "The CNAs (certified nursing assistants)." When asked how the aides would know a resident was to receive restorative nursing services, LPN #7 stated, "It's in the (name of software)." When asked if the aides documented after they provided the service, LPN #7 stated they did. When asked to review Resident #4's clinical record for documentation of the restorative nursing program, LPN #7 stated, "It's not there." An interview was conducted on 11/15/17 at 8:05 a.m. with ASM (administrative staff member) #2, the director of clinical services. When asked about the restorative nursing program, ASM #2 stated, "Our program is a work in progress. We are in the process right now to train a restorative aide to provide care to all of the residents. Currently it is the responsibility of the floor CNA." ASM #2 was made aware of the findings at that time. An interview was conducted on 11/15/17 at 4:45 p.m. with ASM #2, regarding physician notification. ASM #2 stated, "Any change in condition, any seriously abnormal vital signs, abnormal lab (laboratory) values." When asked	F 157	2. Current residents in the Center have had their current physician□s' orders reviewed to determine if any changes occurred that require physician notification. Current residents reviewed for Restorative Nursing to ensure Restorative Nursing Program has been initiated. 3. Director of Clinical Services, or designee, re-educated licensed nursing staff that any change in the resident□s' status or condition is to be reported to the attending physician and responsible party. 4. Director of Clinical Services, or designee, to conduct Quality Monitoring Review for proper physician notification of resident□s' change in status or condition five times a week for four weeks, then weekly for two months, then monthly. Unit Manager, or designee, to review residents with orders for Restorative Nursing to ensure program is initiated. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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F 157	Continued From page 4	F 157		

what staff would do if the physician's order was not completed, ASM #2 stated, "They (physician) should be notified." When asked if the physician should have been notified when Resident #4's restorative nursing services were not performed, ASM #2 stated yes.

Review of the facility's policy titled, "Notification of Change in Condition" documented, "POLICY: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition."

No further information was provided prior to exit.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.
2. The facility staff failed to notify the physician when the restorative nursing program was not initiated as ordered for Resident #14.

Resident #14 was admitted to the facility on 10/7/16 with diagnoses that included, but were not limited to: slow heart rate, cognitive communication deficit, high blood pressure, dementia and altered mental status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 5	F 157		

Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/4/17, coded Resident #14 as having a BIMS (brief interview for mental status) as 11 out of a possible 15, indicating Resident #14 is moderately cognitively impaired with activities of daily living.

A review of Resident #14's clinical record revealed a physician order dated 10/4/17: "Restorative nursing, 3 - 6 times / wk (per week) x (for) 90 days for ROM (range of motion) exercise and transfers / gait. Start Date: 10/6/17."

Further review of Resident #14's clinical record did not reveal any evidence restorative nursing had been initiated as ordered.

A review of Resident #14's comprehensive care plan dated 10/7/16 did not reveal any information regarding restorative nursing.

An end of day meeting was conducted with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services on 11/15/17 at 4:50 p.m. ASM #2 was asked under what circumstances the physician would be notified about a resident. ASM #2 stated the physician would be notified with any resident change in condition, abnormal vital signs or any laboratory values. ASM #2 was asked what occurred when a physician order was not completed as ordered. ASM #2 stated, "The MD (medical doctor) should be notified." ASM #2 was asked to state the purpose of restorative nursing. ASM #2 stated, "Therapy recommends restorative when a resident is discharged from therapy to maintain function with ADLs (activities of daily living)." ASM #2 was asked about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 6	F 157		

order for Resident #14 dated 10/4/17 for restorative nursing and what should be in the clinical record when a resident is on restorative nursing. ASM #2 stated, "There should be restorative nursing minutes and documentation on how the resident tolerated the restorative nursing, there should be at least three to four notes each week." ASM #2 was asked to review Resident #14's clinical record for restorative notes. ASM #2 stated there was no documentation that Resident #14 had received restorative nursing.No further documentation was provided prior to the end of the survey process.
3. The facility staff failed to notify the physician that Resident #11did not receive restorative nursing services as ordered.

Resident #11 was admitted to the facility on 6/13/13 and readmitted on 6/18/17 with diagnoses that included but were not limited to: displaced fracture of the left tibia, hypothyroidism, anxiety disorder, COPD (chronic obstructive pulmonary disease), major depressive disorder, high blood pressure, osteoarthritis and degenerative joint disease. Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/29/17. Resident #11 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #11 was coded as requiring extensive assistance with one to two staff members with transfers, dressing, toileting, personal hygiene, and bathing. Review of Section O (Special treatments, procedures, and programs) documented Resident #11 as not receiving restorative nursing.

Review of Resident #11's POS (physician order

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F 157	Continued From page 7	F 157		

sheet) dated 10/31/17 documented the following order: "RNP (restorative nursing program) 6X (times)/wk (week) for 90 days for range of motion exercise and gait training."

Review of Resident #11's clinical record revealed the following note for physical therapydated: "Therapy communication to restorative nursing program. Current functional status: PT (patient) is independent with bed mobility, pt is supervision for transfers, pt is contact guard assist for ambulation using a walker. Problems/needs: Range of Motion exercises to decrease risk of functional decline. Ambulation using a wheeled walker to improve functional mobility and self-function. Recommendations/approaches: Perform ROM (range of motion) exercises to maintain joint integrity and muscle performance. Perform ambulation daily from room to hallway 100 ft (feet) using a rolling walker with contact guard assist to improve functional mobility. Restorative nursing start date: 8/18/17."

Further review of Resident #11's clinical record revealed no evidence of restorative nursing notes. There was no evidence that the physician was made aware that the restorative nursing program had not been implemented.

On 11/15/17 at 8:11 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Clinical Services. ASM #2 stated she could not find restorative nursing notes for Resident #11. ASM #2 stated the restorative nursing program was a work in progress and the CNAs (certified nursing assistants) on the floor were currently the restorative aides as well as the CNAs. ASM #2 stated the facility was trying to get a designated

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F 157	Continued From page 8 restorative aide in place. ASM #2 was asked about the process staff follows when restorative nursing is recommended. ASM #2 stated therapy recommends the program and then the program is put into PCC (point click care) to alert the CNAs that the resident is on the program. ASM #2 stated it was difficult for the floor CNAs to also do restorative nursing. ASM #2 stated restorative nursing can take a long time and may take away from other things. ASM #2 stated she has tried to educate her staff by showing them that some restorative nursing exercises can be done during ADL (activities of daily living) care. On 11/15/17 4:58 p.m., further interview was conducted with ASM #2. When asked when nursing staff would notify the physician, ASM #2 stated the physician would be notified for any change of condition, abnormal vital signs, labs etc. When asked if the physician would be notified if an order was never carried out, ASM #2 stated yes. When asked if the physician should have been notified Resident #11 did not receive restorative nursing, ASM #2 stated because restorative nursing was written as an order, then the physician should have been notified. On 11/15/17 at 4:58 p.m. ASM #1, the executive director and ASM #2 the Director Clinical Services, were made aware of the above findings. No further information was presented prior to exit.	F 157		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must-	F 225		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 9 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 10 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to report an allegation of abuse/neglect to the appropriate state agencies in a timely manner for one resident (Resident #25) in the survey sample of 25 residents. The facility staff failed to immediately report an allegation of neglect for Resident #25 reported to the executive director on 11/11/17 to the appropriate state agencies. The allegation of neglect was not reported to the appropriate state agencies until 11/14/17, 4 days after the allegation was reported to the executive director. The findings include:	F 225	1. The Center'□s Executive Director submitted an allegation of neglect for resident # 25 to the state agencies on 11/14/17. Resident # 25 continues to reside in the Center and the report was unsubstantiated for neglect. ASM #1 was re-educated by the Divisional Director of Clinical Services about reporting allegations of abuse and neglect to state agencies in accordance with state and federal guidelines. 2. Current residents in the Center who are cognitively intact (BIMS between 13-15) will be interviewed to determine if	

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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 225	Continued From page 11 Resident #25 was admitted to the facility on 6/15/2010 and readmitted on 6/30/2017 with diagnoses that included but were not limited to: high blood pressure, anemia, high cholesterol, dementia and anxiety disorder. Resident #25's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/18/17. Resident #25 was coded as being severely impaired in cognitive function scoring a "03" on the Staff Interview for Mental Status Exam. Resident #25 was coded as requiring total dependence on one staff member with most ADLS (activities of daily living). On 11/15/17 at approximately 7:00 a.m., ASM (administrative staff member) #1, the executive director handed this writer a FRI (facility reported incident). ASM #1 stated she had been working on the FRI until the state had arrived to the facility. ASM #1 stated it was regarding a staff member (CNA (certified nursing assistant) #9. Review of the FRI documented a family member had reported the allegation on 11/11/17. The following was documented: "Family member of another resident on the unit reported to ED (executive director) and alleged CNA, (Name of CNA #9), was not using proper practices in assisting resident (Resident #25) with her meal. Family member also reported that she did not observe this CNA provide incontinence care to other residents on the unit during her visits." The FRI was documented as being an allegation of neglect. The allegation was not reported to the appropriate state agencies until 11/14/17, 4 days after the allegation was reported to the ED.	F 225	they have experienced any abuse or neglect. Residents in the Center who are not cognitively intact will have a skin assessment completed to determine if there are any visible signs of abuse or neglect. Follow up based on findings. 3. Divisional Director of Clinical Services has re-educated Executive Director and Director of Clinical Services about reporting allegations of abuse and neglect to state agencies in a timely manner, as designated by state and federal regulations. 4. Regional Director of Clinical of Services to conduct Quality Monitoring Review weekly for four weeks, then monthly to determine if allegations are reported in a timely manner to state agencies. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 225	Continued From page 12 On 11/15/17 at 2:46 p.m., an interview was conducted with ASM (administrative member) #1, the Executive Director (ED). When asked about the process for reporting abuse, ASM #1 stated if abuse had occurred, she would report the abuse within a two-hour window period as required. ASM #1 stated she would then investigate and send the follow up within 5 working days. ASM #1 sated the family member had reported the abuse directly to her on 11/11/17. When asked why she did not report immediately (within 24 hours) report the allegation, ASM #1 stated she was still in the process of investigating. ASM #1 stated that she should have reported within 24 hours. On 11/15/17 at 4:48 p.m., ASM #1, the ED and ASM #2, the Director of Clinical Services were made aware of the above concerns. The facility policy titled, "Resident Abuse," documents in part, the following: "Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator."	F 225		
F 226	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC	F 226		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226 SS=D	Continued From page 13 POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to implement abuse policies and failed report an	F 226	1. The Center'□s Executive Director submitted an allegation of neglect for resident #25 to the state agencies on 11-	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 226	Continued From page 14 allegation of abuse/neglect to the appropriate state agencies in a timely manner, for one resident (Resident #25) in the survey sample of 25 residents. The Facility staff failed to implement the abuse policy for reporting an allegation of neglect. The facility staff were made aware of an allegation of neglect on 11/11/17 and did not report this allegation to the appropriate state agencies until 11/14/17. The findings include: Resident #25 was admitted to the facility on 6/15/2010 and readmitted on 6/30/2017 with diagnoses that included but were not limited to: high blood pressure, anemia, high cholesterol, dementia and anxiety disorder. Resident #25's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 9/18/17. Resident #25 was coded as being severely impaired in cognitive function scoring a "03" on the Staff Interview for Mental Status Exam. Resident #25 was coded as requiring total dependence on one staff member with most ADLS (activities of daily living). On 11/15/17 at approximately 7:00 a.m., ASM (administrative staff member) #1, the executive director handed this writer a FRI (facility reported incident). ASM #1 stated she had been working on the FRI until the state had arrived to the facility. ASM #1 stated it was regarding a staff member (CNA (certified nursing assistant) #9. Review of the FRI documented a family member	F 226	14-17. Resident #25 continues to reside in the Center and the report was unsubstantiated for neglect. ASM #1 was re-educated by the Divisional Director of Clinical Services about reporting allegations of abuse and neglect to state agencies in accordance with state and federal guidelines. 2. Current residents in the Center who are cognitively intact (BIMS between 13-15) will be interviewed to determine if they have experienced any abuse or neglect. Residents in the Center who are not cognitively intact will have a skin assessment completed to determine if there are any visible signs of abuse or neglect. Follow up based on findings. 3. Director of Clinical Services, or designee, has re-educated Center staff about the Center□'s policy on reporting abuse and neglect in a timely manner. 4. Regional Director of Clinical Services, or designee, to conduct Quality Monitoring Review weekly for four weeks, then monthly, to determine if allegations are reported in a timely manner to state agencies. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 15	F 226		

had reported the allegation on 11/11/17. The following was documented: "Family member of another resident on the unit reported to ED (executive director) and alleged CNA, (Name of CNA #9), was not using proper practices in assisting resident (Resident #25) with her meal. Family member also reported that she did not observe this CNA provide incontinence care to other residents on the unit during her visits." The FRI was documented as being an allegation of neglect. The allegation was not reported to the appropriate state agencies until 11/14/17, 4 days after the allegation was reported to the ED.

On 11/15/17 at 2:46 p.m., an interview was conducted with ASM (administrative member) #1, the Executive Director (ED). When asked about the process for reporting abuse, ASM #1 stated if abuse had occurred, she would report the abuse within a two-hour window period as required. ASM #1 stated she would then investigate and send the follow up within 5 working days. ASM #1 sated the family member had reported the abuse directly to her on 11/11/17. When asked why she did not report immediately (within 24 hours) report the allegation, ASM #1 stated she was still in the process of investigating. ASM #1 stated that she should have reported within 24 hours.

On 11/15/17 at 4:48 p.m., ASM #1, the ED and ASM #2, the Director of Clinical Services were made aware of the above concerns.

