DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	C 07/07/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 7/6/17 through 7/7/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 84 certified bed facility was 75 at the time of the survey. The survey sample consisted of three current resident reviews (Residents 1 through 3).	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of three residents in the survey sample, Resident #2. The facility staff failed to transcribe Resident #2's physician's orders for sacral (1) wound care dated 6/21/17 and 6/28/17 onto the June 2017 TAR (treatment administration record) The findings include: Resident #2 was admitted to the facility on 8/31/16. Resident #2's diagnoses included but	F 281	1. Resident #2 wound orders and wound physician recommendation were clarified, physician clarification order received and physician order wound treatment updated and rewritten on the Treatment Administration Records(TARs)	July 26, 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles E Phillips Jr. | TITLE: ED | (X6) DATE: 7-25-17

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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were not limited to: diabetes, high blood pressure and paraplegia (2). Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/7/17, coded the resident as being cognitively intact.

Review of Resident #2's clinical record revealed a physician's order dated 6/21/17 that documented, "Sacral wdx (wound treatment): Clean (with) NS, pat dry; apply collagen (3) dsg (dressing), calcium alginate (4), cover (with) foam dsg Q (every) day & prn (as needed)." Another physician's order dated 6/28/17 documented, "D/C previous sacrum orders. Sacrum Cleanse (with) hibiclens (5) 3 x (times) a week; apply collagen & cover (with) DD (dry dressing). Sacrums (sic) cleanse (with) normal saline 4 x a week; apply collagen & cover (with) DD."

Resident #2's June 2017 TAR failed to document the above orders dated 6/21/17 and 6/28/17.

On 7/7/17 at 12:10 p.m. an interview was conducted with RN (registered nurse) #1. RN #1 was asked what process was in place to ensure nurses completed treatment orders. RN #1 stated, "I wound say on the TAR. That is where I go to find out what treatments I need to do." RN #1 stated the night shift nurses are supposed to complete chart checks every night and for every chart but were not doing so. RN #1 stated orders were getting missed being transcribed onto the TARs because the nurses were not completing the chart checks.

On 7/7/17 at 12:25 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made

2. DCS/designee completed a quality review on current Residents with wounds for physician orders. Physician orders for wound treatments clarified as indicated with wound physician, new physician clarification orders written as indicated and transcribed on the TAR.

3. Director of Clinical Services (DCS) /designee met with wound physician and discussed plan to ensure recommendations are followed through to telephone orders.

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aware of the above concern. ASM #2 was asked what standard of practice the facility followed regarding transcription. ASM #2 stated the facility staff follows the facility policies.

The facility policy titled, "Physician Orders" documented, "A Clinical Nurse may accept a telephone order from the physician only or Physician Assistant or Nurse Practitioner...The order must then be transcribed to all appropriate areas (MAR (medication administration record), TAR, etc...)

No further information was presented prior to exit.

(1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis..." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(2) "Paralysis of the lower half of your body, including both legs, is called paraplegia." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=paraplegia&_ga=2.165315772.246107152.1499704680-139120270.1477942321

(3) Collagen dressings are used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3601889/

(4) Calcium Alginate is a dressing used to treat wounds. This information was obtained from the website:

Using the 24 Hour chart check process orders to be checked for accurate transcription. DCS/designee provided re-education to the licensed nursing staff on policy and procedure for transcribing physician orders & chart check procedure to ensure physician orders are being transcribed correctly & documentation on the 24 hour report sheet of any new orders.

Physician orders to be reviewed in Daily Clinical meeting. Wound doctor recommendations and wound orders to be reviewed weekly after wound physician visit to ensure orders match the recommendations as well as reviewed weekly in Weekly Clinical Meeting.

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https://www.ncbi.nlm.nih.gov/pubmed/8954425

(5) Hibiclens (chlorhexidine) is an antiseptic antibacterial agent used to clean the skin. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009564/?report=details

F 309 SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

4. The Director of Clinical Services or designee to conduct Quality Monitoring 3 times per week for 4 weeks on each shift to ensure compliance with wound treatment orders then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule to be modified based on finding of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations

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F 281	Continued From page 3 https://www.ncbi.nlm.nih.gov/pubmed/8954425 (5) Hibiclens (chlorhexidine) is an antiseptic antibacterial agent used to clean the skin. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009564/?report=details	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309	1. Resident #3 wound orders and wound physician recommendation were clarified, physician clarification order received and physician order wound treatment updated and rewritten on the Treatment Administration Records(TARs)	uly 26, 2017

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(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a resident's highest level of well-being for one of three residents in the survey sample, Resident #3.

The facility staff failed to change Resident #3's wound care treatment as recommended by the wound care physician on 6/7/17. The change in treatment was not implemented until 6/14/17.

The findings include:

Resident #3 was admitted to the facility on 5/20/17. Resident #3's diagnoses included but were not limited to: diabetes, seizures and acute kidney failure. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/30/17, coded the resident as being cognitively intact. Section M documented Resident #3 presented with one venous and arterial ulcer.

Review of Resident #3's clinical record revealed a wound care specialist evaluation signed by the wound care physician on 6/7/17. The evaluation documented, "Assessment And Plan Of Care Recommendations: VENOUS WOUND OF THE LEFT CALF (1)...Discontinue: Zinc Ointment (2) - Once Daily. Continue: Dry Protective Dressing- Once Daily. Add: Calcium Alginate (3) - Once

F 309

2. DCS/designee completed a quality review on current Residents with wounds for physician orders. Physician orders for wound treatments clarified as indicated with wound physician, new physician clarification orders written as indicated and transcribed on the TAR.