Facility policy titled, "Facility policy titled, "Resident Abuse," documents in part, the following: "Any employee, who witnesses or has knowledge of an act of abuse or an allegation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 226	Continued From page 16 abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator."	F 226		
F 247 SS=E	RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE CFR(s): 483.10(e)(6) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide proper notification for a room change for four of 24 residents in the survey sample, Residents #1, 4, 8 and 3. 1. The facility staff failed to notify Resident #1 of a room change on 10/25/17 or introduce Resident #1 to the new roommate prior to the room change.	F 247	1. Resident #1 has not experienced a room change since 10/26/17. He was interviewed by the Social Worker and did not express a desire for a room change and expressed satisfaction with current roommate. Resident #4 has not experienced a room change since 9/14/17. He was interviewed by the Social Worker and did not express a desire for a room change	12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 247	Continued From page 17 2. The facility staff failed to notify Resident #4 of a room change on 9/14/17 or introduce the resident to the new roommate prior to the room change. 3. The facility staff failed to notify Resident #8's guardian of a room change on 6/27/17. 4. The facility staff failed to notify Resident #3, and/or his RP (responsible party), or introduce Resident #3 to his new roommate prior to room changes that occurred on 3/28/17 and 8/7/17. The findings include: 1. Resident #1 was admitted to the facility on 4/3/12 and readmitted on 9/12/17 with diagnoses that included but were not limited to: heart failure, kidney failure, high blood pressure, dementia, diabetes and impaired vision. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 9/25/17 coded Resident #1 as having scored a 12 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the physician's order dated, 10/25/17 at 1:14 p.m. documented, "Resident transfer from room (number) to (room number)." Review of the nurse's notes dated 10/25/17 at 1:20 p.m. documented, "Resident alert to self. Transferred from room (number) to room (number)." Further review of the nurse's notes did not evidence documentation the resident had	F 247	and expressed satisfaction with current roommate. Resident #8 no longer resides in the Center. Resident #3 has not experienced a room change since 8/7/17. He was interviewed by the Social Worker and did not express a desire for a room change and expressed satisfaction with current roommate. 2. Review of room changes occurring since 10/15/17 has been conducted to ensure proper notification of room change was given to resident, responsible party and prospective roommate prior to room change. Follow up based on findings. 3. Director of Clinical Services, or designee, has re-educated Social Worker and Licensed nursing staff on Center'□s policy for room change notification. 4. Director of Clinical Services, or designee, to conduct Quality Monitoring Review of Center'□s staff documentation regarding resident room change notification weekly for four weeks, bi-weekly for two weeks, and then monthly to ensure Center□'s policy is followed. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 247	Continued From page 18	F 247		

been notified of the move in advance of the move or that the resident had been given the opportunity to see the new room or to meet the roommate prior to the move.

An interview was conducted on 11/14/17 at 11:35 a.m. with LPN (licensed practical nurse) #7, the unit manager. When asked about the process staff followed when a resident's room was being changed, LPN #7 stated, "We let the resident know and let the physician know. If the resident is okay with it then we talk to the family. Orders are written. There is a form that social services should be filling out."

An interview was conducted on 11/14/17 at 1:20 p.m. with OSM (other staff member) #1, social services. OSM #1 stated she had started at the facility in October 2017. When asked about the process followed by staff for a resident room change, OSM #1 stated, "We notify the resident and the roommate. We explain the reason for the change and if they accept it we notify their responsible party or legal guardian and document that the change occurred." When asked if the resident was given the opportunity to visit the new room and roommate, OSM #1 stated that they should and that there was a form that the resident would sign to approve it (the room change). A request was made at this time for the completed form for Resident #1's room change on 10/25/17.

On 11/14/17 at 2:15 p.m. OSM #1 returned with Resident #1's nurse's note dated 10/25/17 (as noted above). OSM #1 stated, "This is all I could find. That was when they didn't have a social worker."

On 11/14/17 at 5:55 p.m. ASM (administrative

on findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 247	Continued From page 19	F 247		

staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

On 11/15/17 an attempt was made to interview the resident but the resident was out of the facility.

Review of the facility's policy titled, "Room Changes" documented, "Policy: It is the policy of the Company to provide safe and necessary room changes. Procedure: 1. Team members should consider the pros and cons of the room change with input from the resident and/or interested party whenever feasible. 2. Prior to the room change, the team should give the resident/legal representative notice to allow the resident/legal representative time to prepare for the room change. The notice period may be waived by the resident/legal representative. 3. Room change should be documented in the resident's chart. The documentation may include: The reason for the change. Notification of resident, legal representative, and their assent. Notification of the roommate if applicable."

No further information was provided prior to exit.

2. The facility staff failed to notify Resident #4 of a room change on 9/14/17 or introduce the resident to the new roommate prior to the room change.

Resident #4 was admitted to the facility on 4/3/15 and readmitted on 7/5/17 with diagnoses that included but were not limited to: stroke, diabetes, elevated cholesterol, depression and urinary tract infection.

The most recent MDS (minimum data set), a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 247	Continued From page 20	F 247		

quarterly assessment, with an ARD (assessment reference date) of 9/16/17 coded Resident #4 as having scored a 15 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the meal tray was prepared.

Review of the physician's orders dated 9/14/17 at 10:30 a.m. documented, "Resident Room Change from (room number) to (room number)."

Review of the nurse's notes dated 9/14/17 at 3:30 p.m. documented, "resident (sic) transferred from (room number) to (room number)." Further review of the nurse's notes did not evidence documentation that the resident had been notified of the move in advance of the move or that the resident had been given the opportunity to see the new room or to meet the roommate prior to the move.

Did we interview this resident with a BIMS of 15?

An interview was conducted on 11/14/17 at 1:20 p.m. with OSM (other staff member) #1, social services. OSM #1 stated she had started at the facility in October 2017. When asked about the process followed by staff for a resident room change, OSM #1 stated, "We notify the resident and the roommate. We explain the reason for the change and if they accept it we notify their responsible party or legal guardian and document that the change occurred." When asked if the resident was given the opportunity to visit the new room and roommate, OSM #1 stated they should and that there was a form that the resident would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 247	Continued From page 21	F 247		

sign to approve it (the room change). A request was made at this time for the completed form for Resident #4's room change on 10/25/17.

On 11/14/17 at 2:15 p.m. OSM #1 returned and stated she could not find the social worker form for Resident #4.

On 11/14/17 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to notify Resident #8's guardian of a room change on 6/27/17.

Resident #8 was admitted to the facility on 4/28/17 and readmitted on 9/28/17 with diagnoses that included but were not limited to: anoxic (1) brain damage, anemia, malnutrition, sepsis (2) and contractures of legs and arms (3).

The most recent MDS, a modified five day assessment, with an ARD of 10/2/17 coded Resident #8 as having short and long term memory impairment and as being severely impaired cognitively. The resident required extensive assistance from staff for all activities of daily living.

Review of the physician's orders dated 6/27/17 documented, "Resident Room change from LTC1 (long term care one) (room number) to LTC 1 (room number)."

Review of the nurse's notes did not evidence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 247	Continued From page 22	F 247		

documentation regarding the room change or that the resident's legal guardian had been notified.

An interview was conducted on 11/14/17 at 1:20 p.m. with OSM (other staff member) #1, social services. OSM #1 stated she had started at the facility in October 2017. When asked about the process staff follows for a resident room change, OSM #1 stated, "We notify the resident and the roommate. We explain the reason for the change and if they accept it we notify their responsible party or legal guardian and document that the change occurred." When asked if the resident was given the opportunity to visit the new room and roommate, OSM #1 stated that they should and that there was a form that the resident would sign to approve it (the room change). A request was made at this time for the completed form for Resident #8's room change on 10/25/17 was requested.

On 11/14/17 at 2:15 p.m. OSM #1 returned and stated she could not find the social worker form for Resident #8.

On 11/14/17 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

(1) Anoxia -- hypoxia especially of such severity as to result in permanent damage This information was obtained from: https://www.merriam-webster.com/dictionary/anoxia

(2) Sepsis -- Sepsis is a serious illness. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 247	Continued From page 23	F 247		

happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. This information was obtained from: https://medlineplus.gov/sepsis.html

(3) Contractures -- Limb contractures are a common impairment in neuromuscular diseases (NMD). They contribute to increased disability due to decreased motor performance, mobility limitations, reduced functional range of motion, loss of function for activities of daily living (ADL), and increased pain. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482407/

4. The facility staff failed to notify Resident #3, and/or his RP (responsible party), or introduce Resident #3 to his new roommate prior to room changes that occurred on 3/28/17 and 8/7/17.

Resident #3 was admitted to the facility on 9/4/15 with a readmission on 6/14/17 with diagnoses that included, but were not limited to, bronchitis, chronic pain, chronic respiratory failure, anemia, COPD (chronic obstructive pulmonary disease), and high blood pressure.

Resident #3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/21/17, coded Resident #3 as having a BIMS (brief interview for mental status) of 14 out of a possible 15, indicating that Resident #3 is cognitively intact with activities of daily living.

A review of Resident #3's clinical record revealed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 247	Continued From page 24	F 247		

Resident #3 changed rooms on 3/28/17 and 8/7/17.

Further review of Resident #3's clinical record did not reveal documentation regarding Resident #3 changing rooms.

An interview was conducted with OSM (other staff member) #1, the social worker, on 11/14/17 at 1:20 p.m. OSM #1 was asked what her role was when a resident was to change rooms. OSM #1 stated, "I notify the resident who is moving and explain why the move is necessary. I notify the RP (responsible party) and make sure that all parties are agreeable to that change." OSM #1 was asked if there was any documentation associated with a resident move. OSM #1 stated, "We have a form the resident would sign to show they are agreeable to change rooms." OSM #1 was asked to provide evidence Resident #3 was notified of the room changes that occurred on 3/28/17 and 8/7/17.

On 11/14/17 at 3:20 p.m. OSM #1 stated she did not have any documentation for Resident #3 to evidence he was notified of the room changes that occurred on 3/28/17 and 8/7/17. OSM #1 further stated she had only been in the role of social worker at the facility for a short time.

An end of day meeting was conducted with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services on 11/15/17 at 4:50 p.m. ASM #1 and ASM #2 were made aware of the above concerns at this time. ASM #1 and ASM #2 were asked if Resident #3 should have been provided notification of the room changes that occurred on 3/28/17 and 8/7/17. ASM #1 and ASM #2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 247	Continued From page 25 was no documentation regarding the room changes. No further documentation was provided prior to the end of the survey process.	F 247		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than	F 278		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 26 $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to complete an accurate MDS (minimum data set) assessment for three of 24 residents in the survey sample, Resident #5, 6, and #1. 1. The facility staff inaccurately coded section H; Bladder and Bowel on Resident #5's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/2/17. Resident #5 was observed with a Foley catheter in place during the survey. Resident #5's quarterly MDS assessment with an ARD of 11/2/17, coded the resident under section H; Bladder and Bowel as always incontinent and not having appliances in place for bladder or bowel. 2. The facility staff inaccurately coded section G; Functional Status on Resident #6's quarterly MDS assessment with an ARD of 10/10/17. Resident #6 was observed ambulating during survey and his quarterly MDS coded the resident as having impairments to both lower extremities. 3. The facility staff failed to code that Resident #1 was receiving dialysis therapy on the 14 day MDS (minimum data set) with an ARD (assessment reference date) of 9/25/17. The findings include: 1. Resident #5 was admitted to the facility on	F 278	1. Resident #5'□s MDS was modified in order to capture indwelling catheter on section H0300. Resident #6'□s MDS was modified in order to capture no impairment in range of motion to bilateral lower extremities in section G0400B. Resident #1'□s MDS was modified in order to capture dialysis in section O100J. 2. MDS Coordinator completed review of most recent MDS assessment for current residents with indwelling catheter or ostomy tube to ensure section H0300 is coded correctly. Follow up based on findings. MDS Coordinator to review most recent MDS assessment for current residents who ambulate independently to ensure section G0400B is coded accurately. Follow up based on findings. MDS Coordinator to review most recent MDS assessment for current residents who receive dialysis to ensure section O100J is coded accurately. Follow up based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 27 1/23/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), urinary frequency, high blood pressure, congestive heart failure, and anxiety disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one to two staff members with most ADLS (activities of daily living). Resident #5 was coded as requiring limited assistance with meals from one staff member. Further review of Resident #5's 11/2/17 MDS documented the following in Section H; Bladder and Bowel: "H0l00. Appliances (check all that apply): A. Indwelling urinary catheter, B. External catheter, C. Ostomy, D. Intermittent catheterization Z. None of the above." An "X" was documented for letter "Z" indicating that Resident #5 did not have appliances in place for bladder or bowel. Further review of Section H0300; Urinary Continence documented the following: " Urinary Continence-Select the one category that best describes the resident: 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinence) 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding), 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days." A "3" was coded indicating	F 278	3. Regional Case Mix Coordinator, or designee, to re-educate MDS Coordinators about accurately coding sections H0300, G0300B and O100J on the MDS. 4. Executive Director, or designee, will conduct Quality Monitoring Review of MDS section H0300, G0300B, and O100J to ensure accurate coding of resident□s' status weekly for four weeks, bi-weekly for two weeks, and then monthly. Areas of concern will be addressed immediately. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 28	F 278		

that Resident #5 was always incontinent.

On 11/13/17 at 2:47 p.m. and 3:40 p.m.; and 11/14/17 at 9: 00 a.m., and 2:50 p.m., an observation was made of Resident #5. She was observed to have a Foley catheter in place.

Review of Resident #5's most recent POS (physician order sheet) dated 10/31/17, documented the following order: "Foley Catheter #16 Fr (French)/10 ml (milliliters) for retention." This order was initiated on 1/23/17.

Review of Resident #'s care plan dated 8/9/17 documented the following: "(Name of Resident #5) has the potential for infection r/t (related to) -indwelling Foley catheter: 16 Fr. (French) 10 cc. Goal: (Name of Resident #5) will decrease potential for infection due to F/C (Foley catheter) through next review date. Interventions: Change Foley Catheter per MD's (medical doctors) order...Foley catheter per md order..."

On 11/14/17 at 1:57 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. When asked about the process followed for filling out Section H, RN #1 stated she will check the medical record to see if the resident had any incontinent episodes and the frequency of incontinent episodes. If the resident did not have any incontinent episodes, she will code them as continent. RN #1 stated if a resident has a Foley catheter, she will document that the resident was "not rated" due to a catheter. When asked if Resident #5 had a Foley catheter in place, RN #1 stated that she did. When asked why Resident #5 was coded as being frequently incontinent on her MDS, RN #1, stated it was a coding error. RN #1 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 29	F 278		

she uses the RAI (Resident Instrument Manual) as a reference when completing the MDS assessment.

On 11/14/17 at 5:57 p.m., ASM (administrative staff member) #1 the Executive Director and ASM #2, the Director of Clinical Services were made aware of the above concerns.

The facility policy titled, "MDS," in part the following: "Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy."

No further information was presented prior to exit.

The RAI 3.0 (resident assessment instrument) manual documents in part, the following:

"Steps for Assessment
1.Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2.Interview the resident if he or she is capable of reliably reporting his or her continence. Speak with family members or significant others if the resident is not able to report on continence.
3.Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions
·Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
·Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 30	F 278		

dampen undergarments, briefs, or pads during daytime or nighttime.
·Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
·Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids.
·Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days."

2. The facility staff inaccurately coded section G; Functional Status on Resident #6's quarterly MDS assessment with an ARD of 10/10/17.

Resident #6 was admitted to the facility on 7/28/27 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), difficulty swallowing, underactive thyroid, schizophrenia, anxiety disorder, heart disease, high blood pressure, type two diabetes, and anemia. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/10/2017. Resident #6 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring supervision only with all ADLs (activities of daily living).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 31	F 278		

Further review of Resident #6's quarterly MDS documented Resident #6 in section G0400 (Functional Limitation in Range of Motion) as having impairments to both lower extremities.

On 11/13/17 at 3:45 p.m., an observation was made of Resident #6. He was observed ambulating in his room independently. No impairments were noted to his bilateral lower extremities.

On 11/14/17 at 8:20 a.m., an observation was made of Resident #6. He was observed ambulating in the hallway independently. No impairments were noted to his bilateral lower extremities.

On 11/14/17 at 2:13 p.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. When asked about the process followed for filling out Section G0400, RN #1 stated she would look at the clinical record for ADL documentation. RN #1 stated if the resident is having a period of weakness or injury to a particular extremity that impedes their functional ability, she will document that impairments are present. When asked if Resident #6 had impairments to his bilateral lower extremities, RN #1 stated he (Resident #6) did not have impairments to his bilateral extremities and that he ambulated around the facility. When asked why she coded Resident #6 as having impairments to his bilateral lower extremities on his quarterly MDS, RN #1 stated he may have had weakness during that period. RN #1 stated, "I will look in the clinical record."

On 11/14/17 at 3:25 p.m., further interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 32	F 278		

conducted with RN #1. RN #1 stated she was not sure why Resident #6 was coded as having impairments to his bilateral lower extremities. RN #1 stated she could not find anything in the clinical record that would evidence he was having weakness or any other impairments. RN #1 stated she used the RAI (Resident Assessment Instrument) manual as a reference when completing the MDS assessment.

On 11/14/17 at 5:57 p.m., ASM (administrative staff member) #1 the executive director and ASM #2, the Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit.

The RAI 3.0 Manual documents in part, the following:

"3. Coding for functional ROM limitations is a 3 step process:
·Test the resident 's upper and lower extremity ROM.
·If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
·Code G0400 A/B as appropriate based on the above assessment.

4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).

5.Staff observations of various activities, including ADLs, may be used to determine if any ROM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 33	F 278		

limitations impact the resident's functional abilities.

6.Although this item codes for the presence or absence of functional limitation related to ROM; thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
·Ask the resident to follow your verbal instructions for each movement.
·Demonstrate each movement (e.g., ask the resident to do what you are doing).
·Actively assist the resident with the movements by supporting his or her extremity and guiding it through the joint ROM.

Lower Extremity- includes hip, knee, ankle, and foot
While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot. Then ask the resident to lift his or her leg one at a time, bending it at the knee to a right angle (90 degrees) Then ask the resident to slowly lower his or her leg and extend it flat on the mattress. If assessing lower extremity ROM by observing the resident, the flexion and extension of the food mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower body clothing.

Coding Tips
·Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 34	F 278		

July 2010 Page G-30CMS ' s RAI Version 3.0 Manual CH 3: MDS Items [G]

G0400: Functional Limitation in Range of Motion (cont.)
Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)
·Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities.
·Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.
·Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury."

3. The facility staff failed to code that Resident #1 was receiving dialysis therapy on the 14 day MDS (minimum data set) with an ARD (assessment reference date) of 9/25/17.

Resident #1 was admitted to the facility on 4/3/12 and readmitted on 9/12/17 with diagnoses that included but were not limited to: heart failure, kidney failure, high blood pressure, dementia, diabetes and impaired vision.

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 9/25/17 coded the resident as having scored a 12 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 278	Continued From page 35	F 278		

assistance from staff for all activities of daily living. In Section O -- Special Treatments, Procedures, and Programs. "Check all of the following treatments, procedures, and programs that were performed during the last 14 days....2. While a Resident. Performed while a resident of this facility and within the last 14 days." There was no documentation that Resident #1 had received dialysis during that time period.

Review of Resident #1's care plan initiated on 11/2/16 and revised on 10/10/17 documented, "Focus. The resident has alteration in perfusion r/t (related to): ...Dialysis: M (Monday) - W (Wednesday) - F (Friday)."

Review of the physician's orders dated 9/12/17 documented, "DIALSYSIS (sic) THREE TIMES WEEKLY ON MONDAYS, WEDNESDAYS, AND FRIDAYS..."

Review of Resident #1's September 2017 treatment administration record documented, "Dialysis on Monday, Wednesday, Friday..." The September TAR documented Resident #1 had received dialysis as ordered from 9/13/17 through 9/29/17.

An interview was conducted on 11/14/17 AT 1:58 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked the role of the MDS coordinator, RN #1 stated, "As MDS coordinator I assess the resident and collect data and put it into the computer." When asked what was done with the assessment, RN #1 stated, "I check it for accuracy and we transmit it." When asked if she completed Section O of the MDS assessments, RN #1 stated she did. When asked if a resident was receiving dialysis would that be coded, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 278	Continued From page 36 #1 stated, it would. When asked if she was familiar with Resident #1, RN #1 stated she was. When asked if the resident received dialysis, RN #1 stated the resident did receive dialysis. RN #1 was asked to review Section O for dialysis of Resident #1's 9/25/17 14 day MDS assessment. RN #1 stated, "It's not coded." When asked why it would not be coded, RN #1 stated, "It was an oversight." When asked what reference she used, RN #1 stated, "The RAI (resident assessment instrument) manual." On 11/14/17 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit.	F 278		
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	F 279		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 37	F 279		

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

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 279	Continued From page 38 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined the facility staff failed to develop a comprehensive care plan based on triggered care area assessments (CAAs) for one of 24 residents in the survey sample, Resident #1. The facility staff failed to develop a comprehensive care plan for communication as triggered on the care area assessments (CAAs) of Resident #1's 9/19/17 significant change MDS (minimum data set) assessment. The findings include: The facility staff failed to develop a comprehensive care plan for communication as triggered on the care area assessments (CAAs) of Resident #1's 9/19/17 significant change MDS (minimum data set) assessment. Resident #1 was admitted to the facility on 4/3/12 and readmitted on 9/12/17 with diagnoses that included but were not limited to: heart failure, kidney failure, high blood pressure, dementia, diabetes and impaired vision. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 9/25/17 coded Resident #1 as having scored a 12 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was moderately impaired to make daily	F 279	1. Resident #1'□s care plan was updated to reflect communication deficit as identified on Care Area Assessment. 2. MDS Coordinator has reviewed most recent comprehensive MDS assessment for current residents to ensure all care areas triggered are care planned appropriately. Follow-up based on findings. 3. Regional Case Mix Coordinator, or designee, has re-educated MDS Coordinators regarding Care Area Assessment process and care planning. 4. Executive Director, or designee, to conduct Quality Monitoring Review of comprehensive MDS assessments to ensure all care areas triggered are appropriately care planned, weekly for four weeks, bi-weekly for two weeks, and then monthly. Areas of concern to be addressed immediately. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 39	F 279		

decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the significant change MDS assessment with an ARD of 9/19/17 revealed in Section V - the care area assessment (CAAs) documentation that the resident should have a communication care plan developed.

Review of Resident #1's comprehensive care plan initiated on 11/2/16 and revised on 5/8/17 did not evidence documentation regarding a communication care plan.

An interview was conducted on 11/14/17 at 1:20 p.m. with OSM (other staff member) #1, the social worker. OSM #1 stated that she had started working at the facility in October 2017. When asked if she developed resident care plans, OSM #1 stated, "I'm still learning. I haven't done any of that yet but it will be part of it (what I do)." When asked what she would do if a resident triggered on the MDS assessment to have a communication care plan completed, OSM #1 stated a care plan should be developed. OSM #1 was asked to review Resident #1's care plan for a communication plan of care. OSM #1 stated there was none.

An interview was conducted on 11/14/17 at 1:58 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked why residents had care plans, RN #1 stated, "They are a working tool." When asked who used the care plan, RN #1 stated, "Everybody that cares for the resident." When asked if a care plan would be developed if a resident had a specific need, RN #1 stated, "Yes." When asked who developed the residents'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 279	Continued From page 40 care plans, RN #1 stated, "We (MDS coordinators) do the comprehensive care plans. When asked if care plans were developed from the care assessment area, RN #1 stated, "Based on what triggered on the assessment." When asked if a plan of care would be developed, if communication triggered in the CAA of a MDS assessment, RN #1 stated it would. RN #1 was asked to review Section V of Resident #1's significant change MDS assessment and Resident #1's comprehensive care plan for a communication plan of care. RN #1 stated there was none (no communication care plan). On 11/14/17 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." No further information was obtained prior to exit.	F 279		
F 280 SS=E	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	F 280		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 280	Continued From page 41 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 42 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 43 Based on staff interview, facility document review and clinical record review, it was determined, the facility staff failed to review and revise the comprehensive care plan for four of 24 residents in the survey sample, Resident # 2, #14, #1 and #11. 1. The facility staff failed to review and revise Resident #2's comprehensive care plan following a fall that occurred on 7/8/17 and a newly diagnosed ankle fracture on 7/18/17. 2. The facility staff failed to include restorative nursing on Resident #14's comprehensive care plan when it was ordered by the physician on 10/4/17. 3. The facility staff failed to revise Resident #1's comprehensive care plan following the resident's 9/5/17 fall that resulted in the resident sustaining a scalp laceration. 4. The facility staff failed to revise the comprehensive care plan after Resident #11 to include restorative nursing after the resident was placed on a restorative nursing program. The findings include: 1. The facility staff failed to review and revise Resident #2's comprehensive care plan following a fall that occurred on 7/8/17. Resident #2 was admitted to the facility on 6/16/14 with a readmission on 7/24/17 with diagnoses that include, but are not limited to: ankle fracture, anemia, stroke, high blood pressure, Parkinson's disease and difficulty swallowing.	F 280	1. Resident #1'□s care plan has been reviewed and updated to reflect the current plan of care. Resident #2□'s care plan has been reviewed and updated to reflect the current plan of care. Resident #11□'s care plan has been reviewed and updated to reflect the current plan of care. Resident #14□'s care plan has been reviewed and updated to reflect the current plan of care. 2. Interdisciplinary team to review Center□'s current residents' care plans for any order changes, falls, injuries or changes to the plan of care in the last 30 days to ensure care plan is accurate. Follow-up based on findings. 3. Director of Clinical Services, or designee, has re-educated interdisciplinary team members on updating resident care plans with all order changes or changes in plan of care during Clinical Start-Up Meeting. 4. Director of Clinical Services, or designee, will conduct Quality Monitoring Review weekly for four weeks, bi-weekly for two weeks, and then monthly, to ensure care plans are updated with accurate and complete information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 280	Continued From page 44 Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/27/17, coded Resident #2 as having a BIMS (brief interview for mental status) score of two out of a possible 15 indicating Resident #2 was severely cognitively impaired to make decisions regarding activities of daily living. A review of Resident #2's progress notes revealed, in part, the following documentation; "7/8/17 3 p.m. At 2:30 p.m. Resident was observed on (sic) a sitting position on the floor in her bathroom. When asked resident stated "I was trying to go to the bathroom then I slide (sic) from wheelchair to the floor." Upon assessment no apparent injury noted @ (at) this time." A review of Resident #2's comprehensive care plan dated 6/28/16 with a revision of 7/24/17 revealed, in part, the following documentation; "Focus. (Name of Resident #2) has the potential for injury r/t History of falls. Interventions: RESOLVED: Medication as ordered. Date Initiated: 6/28/2016. RESOLVED: OT (occupational therapy) to evaluate. Date Initiated: 6/28/17." There were no entries regarding a fall occurring on 7/8/17. On 11/14/17 at 3:45 p.m. an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked who was responsible for developing and revising the comprehensive care plans. LPN #1 stated nursing staff. LPN #1 was asked when the comprehensive care plan would be reviewed and revised. LPN #1 stated, "Whenever there is a change in condition, any skin changes, any falls	F 280	Areas of concern will be addressed immediately. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule will be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 280	Continued From page 45	F 280		

or anything that changes the care of the resident.

On 11/15/17 at 10:45 a.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked when a resident's comprehensive care plan would be reviewed and revised. RN #1 stated, "A care plan would be updated for any event." RN #1 was asked why a care plan should be updated. RN #1 stated, "It is a working tool. It is our guide, like a "bible. We can refer to the care plan for directives on caring for the residents." RN #1 further stated it was important for the nursing staff to refer to the care plan for information on caring for the residents.

On 11/15/17 at 3:45 p.m. an interview was conducted with RN #1, the MDS coordinator. RN #1 was asked to review Resident #2's comprehensive care plan. RN #1 was asked if she was able to locate a revision to Resident #2's comprehensive care plan for the fall that occurred on 7/8/17. RN #1 stated that she could not. RN #1 was asked if Resident #2's comprehensive care plan should have been reviewed and revised. RN #1 stated it should have been, it was overlooked.

An end of day meeting was conducted with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services on 11/15/17 at 4:50 p.m. ASM #1 and ASM #2 were made aware of the above findings.

Review of the facility's policy titled, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 280	Continued From page 46	F 280		

extent practicable and updated in accordance with state and federal regulatory requirements. Procedure: Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA (Omnibus Budget Reconciliation Act) MDS assessment (except discharge assessments, and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."

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

2. The facility staff failed to include restorative nursing on Resident #14's care plan when it was ordered by the physician on 10/4/17.

Resident #14 was admitted to the facility on 10/7/16 with diagnoses that included, but were not limited to: slow heart rate, cognitive communication deficit, high blood pressure, dementia and altered mental status.

Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/4/17, codes Resident #14 as having a BIMS (brief interview for mental status) as 11 out of a possible 15, indicating Resident #14 is moderately cognitively impaired with activities of daily living.

A review of Resident #14's clinical record revealed, in part, the following physician order dated 10/4/17; "Restorative nursing, 3 - 6 times /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 280	Continued From page 47	F 280		

wk (per week) x (for) 90 days for ROM (range of motion) exercise and transfers / gait. Start Date: 10/6/17."

A review of Resident #14's comprehensive care plan dated 10/7/16 did not reveal any information regarding restorative nursing.

On 11/14/17 at 3:45 p.m. an interview was conducted with LPN (licensed practical nurse) #1, a floor nurse. LPN #1 was asked who was responsible for developing and revising the comprehensive care plans. LPN #1 stated nursing staff. LPN #1 was asked when the comprehensive care plan would be reviewed and revised. LPN #1 stated, "Whenever there is a change in condition, any skin changes, any falls or anything that changes the care of the resident. We get really busy and sometimes forget." LPN #1 was asked if restorative nursing would be included in the care plan. LPN #1 stated it should be.

On 11/15/17 at 10:45 a.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked when a care plan would be reviewed and revised. RN #1 stated, "A care plan would be updated for any event." RN #1 was asked why a care plan should be updated. RN #1 stated, "It is a working tool. It is our guide, like a "bible. We can refer to the care plan for directives on caring for the residents." RN #1 further stated it was important for the nursing staff to refer to the care plan for information on caring for the residents.

An end of day meeting was conducted with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 280	Continued From page 48	F 280		

services on 11/15/17 at 4:50 p.m. ASM #2 was asked to describe the purpose of the comprehensive care plan, ASM #2 stated, "It is a working tool that shows the personalized plan for a resident. It describes a resident's needs, goals and safety." ASM #2 was asked when a comprehensive care plan is reviewed and revised. ASM #2 stated, "The care plan is reviewed with every MDS, also with any change, clinical and psychosocial, anything that changes with relevance." ASM #2 was asked if a resident is placed on restorative nursing should that be reflected on the care plan. ASM #2 stated, "A resident placed on restorative nursing should be on the care plan because there is a goal and it can impact the resident. Restorative nursing is conducted to promote functionality and independence." ASM #2 was asked to review Resident #14's clinical record, and to provide evidence that Resident #14 was placed in the restorative program and care planned for restorative care. ASM #2 stated that Resident #14's clinical record did not include any documentation for restorative nursing and Resident #14's comprehensive care plan did not include restorative nursing.No further documentation was provided prior to the end of the survey process.

3. The facility staff failed to revise Resident #1's comprehensive care plan following the resident's 9/5/17 fall that resulted in the resident sustaining a scalp laceration.

Resident #1 was admitted to the facility on 4/3/12 and readmitted on 9/12/17 with diagnoses that included but were not limited to: heart failure, kidney failure, high blood pressure, dementia, diabetes and impaired vision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 280	Continued From page 49	F 280		

The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 9/25/17 coded Resident #1 as having scored a 12 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 9/5/17 at 6:50 a.m. documented in part, "The aide was transferring resident to bed when he slid from the shower chair and fell face forward and sustained a laceration to Rt (right) forehead with bleeding to Rt lower leg.... (Name of physician) was notified. He gave an order to transfer resident to (name of hospital) for further evaluation."

Review of Resident #1's fall care plan initiated on 11/2/16 and revised on 10/10/17 did not evidence documentation regarding the resident's 9/5/17 fall.

Review of the September 2017 treatment administration record documented, "Monitor stiches (sic)/steristrips to laceration on Forehead q (every) shift." It was documented that the stitches were monitored.

An interview was conducted on 11/14/17 at 1:58 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked why residents had care plans, RN #1 stated, "It's a tool. It's our guide in the care of the resident." When asked who used the care plan, RN #1 stated, "The nurses are supposed to use the care plan." When asked who reviewed and revised care plans, RN #1 stated she did. When asked when a care plan would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 280	Continued From page 50	F 280		

revised, RN #1 stated, "At the quarterly care plan meeting." RN #1 also stated, "In the morning meetings the managers bring new orders (for the residents) and we update it (the care plan)." When asked if the care plan was updated for any incidents, RN #1 stated, "For example falls, yes." When asked who ensured the care plan was updated, RN #1 stated, "The MDS department and the director of nursing is our champion." RN #1 was asked to review Resident #1's 9/5/17 nurse's note regarding the fall and the care plan. RN #1 stated, "I'm not seeing it (the 9/5/17 fall on the care plan)."

An interview was conducted on 11/15/17 at 4:45 p.m. with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services. When asked why residents had care plans, ASM #2 stated, "It's meant to be a working tool for us to know a personalized plan for every patient. What their goals are. We need to know what we need to do to keep them safe." When asked when the care plan would be updated, ASM #2 stated, "Any new wounds, falls, change in code status, change in medications. Any change that comes up that has an impact on the care of the resident." ASM #1 and ASM #2 were made aware of the findings at that time.

No further information as provided prior to exit.

4. The facility staff failed to revise the comprehensive care plan after Resident #11 was placed on a restorative nursing program.

Resident #11 was admitted to the facility on 6/13/13 and readmitted on 6/18/17 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

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F 280	Continued From page 51	F 280		

diagnoses that included but were not limited to: displaced fracture of the left tibia, hypothyroidism, anxiety disorder, COPD (chronic obstructive pulmonary disease), major depressive disorder, high blood pressure, osteoarthritis and degenerative joint disease. Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/29/17. Resident #11 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #11 was coded as requiring extensive assistance with one to two staff members with transfers, dressing, toileting, personal hygiene, and bathing. Review of Section O (Special treatments, procedures, and programs) documented Resident #11 as not receiving restorative nursing.

Review of Resident #11's POS (physician order sheet) dated 10/31/17 documented the following order: "RNP (restorative nursing program) 6 X (times)/wk (week) for 90 days for range of motion exercise and gait training."

Review of Resident #11's clinical record revealed the following note for physical therapy: "Therapy communication to restorative nursing program. Current functional status: PT (patient) is independent with bed mobility, pt is supervision for transfers, pt is contact guard assist for ambulation using a walker. Problems/needs: Range of Motion exercises to decrease risk of functional decline. Ambulation using a wheeled walker to improve functional mobility and self function. Recommendations/approaches: Perform ROM (range of motion) exercises to maintain joint integrity and muscle performance. Perform ambulation daily from room to hallway

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 52 100 ft (feet) using a rolling walker with contact guard assist to improve functional mobility. Restorative nursing start date: 8/18/17." Review of Resident #11's comprehensive care plan failed to reveal an intervention for a restorative nursing program. On 11/15/17 at 4:58 p.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Clinical Services (DCS). When asked the purpose of the care plan, ASM #2 stated the care plan was a working tool so that nursing staff know the personalized plan for each resident. When asked when she would expect the care plan to be reviewed or revised, ASM #2 stated she would expect revisions quarterly or for any new change in the resident's condition such as falls, code status, behavior changes or any relevant care provided to them. When asked if restorative nursing should be on the care plan, ASM #2 stated, "Absolutely, it would be on the care plan." ASM #2 stated that restorative nursing would affect ADL (activities of daily living) and that the care plan should reflect that. On 11/15/17 at 5:00 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the Director Clinical Services were made aware of the above concerns. The facility policy titled, "Restorative Nursing Services" documents in part the following: "Restorative programming will be included in the resident written plan of care."	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 282	Continued From page 53 CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow the written plan of care for one of 24 residents in the survey sample, Resident #4. The facility staff failed to provide restorative nursing services per Resident #4's care plan and as ordered by the physician on 9/20/17. The findings include: Resident #4 was admitted to the facility on 4/3/15 and readmitted on 7/5/17 with diagnoses that included but were not limited to: stroke, diabetes, elevated cholesterol, depression and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/16/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after	F 282	1. Resident #4'□s care plan was reviewed and updated to reflect the most current plan of care regarding restorative nursing program. 2. Current Center residents with restorative nursing programs have had their care plans reviewed to ensure programs are care planned appropriately. Current Center residents with restorative nursing programs have been reviewed to ensure programs are completed and documented in the medical record. Follow-up based on findings. 3. Director of Clinical Services, or designee, has re-educated restorative nurse and restorative aides regarding following residents' plan of care for restorative programs. 4. Director of Clinical Services, or designee, to conduct Quality Monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 282	Continued From page 54 the meal tray was prepared. Review of Resident #4's comprehensive care plan initiated on 7/5/17 and revised on 9/29/17 documented, "Focus. SAFETY: Potential for injury r/t (related to) - Decreased mobility...Gait/balance problems. Interventions. Restorative nursing exercise program as written." Review of the physician's orders dated and signed on 9/20/17 documented, "Restorative Nursing Program iniated (sic) to address UE (upper extremity) strength and w/c (wheelchair) tolerance for 6 days per week for 90 days." Review of the clinical record for Resident #4 did not evidence documentation that restorative nursing services were provided. An interview was conducted on 11/14/17 at 11:35 a.m. with LPN (licensed practical nurse) #7, the unit manager. When asked who provided restorative nursing services to the residents, LPN #7 stated, "The CNAs (certified nursing assistants)." When asked how the aides would know that a resident was to receive restorative nursing services, LPN #7 stated, "It's in the (name of software)." When asked if the aides documented after they provided the restorative nursing service, LPN #7 stated they did. When asked to review Resident #4's clinical record for documentation of the restorative nursing program, LPN #7 stated, "It's not there." An interview was conducted on 11/15/17 at 4:45 p.m. with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services. When asked why residents had care plans, ASM #2 stated, "It's meant to be a	F 282	Review of restorative nursing program documentation to ensure programs are completed and documented in the medical record, according to the plan of care weekly. Areas of concern will be addressed immediately. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 282	Continued From page 55 working tool for us to know a personalized plan for every patient. What their goals are. We need to know what we need to do to keep them safe." When asked if staff were expected to follow the care plans, ASM #2 stated, "Yes ma'am. If the resident doesn't want something that's been ordered or being done, then that should be care planned. That should be your road map." ASM #1 and ASM #2 were made aware of the findings at that time. Review of the facility's policy titled, "Plans of Care" documented, "Develop and implement an Individualized Person-Centered baseline plan of care..." There was no specific documentation regarding following the plan of care. No further information was provided prior to exit.	F 282		
F 311 SS=E	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.24(a)(1) (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) 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 the facility staff failed to initiate a restorative nursing program as ordered by the physician for three of 24 residents in the survey sample, Resident #4, Resident #14 and Resident #11. 1. The facility staff failed to provide restorative nursing services to Resident #4 as ordered by the	F 311	1. Resident #4 was screened by Center'□s rehabilitation staff and evaluated by restorative nurse to determine appropriate restorative nursing program. Resident #4 is receiving range of motion and locomotion restorative nursing program. Resident #14 was screened by Center'□s	12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 311	Continued From page 56 physician on 9/20/17. 2. The facility staff failed to initiate and document Resident #14's participation in a restorative nursing program as ordered by the physician. 3. The facility staff failed to provide a restorative nursing program to Resident #11 as ordered by the physician on 8/18/17. The findings include: 1. Resident #4 was admitted to the facility on 4/3/15 and readmitted on 7/5/17 with diagnoses that included but were not limited to: stroke, diabetes, elevated cholesterol, depression and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/16/17 coded Resident #4 as having scored a 15 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the meal tray was prepared. Review of the care plan initiated on 7/5/17 and revised on 9/29/17 documented, "Focus. SAFETY: Potential for injury r/t (related to) - Decreased mobility...Gait/balance problems. Interventions. Restorative nursing exercise program as written." Review of the physician's orders dated and signed on 9/20/17 documented, "Restorative Nursing Program iniated (sic) to address UE	F 311	rehabilitation staff and evaluated by restorative nurse to determine appropriate restorative nursing program. Resident #14 is receiving range of motion and ambulatiion restorative nursing program. Resident #11 was screened by Center□'s rehabilitation staff and evaluated by restorative nurse to determine appropriate restorative nursing program. Resident #11 is receiving range of motion and ambulation restorative nursing program. 2. Current residents in the Center with a restorative nursing program in place were screened by rehabilitation staff and evaluated by restorative nurse to determine appropriate restorative nursing program. Resident□s' Restorative Nursing Program updated as indicated by screen and evaluation. Center has designated specific staff to provide and document restorative nursing programs on residents who are determined to be appropriate for a program. 3. Director of Clinical Services, or designee, has educated restorative nurse and restorative CNA regarding evaluations, implementation of restorative programs, documentation of restorative programs, and continued monitoring of progress and appropriateness for restorative nursing program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 311	Continued From page 57 (upper extremity) strength and w/c (wheelchair) tolerance for 6 days per week for 90 days." Review of the clinical record for Resident #4 did not evidence documentation that restorative nursing services were provided. An interview was conducted on 11/14/17 at 11:35 a.m. with LPN (licensed practical nurse) #7, the unit manager. When asked who provided restorative nursing services to the residents, LPN #7 stated, "The CNAs (certified nursing assistants)." When asked how the aides would know that a resident was to receive restorative nursing services, LPN #7 stated, "It's in the (name of software)." When asked if the aides documented after they provided the service, LPN #7 stated they did. When asked to review the CNAs documentation for Resident #4's restorative nursing program, LPN #7 stated, "It's (restorative nursing) not there." When asked if it had been done, LPN #7 stated it had not. On 11/14/17 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. An interview was conducted on 11/15/17 at 8:05 a.m. with ASM #2, the director of clinical services. When asked about the restorative nursing program, ASM #2 stated, "Our program is a work in progress. We are in the process right now to train a restorative aide to provide care to all of the residents. Currently it is the responsibility of the floor CNA." When asked if Resident #4 had received the restorative nursing services as ordered by the physician ASM #2 stated he had not.	F 311	4. Director of Clinical Services, or designee, to conduct Quality Monitoring Review of restorative nursing program documentation weekly for four weeks, bi-weekly for two weeks, and then monthly to ensure appropriate documentation is present. Follow-up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 58	F 311		

An interview was conducted on 11/15/17 at 4:15 p.m. with CNA (certified nursing assistant) #8, Resident #4's aide regarding the restorative nursing program. CNA #8 stated, "You know they go to physical therapy. When they discharge them (the residents) they put them in the program." When asked how staff would know the resident was in the restorative nursing program, CNA #8 stated, "It's in the (name of software). It tells you what to do." When asked the process staff followed when the exercises were completed, CNA #8 stated, "When you do it you document it." When asked which of her residents were receiving restorative nursing services, CNA #8 stated, "I don't have nobody." When asked if she had Resident #4, CNA #8 stated she did. When asked if she was aware that the resident was to be in the restorative nursing program, CNA #8 stated she was not.

Review of the facility's policy titled, "Restorative Nursing Services" documented, "POLICY: Restorative Nursing will be provided to residents as indicated upon evaluation to assist in achieving the highest practicable level of physical functioning as possible."

No further information was provided prior to exit.
2. The facility staff failed to initiate and document Resident #14's participation in a restorative nursing program as ordered by the physician.

Resident #14 was admitted to the facility on 10/7/16 with diagnoses that included, but were not limited to: slow heart rate, cognitive communication deficit, high blood pressure, dementia and altered mental status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 311	Continued From page 59	F 311		

Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/4/17, coded Resident #14 as having a BIMS (brief interview for mental status) of 11 out of a possible 15, indicating Resident #14 is moderately cognitively impaired with activities of daily living.

A review of Resident #14's clinical record revealed, in part, the following physician order dated 10/4/17; "Restorative nursing, 3 - 6 times / wk (per week) x (for) 90 days for ROM (range of motion) exercise and transfers / gait. Start Date: 10/6/17."

Further review of Resident #14's clinical record did not reveal any evidence that restorative nursing had been initiated as ordered.

A review of Resident #14's comprehensive care plan dated 10/7/16 did not reveal any information regarding restorative nursing.

On 11/15/17 at 4:05 p.m. an interview was conducted with RN (registered nurse) #1, the MDS (minimum data set) coordinator. RN #1 was asked when restorative nursing would normally be ordered. RN #1 stated when a resident was discharged from therapy an order would be written to start restorative nursing. RN #1 was asked how restorative nursing is conducted. RN #1 stated, "Whoever is responsible to enter the orders into the computer must enter it so that the CNAs (certified nursing assistants) can access it on their system. If it is in the computer, the CNAs can "see" it." RN #1 was asked who completed the restorative nursing care. RN #1 stated, "Anyone taking care of the resident does the restorative nursing. If a CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 311	Continued From page 60	F 311		

performs restorative nursing it is documented in the computer and will show the number of days, it was performed (restorative) and I can code it."

On 11/15/17 at 4:15 a.m. an interview was conducted with CNA #8. CNA #8 was asked when she would perform range of motion (ROM) for a resident. CNA #8 stated, "I can't just do it, I have to have an order to do it." CNA #8 was asked how she would know when to perform ROM / restorative nursing. CNA #8 stated, "It's in our kardex (a method of communication for CNAs), and we document when done." CNA #8 stated, "When the resident is discharged from skilled therapy they (nursing staff) put them (residents) in the restorative nursing program." CNA #8 was asked why a resident would be placed on restorative nursing, CNA #8 stated, "To restore / maintain their physical condition. If it is in the (name of the computer program) and it will tell you what to do. If it's on the (name of the computer program) I do it." CNA #8 was asked if Resident #14 was on the restorative program, CNA #8 stated, "She (Resident #14) is not on my assignment. If restorative is performed it would be documented in the (name of the computer program)."

An end of day meeting was conducted with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services on 11/15/17 at 4:50 p.m. ASM #2 was asked to state the purpose of restorative nursing. ASM #2 stated, "Therapy recommends restorative when a resident is discharged from therapy to maintain function with ADLs (activities of daily living)." ASM #2 was asked about the order for Resident #14 dated 10/4/17 for restorative nursing and what should be in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 61	F 311		

clinical record when a resident is on restorative nursing. ASM #2 stated, "There should be restorative nursing minutes and documentation on how the resident tolerated the restorative nursing; there should be at least three to four notes each week." ASM #2 was asked to review Resident #14's clinical record for restorative nursing notes. ASM #2 stated there was no documentation that Resident #14 had received restorative nursing.

No further documentation was provided prior to the end of the survey process.
3. The facility staff failed to provide a restorative nursing program to Resident #11 as ordered by the physician on 8/18/17.

Resident #11 was admitted to the facility on 6/13/13 and readmitted on 6/18/17 with diagnoses that included but were not limited to: displaced fracture of the left tibia, hypothyroidism, anxiety disorder, COPD (chronic obstructive pulmonary disease), major depressive disorder, high blood pressure, osteoarthritis and degenerative joint disease. Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/29/17. Resident #11 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #11 was coded as requiring extensive assistance with one to two staff members with transfers, dressing, toileting, personal hygiene, and bathing. Review of Section O (Special treatments, procedures, and programs) documented Resident #11 as not receiving restorative nursing.

Review of Resident #11's POS (physician order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 311	Continued From page 62	F 311		

sheet) dated 10/31/17 documented the following order: "RNP (restorative nursing program) 6 X (times)/wk (week) for 90 days for range of motion exercise and gait training."

Review of Resident #11's clinical record revealed the following note for physical therapy: "Therapy communication to restorative nursing program. Current functional status: PT (patient) is independent with bed mobility, pt is supervision for transfers, pt is contact guard assist for ambulation using a walker. Problems/needs: Range of Motion exercises to decrease risk of functional decline. Ambulation using a wheeled walker to improve functional mobility and self function. Recommendations/approaches: Perform ROM (range of motion) exercises to maintain joint integrity and muscle performance. Perform ambulation daily from room to hallway 100 ft (feet) using a rolling walker with contact guard assist to improve functional mobility. Restorative nursing start date: 8/18/17."

Further review of Resident #11's clinical record revealed no evidence of restorative nursing notes.

Review of Resident #11's care plan failed to reveal an intervention for a restorative nursing program.

On 11/15/17 at 8:11 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Clinical Services (DCS). ASM #2 stated she could not find restorative nursing notes for Resident #11. ASM #2 stated the restorative nursing program was a work in progress and the CNAs (certified nursing assistants) on the floor were currently the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 63	F 311		

restorative aides as well as the CNAs. ASM #2 stated the facility was trying to get a designated restorative aide in place. When asked about the process followed when restorative nursing is recommended, ASM #2 stated therapy recommends the program and then the program is put into PCC (point click care) to alert the CNAs that the resident is on the program. ASM #2 stated it was difficult for the floor CNAs to also do restorative nursing. ASM #2 stated restorative nursing can take a long time and may take away from other things. ASM #2 stated she has tried to educate her staff by showing them that some restorative nursing exercises can be done during ADL (activities of daily living) care.

On 11/15/17 at 3:25 p.m., an interview was conducted CNA (certified nursing assistant) #8. When asked how she would know if a resident was on a restorative nursing program, CNA #8 stated first an order would be required for restorative nursing. When asked how she would know an order was in place for restorative nursing, CNA #8 stated she would look on her Kardex in PCC (point click care) and it should be documented that the resident needs restorative nursing therapy. CNA #8 stated, "PCC will tell you what to do with them." CNA #8 was not sure if Resident #11 was on a restorative nursing program. CNA #8 stated she did not work with Resident #11. CNA #8 stated that if the task is on PCC then the CNAs should know to do restorative nursing and then document each shift that it was completed. When asked CNA #8 if she felt that she had enough time to do restorative nursing, CNA #8 stated she had time to do restorative nursing with her residents because she knows how to prioritize her time. CNA #8 stated that some restorative nursing exercises

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F 311	Continued From page 64 can be done while doing some ADL care. On 11/15/17 at 4:48 p.m., ASM #1, the executive director and ASM #2, the Director of Clinical Services were made aware of the above concerns.	F 311		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 315		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 65 (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide appropriate treatment and services for the use of a urinary catheter to prevent infections for one of 24 residents in the survey sample, Resident #5 During multiple observations Resident #5's Foley catheter bag was observed directly touching the floor. The findings include: Resident #5 was admitted to the facility on 1/23/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), urinary frequency, high blood pressure, congestive heart failure, and anxiety disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one to two staff members with most ADLS (activities of daily living). Resident #5 was coded as requiring limited assistance with meals from one staff member.	F 315	1. The catheter drainage bag for Resident #5 was changed and secured. Resident #5□'s catheter drainage bag is maintained below the bladder with no contact with the floor. 2. Current residents in the Center with an indwelling catheter were reviewed. Drainage bags were changed and properly secured below the bladder and not touching the floor based on review. 3. Director of Clinical Services, or designee, has re-educated Nursing Staff about appropriate placement of indwelling catheter drainage bags to ensure proper drainage in accordance with infection control guidelines. 4. Director of Clinical Services to conduct Quality Monitoring Review to be completed weekly for four weeks, bi-weekly for two weeks, then monthly, to ensure indwelling catheter drainage bags are secured properly and catheter drainage bags are maintained following infection control standards. Findings to	

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F 315	Continued From page 66 Review of Resident #5's most recent POS (physician order sheet) dated 10/31/17, documented the following order: "Foley Catheter #16 Fr (french)/10 ml (milliliters) for retention." On 11/13/17 at 2:47 p.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor. On 11/13/17 at 3:40 p.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor. On 11/14/17 at 7:46 a.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor. On 11/14/17 at 9:00 a.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the right side of the bed. The bottom of the Foley bag was touching the floor. On 11/14/17 at 2:50 p.m., an observation was made of Resident #5. Her bed was slightly higher than before. Her Foley catheter was hanging from the bed frame and not in contact with the floor.	F 315	be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 315	Continued From page 67	F 315		

Review of Resident #5's comprehensive care plan dated 8/9/17 documented the following: "(Name of Resident #5) has the potential for infection r/t (related to) -indwelling Foley catheter: 16 Fr. (french) 10 cc (cubic centimeter). Goal: (Name of Resident #5) will decrease potential for infection due to F/C (Foley catheter) through next review date. Interventions: Change Foley Catheter per MD's (medical doctors) order, Encourage PO (by mouth) fluid intake, Foley catheter per md (sic) order, labs as ordered, Monitor for infection: urine odor, urine color, urine sediments, monitor temperature PRN (as needed)."

On 11/14/17 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #5's nurse. When asked how a resident's catheter should be maintained while a resident is in bed, LPN #1 stated the catheter should hang from the bed frame below the level of the bladder. When asked if the catheter should ever touch the floor, LPN #1 stated it should not. When asked if she had been in Resident #5's room during the 7-3 shift, LPN #1 stated she had. When asked if she had noticed anything about Resident #5's catheter, LPN #1 stated she did not. CNA (certified nursing assistant) #1, Resident #5's CNA interjected and stated Resident #5's Foley catheter was touching the ground during the morning hours because her bed was in the lowest position. CNA #1 stated she had fixed Resident #5's bed after AM (morning) care. When CNA #1 was asked why the Foley catheter should not be touching the floor, CNA #1 stated it was an infection control issue.

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F 315	Continued From page 68 On 11/14/17 at 5:57 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the Director of Clinical Services were made aware of the above concerns. The facility policy titled, "Catheter Care, Urinary" did not address the above concerns. No further information was presented prior to exit.	F 315		
F 371 SS=D	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 371	Continued From page 69 by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to store food in a sanitary manner. A box of rainbow sugar sprinkles used on desserts was stored with the box opened and the bag of sprinkles opened. The findings include: On 11/13/17 at 11:55 a.m., an inspection of the kitchen was conducted. On 11/13/17 at approximately 12:00 p.m., in the dry storage area a box of rainbow sugar sprinkles used on desserts was observed stored with the box opened and the bag of sprinkles opened. At this time, OSM #5 (Other Staff Member - the dietary manager) stated the sprinkles should have been sealed to prevent pests. A review of the facility policy, "Food Storage: Dry Goods" documented, "5. All packaged and canned food items will be kept clean, dry, and properly sealed." On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.	F 371	1. Box of rainbow sprinkles were immediately discarded on 11/13/17 by the Director of Dietary. 2. Dry storage area was inspected by the Director of Dietary to ensure all items are properly stored in a sanitary manner. Follow-up based on findings. 3. Director of Dietary has re-educated dietary staff on proper dry food storage. 4. Director of Dietary, or designee, to conduct Quality Monitoring Review of dry storage area to ensure proper food storage weekly for four weeks, bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	
F 372 SS=F	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly.	F 372		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 372	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined, the facility staff failed to maintain the dumpster area in a sanitary manner. Rubbish and debris were observed on the ground area, exterior to the exterior dumpsters. The findings include: On 11/14/17 at approximately 3:00 p.m., an inspection was conducted of the dumpster area with OSM #5 (Other Staff Member - the dietary manager). The following items were noted on the ground: 2, plastic 4-ounce juice containers, a packet of sugar, a pancake, a ball of tin foil, several pieces of plastic items such as saran wrap and the plastic wrapper from pre-packaged items. On 11/14/17 at 3:10 p.m., in an interview with OSM #5, he stated that the dumpster area is cleaned twice daily, once after breakfast and once after dinner. He stated the dumpster pick-up comes daily. OSM #5 stated as the dumpster pick-up is emptying the dumpsters, items may fall out. When asked if it was possible to check the area each day after the dumpsters are empty to ensure any dropped trash is picked up, he stated, "That's the thing. They come at all hours. We never know when they are going to come." A review of the facility policy, "Dispose of Garbage and Refuge" documented, "1. The	F 372	1. Dumpster area was immediately cleaned on 11/14/17 by the Director of Dietary. 2. Loading dock and dumpster area were thoroughly inspected and cleaned by the Director of Dietary. Schedule for inspection of the dumpster area created to ensure appropriate disposal of garbage. 3. Director of Dietary has re-educated dietary staff regarding proper disposal of garbage and cleanliness of the dumpster area. Maintenance staff has been re-educated regarding proper disposal of garbage and cleanliness of the dumpster area. 4. Dietary staff and Maintenance staff to conduct Quality Monitoring Review of dumpster area based on the created schedule to ensure proper disposal of garbage. Executive Director, or designee, to conduct Quality Review of dumpster area weekly for four weeks, bi-weekly for two weeks, then monthly, to ensure proper disposal of garbage. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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F 372	Continued From page 71 Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris." On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.	F 372		
F 387 SS=E	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, clinical record review, and facility document review, it was determined the facility staff failed to ensure timely physicians visits for seven of 24 residents in the survey sample; Residents #7, #9, #12, #10, #3, #4, and #8. 1. The facility staff failed to ensure Resident #7 was seen by the physician every 30 days for the first 90 days; and failed to ensure on-going visits after the first 90 days, were timely at every 60	F 387	1. Resident #7 has had a physical assessment completed and physician'□s note documented in the medical record on 12/5/17. Resident #9 has had a physical assessment completed and physician'□s note documented in the medical record on 12/5/17.	12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 72 days thereafter. There was a gap of 69 days between the initial admission visit on 1/26/17 and 4/5/17, and a gap of 99 days from the visit on 5/7/17 to the visit of 8/14/17. 2. The facility staff failed to ensure timely physician's visits to Resident #9 every 60 days as required. 3. The facility staff failed to ensure timely physician's visits to Resident #12, every 60 days as required. 4. The facility staff failed to ensure Resident #10 was seen by a physician within a 60-day period between 12/20/16 and 4/29/17, a period of 130 days. 5. The facility staff failed to ensure that Resident #3 was seen by a physician within a 60-day period between 3/14/17 and 6/16/17, a period of 94 days. 6. The facility staff failed to ensure Resident #4 received a physician visit within a 60-day period between 1/15/17 and 5/7/17 a period of 112 days. 7. The facility staff failed to ensure Resident #8 received a physician visit within a 60-day period between 5/4/17 ad 8/27/17 a period of 115 days. The findings include: 1. The facility staff failed to ensure Resident #7 was seen by the physician every 30 days for the first 90 days; and failed to ensure on-going visits after the first 90 days, were timely at every 60 days thereafter. There was a gap of 69 days	F 387	Resident #12 has had a physical assessment completed and physician'□s note documented in the medical record on 12/5/17. Resident #10 has had a physical assessment completed and physician'□s note documented in the medical record on 12/5/17. Resident #3 has had a physical assessment completed and physician□'s note documented in the medical record on 12/5/17. Resident #4 has had a physical assessment completed and physician'□s note documented in the medical record on 12/5/17. Resident #8 no longer resides in the Center. 2. Current residents in the Center were reviewed to ensure each resident has had a timely physician□'s visit documented in the medical record. Follow-up based on findings. 3. Director of Clinical Services, or designee, has re-educated medical records staff on state and federal regulations regarding physician□s' visits. Executive Director and Director of Clinical Services have re-educated physicians on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 73 between the initial admission visit on 1/26/17 and 4/5/17, and a gap of 99 days from the visit on 5/7/17 to the visit of 8/14/17. Resident #7 was admitted to the facility on 1/24/17 with the diagnoses of but not limited to: dementia, subdural hematoma, dysphagia, right wrist and hand fracture, high blood pressure, peripheral vascular disease, and osteoarthritis. Resident #7's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/6/17. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. Resident #7 was coded as requiring total care for transfers, dressing, hygiene, and bathing; supervision for eating; and as incontinent of bowel and bladder. A review of the clinical record revealed the following physician's notes since admission on 1/24/17 to the day of survey, 11/14/17: 1/26/17 4/5/17 5/7/17 8/14/17 9/5/17 There was no evidence Resident #7 was seen by the physician every 30 days for the first 90 days as required. In addition, after the first 90 days, there was no evidence Resident #7 was seen by the physician every 60 days as required. There was no physician's visit for February 2017 or March 2017. There was a gap of 69 days between the initial admission visit of 1/26/17 and 4/5/17. There was a gap of 99 days from the visit of 5/7/17 to the visit of 8/14/17.	F 387	state and federal regulations regarding physician□s' visits. A physician□s visit monitoring schedule was created to track visits. Medical Records staff to report outcome of tracking in Morning Stand Up Meeting for required follow up. 4. Medical Records staff to utilize monitoring schedule weekly to ensure residents are seen by the physician in a timely manner. Areas of concern will be addressed immediately. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 74	F 387		

On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services), ASM #2 stated there were no other physician's visits for this resident (Resident #7).

On 11/15/17 at 8:15 a.m., in an interview with OSM #4 (Other Staff Member, Medical Records), OSM #4 stated the residents are to be seen every 30 days for the first 90, and then every 90 days thereafter (note: regulation requires every 60 days thereafter). OSM #4 stated she is the one responsible for tracking and following physicians visits. She stated she makes a calendar every month for each physician of who they are supposed to see that month. OSM #4 stated many of the physicians don't visit when they are supposed to and when they are called and notified, they say they are too busy, refuse to visit or refuse to write a note if they do visit. OSM #4 stated when they won't come in, the Medical Director is notified, but he won't come in either to see the other physician's residents, and states he is too busy. When asked about her training to ensure compliance with the regulations, OSM #4 stated the DON (Director of Nursing - ASM #2, Director of Clinical Services) educated her on the regulation.

On 11/15/17 at 8:36 a.m., in an interview with ASM #2, she stated OSM #4 has been educated many times on the regulation and should have known visits are required every 60 days, not 90 days, after the first 90 days.

A review of the facility policy, "Medical Care/Standards of Practice" documented, "...A physician supervises the medical care of each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 75	F 387		

resident. Physician supervision includes, but is not limited to: .... The primary attending physician has the responsibility to designate a substitute to be available to attend his/her residents, as necessary, when the attending physician is not available. If either the attending physician or alternate physician cannot be reached, the Medical Director will have the authority to treat.... Physician visits are required according to resident needs and/or State and Federal guidelines.... For short-term care, a physician must see the resident as often as medically necessary according to the medical status of the resident. It is recommended physician visits occur two-three (two to three) times per week.... For long-term care, a physician must see the resident at least once every 30 days for the first 90 days after admission. After 90 days, an alternative schedule of visits, not to exceed 60 days, may be set if the physician justifies in the resident record that the resident's condition does not necessitate visits at 30 day intervals..."

No further information was provided by the end of the survey.

2. The facility staff failed to ensure timely physician's visits to Resident #9 every 60 days as required.

Resident #9 was admitted to the facility on 6/29/16 and readmitted on 10/19/17 with the diagnoses of but not limited to: dementia, chronic obstructive pulmonary disease, thyroid cancer, breast cancer, Parkinson's disease, cataracts, high blood pressure, peripheral vascular disease, borderline personality disorder, and bipolar disorder. Resident #9's most recent MDS (Minimum Data Set) was a quarterly assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 76	F 387		

with an ARD (Assessment Reference Date) of 8/15/17. The resident was coded as being moderately impaired in ability to make daily life decisions. Resident #9 was coded as requiring extensive assistance for dressing, hygiene, and bathing; supervision for transfers, ambulation, and eating; and as continent of bowel and bladder.

A review of Resident #9's clinical record revealed the following physician's visits:
10/30/16 (from the previous survey year, but was used to establish a time frame. Last survey ended 12/1/16.)
5/25/17
11/6/17

There was a gap of 207 days without a physician's visit from 10/30/16 to 5/25/17. Even when utilizing the date of the last survey (12/1/16) instead of the date of the actual physician's visit of 10/30/16, still puts the gap at 175 days. There was also a gap of 165 days between 5/25/17 and 11/6/17 without a physician's visit.

On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services), ASM #2 stated that there were no other physician's visits for this resident (Resident #9).

No further information was provided by the end of the survey.

3. The facility staff failed to ensure timely physician's visits to Resident #12, every 60 days as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 77	F 387		

Resident #12 was admitted to the facility on 3/24/16 and readmitted on 6/21/16 with the diagnoses of but not limited to: atrial fibrillation, heart attack, high blood pressure, cerebral vascular disease, and dementia. Resident #12's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/25/17. The resident was coded as being cognitively intact in ability to make daily life decisions. Resident #12 was coded as requiring extensive care for bathing and transfers; limited assistance for dressing, eating, and hygiene; and as incontinent of bowel and bladder.

A review of Resident #12's clinical record revealed the following physician's visits:
1/6/17
4/10/17
5/7/17
8/12/17
9/5/17

There was a gap of 94 days from 1/6/17 to the 4/19/17 visit; and a gap of 97 days from 5/7/17 to the 8/12/17 visit.

On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services), ASM #2 stated that there were no other physician's visits for Resident #12.

No further information was provided by the end of the survey.

4. The facility staff failed to ensure that Resident #10 was seen by a physician within a 60-day period between 12/20/16 and 4/29/17, a period of 130 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 78	F 387		

Resident #10 was admitted to the facility on 4/6/15 with a readmission on 12/28/15 with diagnoses that included, but were not limited to: anemia, high blood pressure, Alzheimer's and dementia.

Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/17, coded Resident #10 as having a BIMS (brief interview for mental status) score of 0 (zero) out of a possible 15, indicating that Resident #10 was severely cognitively impaired in decisions of activities of daily living.

A review of Resident #10's clinical record did not reveal a physician's visit had occurred between 12/20/16 and 4/29/17, a period of 130 days.

An end of day meeting was held on 11/14/17 at 5:55 p.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware of the above findings. A request was made for any documentation evidencing the physician had seen Resident #10 in between 12/20/16 and 4/29/17. ASM #1 and ASM #2 were asked who was responsible for ensuring timely physician visits. ASM #1 stated the medical records coordinator was responsible.

On 11/15/17 at 8:15 a.m. an interview was conducted with OSM (other staff member) #4, the medical records coordinator. OSM #4 was asked to describe her process for ensuring timely physician visits. OSM #4 stated, "I do a calendar every month for each physician and put it in his/her folder. The calendar shows who is due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 79	F 387		

be seen for that month." OSM #4 was asked what she did if the physician still did not see the resident as needed. OSM #4 stated that she called the physician and sent text message reminders. OSM #4 was asked if the medical director was made aware if the physicians continued to not see the residents within the regulated time frame, OSM #4 stated that he was. OSM #4 was asked what happened when she notified the medical director, OSM #4 stated, "He (the medical director) says he will let the physicians know but that he is too busy to come in. The physician's come and then don't do their notes and (Name of the medical director) refuses to do their notes or see their patients." OSM #4 was asked what she did next. OSM #4 stated, "I go to the director of clinical services and then go to the executive director. Usually they (ASM #1 and ASM #2) can get them to come in. They (the physicians) improve for a little while then back to normal."

On 11/15/17 at 4:50 p.m. an end of day meeting was held with ASM #1 and ASM #2. ASM #1 was asked about the concerns of timely physician visits. ASM #1 stated, "We are aware of the problem and have had some times where the physician visits were not timely. We are working on improving this and have an action plan for quality improvement. The medical records person (OSM #4) does not have a thorough knowledge and has failed to notify the physicians and medical director. There has been a systems breakdown. We have introduced new monitoring and tracking tools."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 80	F 387		

5. The facility staff failed to ensure that Resident #3 was seen by a physician within a 60-day period between 3/14/17 and 6/16/17, a period of 94 days.

Resident #3 was admitted to the facility on 9/4/15 with a readmission on 6/14/17 with diagnoses that included, but were not limited to, bronchitis, chronic pain, chronic respiratory failure, anemia, COPD (chronic obstructive pulmonary disease), and high blood pressure.

Resident #3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/21/17, coded Resident #3 as having a BIMS (brief interview for mental status) of 14 out of a possible 15, indicating that Resident #3 is cognitively intact with activities of daily living.

A review of Resident #3's clinical record revealed Resident #3 had not been seen by a physician between 3/14/71 and 6/16/17, a period of 94 days.

An end of day meeting was held on 11/14/17 at 5:55 p.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services. ASM #1 and ASM #2 were made aware of the above findings and a request was made for any evidence that showed the physician had seen Resident #3 in between 3/14/17 and 6/16/17.

On 11/15/17 at 4:50 p.m. an end of day meeting was held with ASM #1 and ASM #2. ASM #1 was asked about the concerns of timely physician visits. ASM #1 stated, "We are aware of the problem and have had some times where the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 81	F 387		

physician visits were not timely. We are working on improving this and have an action plan for quality improvement. The medical records person (OSM #4) does not have a thorough knowledge and has failed to notify the physicians and medical director. There has been a systems breakdown. We have introduced new monitoring and tracking tools."

No further information was provided by the end of the survey.No further information was provided prior to the end of the survey process.
6. The facility staff failed to ensure Resident #4 received a physician visit within 60 days between 1/15/17 and 5/7/17 a period of 112 days.

Resident #4 was admitted to the facility on 4/3/15 and readmitted on 7/5/17 with diagnoses that included but were not limited to: stroke, diabetes, elevated cholesterol, depression and urinary tract infection.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/16/17 coded Resident #4 as having scored a 15 out of 15 on the BIMS (brief interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. Resident #4 was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the meal tray was prepared.

Review of the clinical record did not evidence documentation that Resident #4 was seen by the physician between 1/15/17 and 5/7/17 a period of 112 days.

On 11/14/17 at 5:55 p.m. a request for any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 82	F 387		

physician visits between 1/15/17 and 5/7/17 was made to ASM (administrative staff member) #2, the director of clinical services.

On 11/15/17 at 7:50 a.m. ASM #2 stated, "We can't find a visit in between January and May. There's a gap."

An interview was conducted on 11/15/17 at 8:15 a.m. with OSM (other staff member) #4, the medical records coordinator. When asked if medical records were responsible for tracking physician visits, OSM #4 stated, "Yes." When asked about the process she followed, OSM #4 stated, "Usually I look at when they (the visits) are due and I put them on the calendar and I do a calendar for each physician and put it in their folder so they can see when they need to do them." When asked what process was followed when the physician did not visit the resident, OSM #4 stated, "We call them and send them a reminder." When asked if the medical director was notified if the physicians did not make their visits, OSM #4 stated, "Right. He says he lets them know (to do the visit). Some come in and refuse to write their notes or don't see the residents." When asked who this was reported to, OSM #4 stated, "I go to (name of director of clinical services) or the administrator (ASM #1, executive director) and they have a meeting with the medical director." When asked if that corrects the issue, OSM #4 stated, "Only for a little while and then it goes back to the way it was." When asked if the medical director would see the patients that were not seen by the other physicians, OSM #4 stated, "No. When we tell him the resident needs to be seen because the other doctor won't come in he says no, he's too busy." When asked why it was important for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 83	F 387		

residents to be seen by the physician, OSM #4 stated, "Because we have patients going to the hospital because they're not seen. To me I think it is about the resident's well-being." When asked how often the residents should be seen by a doctor if the resident was receiving Medicare benefits, OSM #4 stated, "Every month." When asked how often residents should be seen by a doctor if the resident was receiving Medicaid benefits, OSM #4 stated, "Every 90 days (regulation requires a physician visit every 60 days). I know my administrator is always trying to call the office to get them to come in."

An interview was conducted on 11/15/17 at 5:05 p.m. with ASM (administrative staff member) #1, the executive director. When asked about the process for physician visits, ASM #1 stated, "We have been working on a QAPI (quality assurance and performance improvement initiative) project for timely medical visits and the medical records coordinator notifies the physician in a timely manner to ensure it occurs. We've been working on that pretty diligently and we have developed an action plan."

Review of the facility's policy titled, "Medical Care/Standards of Practice" documented, "Policy: Residents will be admitted under the care of a physician of his/her choice provided the physician adheres to applicable federal, state, local regulations, Center policies and procedures. Procedure: Physician visits are required according to resident needs and/or State and Federal guidelines...For long-term care, a physician must see the resident at least once every 30 days for the first 90 days after admission. After 90 days, an alternative schedule of visits, not to exceed 60 days, may be set if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA 22302

(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 84	F 387		

physician justifies in the resident record that the resident's condition does not necessitate visits at 30 day intervals; and if change in the resident's condition warrants, the attending physician is obligated to begin more frequent visits. A physician visit is considered timely if it occurs no later than 10 days after the due the visit was required."

No further information was provided prior to exit.

7. The facility staff failed to ensure that Resident #8 received a physician visit within 60 days between 5/4/17 ad 8/27/17 a period of 115 days.

Resident #8 was admitted to the facility on 4/28/17 and readmitted on 9/28/17 with diagnoses that included but were not limited to: anoxic (1) brain damage, anemia, malnutrition, sepsis (2) and contractures of legs and arms (3).

The most recent MDS, a modified five-day assessment, with an ARD of 10/2/17 coded Resident #8 as having short and long term memory impairment and as being severely impaired cognitively. The resident required extensive assistance from staff for all activities of daily living.

Review of Resident #8's clinical record did not evidence documentation the resident had been seen by the physician between 5/4/17 and 8/27/17, a period of 115 days.

On 11/14/17 at 5:55 p.m. a request for any physician visits between 5/4/17 and 8/27/17 was made to ASM (administrative staff member) #2, the director of clinical services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 85	F 387		

On 11/15/17 at 7:50 a.m. a handwritten note documented the psychiatrist had seen the resident on 5/9/17 and 6/6/17 but there were no attending physician progress notes received.

An interview was conducted on 11/15/17 at 5:05 p.m. with ASM (administrative staff member) #1, the executive director. When asked about the process for physician visits, ASM #1 stated, "We have been working on a QAPI (quality assurance and performance improvement initiative) project for timely medical visits and that the medical records coordinator notifies the physician in a timely manner to ensure it occurs. We've been working on that pretty diligently and we have developed an action plan."

No further information was provided prior to exit.

(1) Anoxia -- hypoxia especially of such severity as to result in permanent damage This information was obtained from: https://www.merriam-webster.com/dictionary/anoxia

(2) Sepsis -- Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. This information was obtained from: https://medlineplus.gov/sepsis.html

(3) Contractures -- Limb contractures are a common impairment in neuromuscular diseases (NMD). They contribute to increased disability due to decreased motor performance, mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 387	Continued From page 86 limitations, reduced functional range of motion, loss of function for activities of daily living (ADL), and increased pain. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482407/	F 387		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 441	Continued From page 87 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain	F 441	1. The catheter drainage bag for Resident #5 was changed and secured. Resident #5'□s catheter drainage bag is	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 441	Continued From page 88 infection control practices with the use of a urinary catheter for one of 24 residents in the survey sample; Resident #5. The facility staff failed to maintain Resident #5's urinary catheter in a sanitary manner. The findings include: Resident #5 was admitted to the facility on 1/23/17 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), urinary frequency, high blood pressure, congestive heart failure, and anxiety disorder. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/2/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance from one to two staff members with most ADLS (activities of daily living). Resident #5 was coded as requiring limited assistance with meals from one staff member. Review of Resident #5's most recent POS (physician order sheet) dated 10/31/17, documented the following order: "Foley Catheter #16 Fr (french)/10 ml (milliliters) for retention." On 11/13/17 at 2:47 p.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor.	F 441	maintained below the bladder with no contact with the floor. 2. Current residents in the Center with an indwelling catheter were reviewed. The drainage bags were changed and properly secured below the bladder and not touching the floor. 3. Director of Clinical Services, or designee, has re-educated Nursing Staff about appropriate placement of indwelling catheter drainage bags to ensure proper drainage in accordance with infection control guidelines. 4. Director of Clinical Services, or designee, to conduct Quality Monitoring Review weekly for four weeks, bi-weekly for two weeks, and then monthly, to ensure indwelling catheter drainage bags are secured properly and maintained following infection control standards. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 441	Continued From page 89	F 441		

On 11/13/17 at 3:40 p.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor.

On 11/14/17 at 7:46 a.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the left side of the bed. The bottom of the Foley bag was touching the floor.

On 11/14/17 at 9:00 a.m., an observation was made of Resident #5. Her bed was in a low position. Her Foley catheter bag was hanging from the bed frame on the right side of the bed. The bottom of the Foley bag was touching the floor.

On 11/14/17 at 2:50 p.m., an observation was made of Resident #5. Her bed was slightly higher than before. Her Foley catheter was hanging from the bed frame and not in contact with the floor.

Review of Resident #5's comprehensive care plan dated 8/9/17 documented the following: "(Name of Resident #5) has the potential for infection r/t (related to) -indwelling Foley catheter: 16 Fr. (french) 10 cc (cubic centimeter). Goal: (Name of Resident #5) will decrease potential for infection due to F/C (Foley catheter) through next review date. Interventions: Change Foley Catheter per MD's (medical doctors) order, Encourage PO (by mouth) fluid intake, Foley catheter per md (sic) order, labs as ordered, Monitor for infection: urine odor, urine color, urine

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 90 sediments, monitor temperature PRN (as needed)." On 11/14/17 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #5's nurse. When asked how a resident's catheter should be maintained while a resident is in bed, LPN #1 stated the catheter should hang from the bed frame below the level of the bladder. When asked if the catheter should ever touch the floor, LPN #1 stated it should not. When asked if she had been in Resident #5's room during the 7-3 shift, LPN #1 stated she had. When asked if she had noticed anything about Resident #5's catheter, LPN #1 stated she did not. CNA (certified nursing assistant) #1, Resident #5's CNA interjected and stated Resident #5's Foley catheter was touching the ground during the morning hours because her bed was in the lowest position. CNA #1 stated she had fixed Resident #5's bed after AM (morning) care. When CNA #1 was asked why the Foley catheter should not be touching the floor, CNA #1 stated it was an infection control issue. On 11/14/17 at 5:57 p.m., ASM (administrative staff member) #1, the Executive Director, and ASM #2, the Director of Clinical Services were made aware of the above concerns. The facility policy titled, "Catheter Care, Urinary" did not address the above concerns. No further information was presented prior to exit.	F 441		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i)	F 504		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 504	Continued From page 91 (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff obtained a laboratory test without a physician's order for one of 24 residents in the survey sample; Resident #12. The facility staff obtained a PT/INR laboratory test for Resident #12, when it was not ordered or scheduled to be obtained. The findings include: Resident #12 was admitted to the facility on 3/24/16 and readmitted on 6/21/16 with the diagnoses of but not limited to: atrial fibrillation, heart attack, high blood pressure, cerebral vascular disease, and dementia. Resident #12's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/25/17. Resident #12 was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing and transfers; limited assistance for dressing, eating, and hygiene; and as incontinent of bowel and bladder. A review of the clinical record revealed a	F 504	1. Resident #12'□s physician was made aware of PT/INR obtained on 8/1/17 without a physician's order. Physician provided a physician'□s order for authorization for lab work. Resident #12 did not experience an adverse effect related to PT/INR obtained without physician'□s order. Resident #12□'s physician'□s orders for lab work are currently being followed as ordered. 2. Current Center resident□s' physician□s' orders for labs in the past 30 days were reviewed to ensure labs were obtained as ordered by the physician. Physicians were notified of any labs that were obtained without orders. 3. Director of Clinical Services, or designee, has re-educated licensed nurses on the lab process and verifying that there are current physician□s' orders for all lab work that is obtained. Labs and physicians' orders for labs reviewed in Morning Clinical Meeting.	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 504	Continued From page 92 physician's order dated 6/27/17 for a PT/INR [1] every 2 weeks on Tuesdays. A review of the laboratory (lab) results filed in Resident #12's clinical record revealed a result for a PT/INR dated 8/1/17, which, when calculated from 6/27/17, was on the opposing week of the ordered 2-week schedule, and for which there was not a separate order to obtain this lab on this date, in addition to the routine scheduled 2-week lab draw. On 11/14/17 at approximately 1:00 P.M., in an interview with ASM #2 (Administrative Staff Member, the Director of Clinical Services), she was notified of the above lab result without a physician's order and asked if there may be an order located in the thinned record. On 11/14/17 at approximately 3:00 p.m., ASM #2 stated there wasn't an order for it. A review of the facility policy "Laboratory, Diagnostic and X-Ray" documented, ".... Obtain a physician's order for laboratory work, diagnostic testing, and x-ray." On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 were made aware of the findings. No further information was provided by the end of the survey. [1] PT and INR are used to monitor the effectiveness of the anticoagulant medication Warfarin. Information obtained from https://labtestsonline.org/understanding/analytes/pt/tab/test	F 504	4. The Director of Clinical Services, or designee, will complete Quality Monitoring Review of residents' lab orders to ensure the labs obtained have physician□s' orders weekly for four weeks, then bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 514	Continued From page 93	F 514		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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:	F 514		12/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 94 Based on staff interview, clinical record review, and complaint investigation, it was determined the facility staff failed to maintain a complete and accurate medical record for two of 24 residents in the survey sample, Resident #8 and Resident #7. 1. The facility staff failed to document that Resident #8 had a bruise on the left thigh. 2. The facility staff failed to document Resident #7's blood pressures obtained prior to administering blood pressure medication, in the clinical record. The findings include: 1. Resident #8 was admitted to the facility on 4/28/17 and readmitted on 9/28/17 with diagnoses that included but were not limited to: anoxic (1) brain damage, anemia, malnutrition, sepsis (2) and contractures of legs and arms (3). The most recent MDS, a modified five-day assessment, with an ARD of 10/2/17 coded Resident #8 as having short and long term memory impairment and as being severely impaired cognitively. The resident was coded as requiring extensive assistance from staff for all activities of daily living. Review of the physician orders dated 9/29/17 documented, "MONITOR BRUISE ON LEFT THIGH EVERY SHIFT UNTIL RESOLVED." Review of the nurse's admission assessment dated 9/29/17 did not evidence documentation of the left thigh bruise. Review of the nurse's notes dated 9/29/17 at 3:00	F 514	1. Resident #8 no longer resides in the Center. The nurse who completed the admission assessment was re-educated about documenting all skin issues accurately on admission. Resident #7'□s Medication Administration Record (MAR) for the month of November is complete with blood pressure (BP) readings daily prior to the administration of Verapamil. Resident #7 has had no events related to her blood pressure readings or Verapamil administration. Licensed nursing staff assigned to provide care within the last 30 days were re-educated on obtaining BPs as indicated and following blood pressure parameters regarding Resident #7. 2. New admissions to the Center since survey exit (11/15/17) were reviewed for accuracy, with focus on complete documentation of skin assessment. Physician□s orders for residents currently residing in the Center have been reviewed for documentation of ordered parameters for medication administration. Follow-up based on findings. 3. Director of Clinical Services, or designee, has re-educated Licensed nursing staff regarding accurate documentation of skin impairment on admission and appropriate documentation of parameters related to medication administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 95 p.m. did not evidence documentation of the left thigh bruise. Review of the September 2017 TAR (treatment administration record) documented, "MONITOR BRUISE ON LEFT THIGH EVERY SHIFT UNTIL RESOLVED. 09/29/17." There was documentation that the bruise had been monitored from 9/29/17 through 9/30/17. Review of the October 2017 TAR (treatment administration record) documented, "MONITOR BRUISE ON LEFT THIGH EVERY SHIFT UNTIL RESOLVED. 09/29/17." There was documentation that the bruise had been monitored each shift during October 2017. Review of the November 2017 TAR documented, "MONITOR BRUISE ON LEFT THIGH EVERY SHIFT UNTIL RESOLVED. 09/29/17." There was documentation that the bruise had monitored each shift until it had resolved on 11/8/17. An interview was conducted on 11/15/17 at 4:45 p.m. with ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services. When asked why staff monitored bruises, ASM #2 stated, "To make sure it's not an injury of unknown origin." When asked about Resident #8's left thigh bruise, ASM #2 stated the bruise had been present on the 9/28/17 admission. ASM #2 stated, "We know it was present on admission because it's on the doctor's admission order sheet. It wasn't on the skin assessment but it was on the (September) TAR to be monitoring it for any changes." When asked the process staff followed if a resident presented with a bruise, ASM #2 stated, "I expect the nurse to document that bruise. You want to document	F 514	4. The Director of Clinical Services, or designee, will complete Quality Monitoring Review of new resident□s' admission assessment weekly for four weeks, bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings. The Director of Clinical Services, or designee, to complete Quality Monitoring Review to ensure any physician ordered parameters are followed and accurately documented in the clinical record weekly for four weeks, bi-weekly for two weeks, then monthly. Follow-up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 96 any skin impairment on admission. If you don't document it, you own it." ASM #1 and ASM #2 were made aware of the findings at that time. The nurse who had completed the admission documentation was not available for interview. No further information was provided prior to exit. Complaint Deficiency (1) Anoxia -- hypoxia especially of such severity as to result in permanent damage This information was obtained from: https://www.merriam-webster.com/dictionary/anoxia (2) Sepsis -- Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. This information was obtained from: https://medlineplus.gov/sepsis.html (3) Contractures -- Limb contractures are a common impairment in neuromuscular diseases (NMD). They contribute to increased disability due to decreased motor performance, mobility limitations, reduced functional range of motion, loss of function for activities of daily living (ADL), and increased pain. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482407/	F 514	F 515 = D Retention of Medical Records 1. Resident #6 no longer resides in the Center. RN #2 was re-educated about retaining all documentation as part of the medical record. 2. Current Center residents on 15 minute safety checks were reviewed to evaluate appropriateness of safety checks and complete retention of documentation. Follow up based on findings of review. 3. Director of Clinical Services, or designee, has re-educated Administrative staff and Licensed Nursing staff about retaining all documentation pertaining to residents as part of their medical record. 4. The Director of Clinical Services, or designee, to complete Quality Monitoring Review to ensure resident safety checks are retained in resident□s medical record weekly for four weeks, then bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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	495203	A. BUILDING _____ B. WING _____	C 11/15/2017

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F 514	Continued From page 97	F 514		

2. The facility staff failed to document Resident #7's blood pressures obtained prior to administering blood pressure medication, in the clinical record.

Resident #7 was admitted to the facility on 1/24/17 with the diagnoses of but not limited to: dementia, subdural hematoma, dysphagia, right wrist and hand fracture, high blood pressure, peripheral vascular disease, and osteoarthritis. Resident #7's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/6/17. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. Resident #7 was coded as requiring total care for transfers, dressing, hygiene, and bathing; supervision for eating; and as incontinent of bowel and bladder.

A review of Resident #7's clinical record revealed a physician order dated 1/24/17 for Verapamil [1] 120 mg (milligrams) every day for hypertension (high blood pressure) - hold for systolic (top number of a blood pressure reading) BP (blood pressure) less than 110.

A review of Resident #7's MAR's (Medication Administration Record) for August 2017, September 2017, and October 2017 failed to reveal any evidence Resident #7's blood pressures were obtained with the daily administration of Verapamil. Further review of the clinical record failed to reveal any evidence of daily blood pressures being documented anywhere else, in correlation with the

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F 514	Continued From page 98 administration of the Verapamil. On 11/14/17 at 10:04 a.m., an interview was conducted with LPN #6 (Licensed Practical Nurse). LPN #6 stated she was the main nurse that administers Resident #7's medication every day. LPN #6 stated she does take Resident #7's blood pressure prior to administering the Verapamil and writes it down on a plain piece of paper. She stated the piece of paper was not part of the clinical record. When asked how anyone could review Resident #7's clinical record and know if the medication should have been held or not, LPN #6 stated they can't. On 11/14/17 at 2:45 p.m., in an interview with ASM #2 (Administrative Staff Member) the Director of Clinical Services, ASM #2 stated if the blood pressures were not documented, then it cannot be validated that they were obtained prior to giving the medication. On 11/14/17 at 6:01 p.m., during the end of day meeting with ASM #1 (Administrative Staff Member, the Executive Director) and ASM #2 (the Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. [1] Verapamil is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a684030.html	F 514		
F 515 SS=D	RETENTION OF RESIDENT CLINICAL RECORDS	F 515		12/22/17

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F 515	Continued From page 99 CFR(s): 483.70(i)(4)(i)-(iii) (i) Medical records. (4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined that facility staff failed to retain medical records for one of 24 residents in the survey sample, Resident #6. The facility staff failed to maintain the integrity of Resident #6's medical record and shredded four months' worth of 15-minute safety check documentation. The findings include: Resident #6 was admitted to the facility on 7/28/27 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease), difficulty swallowing, underactive thyroid, schizophrenia, anxiety disorder, heart disease, high blood pressure, type two diabetes, and anemia. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/10/2017. Resident #6 was coded as being cognitively intact in the ability to make daily	F 515	1. Resident #6 no longer resides in the Center. RN #2 was re-educated about retaining all documentation as part of the medical record. 2. Current Center residents on 15 minute safety checks were reviewed to evaluate appropriateness of safety checks and complete retention of documentation. Follow-up based on findings of review. 3. The Director of Clinical Services, or designee, has re-educated Administrative staff and Licensed Nursing staff about retaining all documentation pertaining to residents as part of their medical record. 4. The Director of Clinical Services, or designee, to complete Quality Monitoring Review to ensure resident safety checks are retained in resident□s' medical record	

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F 515	Continued From page 100 decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring supervision only with all ADLs (activities of daily living). Review of Resident #6's nursing notes revealed the following note dated 8/26/17 at 11:45 p.m., "This writer on way to facility when received call stating resident wanted to "go home." When arrived resident stated that he wanted to get a cab and go home to Rockville. Resident stated he needed to go home to get money and clothes. Writer explained that he has money in his facility account if he needed it. Resident stated that he wanted to go with the cab driver to get his stuff. Writer able to speak with resident to have him remain at facility. Q (every) 15 minute checks initiated to ensure resident's safety..." Review of Resident #6's elopement care plan dated 8/26/17 documented the following: (Name of Resident #6) is at risk for elopement. Goal: (Name of Resident #6) will have decrease potential for elopement through next review date. Interventions: Encourage frequent family visits/involvement. Every 15-minute checks by staff." Review of Resident #6's nursing notes revealed that nursing staff were doing 15-minute checks from 8/26/17 through 8/31/17. Review of Resident #6's clinical record revealed 15-minute check worksheets completed for 11/6/17 and 11/7/17. No further documentation of 15-minute checks could be found in the clinical record.	F 515	weekly for four weeks, bi-weekly for two weeks, then monthly. Follow up based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule to be modified based on findings.	

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F 515	Continued From page 101	F 515		

On 11/14/17 at 5:07 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #6's nurse. When asked why a resident would be placed on 15-minute checks, LPN #2 stated a resident would be placed on 15 minute checks for safety. LPN #2 stated a resident would be placed on checks if they have a history of falls or elopement. When asked if Resident #6 was on 15-minute checks, LPN #2 stated he was on 15-minute checks for falls and elopement. LPN #2 stated Resident #6 was initially placed on 15-minute checks a few months ago because he was going outside in the middle of the night. "He always tries to be independent." LPN #2 was asked if he worked the night Resident #6 left the building, LPN #2 stated he does not work night shift. LPN #2 stated Resident #6 was a "sneaky man" he tries to leave the unit when nurses are passing out medications. LPN #2 stated at one-point Resident #6 had a wanderguard in place, but the resident kept removing it himself. When asked where 15-minute checks were documented, LPN #2 stated that 15-minute checks were documented on a separate form that were kept on the medication cart. When asked if he had been doing 15-minute checks on Resident #6, LPN #2 stated he had. This writer asked LPN #2 to evidence his documentation.

On 11/4/17 at 5:10 p.m., this writer followed LPN #2 to view the documentation of 15-minute checks for 11/14/17. LPN #2 revealed 15-min check sheets for 11/12/17, 11/13/17, and 11/14/17. No other sheets with 15-minute checks were on the medication cart. When asked where the other 15-minute check sheets were kept, LPN #2 stated, "We keep them in this book, and then the unit managers take them out and puts them on the record." Review of Resident #6's clinical

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F 515	Continued From page 102	F 515		

record with LPN #2 revealed no evidence of the other 15-minute check sheets. LPN #2 stated, "I filled out the sheet for today. I don't know what happens after I fill out the form."

On 11/4/17 at 5:20 p.m., an interview was conducted with ASM (administrative staff member) #2, the Regional Director of Clinical Services. When asked what 15-minute checks were used for, ASM #2 stated that 15-minute checks were used to ensure safety for people who have a history of elopement. When asked why Resident #6 was on 15-minute checks, ASM #2 stated 15-minute checks were initiated when Resident #6 tried to elope on 8/26/17 and tried to get a cab driver to take him to his old home. The cab driver did not take him because Resident #6 did not have cash up front. ASM #2 stated Resident #6 tried to leave in the middle of the night. ASM #2 stated Resident #6 was not considered a risk for elopement prior to this incident because his BIMS score was 13. ASM #2 stated the facility tried to initiate a wanderguard after the incident, but the resident kept taking off his wanderguard stating he was not a prisoner. When asked where the 15-minute checks from August 2017 through November 2017 are located, ASM #2 stated she had talked to the unit two manager and had just found out the unit two manager had destroyed all of the other 15-minute check documentation. ASM #2 stated the unit manager keeps a day or two in the MAR and shreds all old 15-minute checks. When asked if the 15-minute checks were part of the clinical record, ASM #2 stated that they are. When asked if it was ever ok to destroy any documentation in the clinical record, ASM #2 stated it was never ok.

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F 515	Continued From page 103 On 11/14/17 at 5:57 p.m., at the end of day meeting, it was requested to speak with the unit two manager. On 11/15/17 at 11:04 a.m., an interview was conducted with RN (registered nurse) #2, the unit two manager. When asked if 15- minute check documentation was part of the clinical record, RN #2 stated, "We keep it in the MAR, we get rid of them after some time." RN #2 stated she thought she was supposed to shred old 15-minute check documentation. RN #2 could not determine if 15-minute checks were a part of the resident's clinical record. On 11/15/17 at 5:57 p.m., ASM #1, the Executive Director, and ASM #2, the Regional Director of Clinical Services were made aware of the above concerns. No further information was presented prior to exit.	F 515		