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F 309	Continued From page 5	F 309	3. Director of Clinical Services/designee met with wound physician and discussed plan to ensure recommendations are followed through to telephone orders. Using the 24 Hour chart check process orders to be checked for accurate transcription. DCS/designee provided re-education to the licensed on policy and procedure for transcribing physician orders & chart check procedure to ensure orders are being transcribed correctly & documentation on the 24 hour report sheet of any new orders.	

Daily..." The recommendation was not implemented until 6/14/17. An order dated 6/14/17 documented, "D/C (Discontinue) previous wound orders to left calf. Cleanse left calf wound (with) NS (normal saline), apply calcium alginate & cover (with) a dry protective drsg (dressing) once daily."

Resident #3's June 2017 TAR (treatment administration record) documented, "5-25-17 Venous Wound L (left) calf: Apply zinc ointment qd (every day) & prn (as needed). Cover with a dry protective Drsg (dressing)." The treatment was signed off as being performed through 6/14/17. The TAR further documented, "6/14/17 Left calf- cleanse (with) Normal saline, apply Calcium alginate cover (with) DD (dry dressing) QD (every day)."

Resident #3's comprehensive care plan initiated on 6/9/17 documented, "The resident has the potential for and impaired skin integrity r/t (related to) Disease process-Venous Medications Left calf Left calf rash...Interventions: Administer medications as ordered..."

On 7/6/17 at 11:05 a.m., an interview was conducted with RN (registered nurse) #1 (the unit manager). RN #1 stated a nurse conducts rounds with the wound care physician every week but the same nurse doesn't always conduct the rounds. RN #1 stated usually she, the assistant director of clinical services or a particular staff nurse conducts rounds. When asked about the facility process for ensuring the wound care physician's recommendations are implemented, RN #1 stated the wound care physician makes recommendations and dictates her notes then the director of clinical services prints out the

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recommendations and nurses write the orders based on the recommendations. RN #1 was asked if nurses always follow the wound care physician's recommendations. RN #1 stated, "I would say yes. If we had a question we wound call but she (the wound care physician) gives the orders." RN #1 was asked why the wound care physician's recommendation noted on 6/7/17 for Resident #3 was not implemented until 6/14/17. RN #1 stated, "Unfortunately I can't answer. I don't know if it got overlooked. I don't have an answer." RN #1 stated the nurse that rounded with the wound care physician on 6/7/17 no longer worked at the facility. RN #1 was asked if the 6/7/17 recommendation should have been written on an order sheet and implemented that same day. RN #1 stated, "Yes." RN #1 stated sometimes the wound care physician verbalizes a different recommendation than the recommendation she writes in her notes. RN #1 stated she reads the wound care physician's documented recommendations after the director of clinical services prints out the notes. RN #1 was asked what should happen if the wound care recommendation documented in the note is different than the recommendation the wound care physician verbalizes. RN #1 stated, "She (the wound care physician) needs to be called."

On 7/6/17 at approximately 2:40 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services). ASM #2 stated she talked to the nurse who rounded with the wound care physician on 6/7/17. ASM #2 stated after the wound care physician assessed residents' wounds she would tell that nurse new verbal orders and if she was going to change treatment or keep the same treatment. ASM #2 stated the nurse remembered the wound

Physician orders to be reviewed daily in Daily Clinical meeting. Wound doctor recommendations and wound orders to be reviewed weekly after wound physician visit to ensure orders match the recommendations as well as in Weekly Clinical Meeting..

4. The Director of Clinical Services or designee to conduct Quality Monitoring 3 times per week for 4 weeks on each shift to ensure compliance with wound treatment orders then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality

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F 309	Continued From page 7	F 309	Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations	

care physician said to continue the current treatment for Resident #3 on 6/7/17. ASM #2 stated the wound care physician stopped by the facility on this day (7/6/17) and stated she probably did tell the nurse to keep the same treatment on 6/7/17 but changed her mind when she dictated her note. ASM #2 was asked what the facility process was for ensuring the recommendations dictated in the wound care physician's notes are implemented. ASM #2 stated she receives the wound care physician's dictated notes the same day the notes are dictated. ASM #2 stated she prints off the notes and gives them to the treatment nurse who rounded with the wound care physician. ASM #2 stated the treatment nurse is supposed to look at the written recommendation and write an order to change the treatment as recommended. ASM #2 was asked what should happen if the dictated recommendation is different than the verbal recommendation given during rounds. ASM #2 stated, "There should be clarification."

On 7/6/17 at 3:15 p.m., a telephone interview was conducted with ASM #4 (the wound care physician). ASM #4 stated sometimes she verbalizes different recommendations than the recommendations she documents in her notes. ASM #4 stated if the nurses ever have a question they can reach out and call her. ASM #4 stated the nurses are good about calling her. ASM #4 stated it's not fair to the nurses when she says one thing and writes another in her note. ASM #4 stated sometimes the computer may not capture her change or she puts the recommendation in the computer wrong. ASM #4 was asked if the recommendations written in her notes or if the treatment orders written should be followed. ASM #4 stated, "I want to say my note is more

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accurate but they are doing what they are supposed to. The wounds are improving."

On 7/6/17 at 4:30 p.m. another telephone interview was conducted with ASM #4. ASM #4 was asked if she wanted staff to discontinue zinc and add calcium alginate to Resident #3's treatment on 6/7/17 as recommended in her note. ASM #4 stated, "They were doing the alginate. I don't know why it wasn't on the TAR." When asked if she wanted staff to add calcium alginate on 6/7/17, ASM #4 stated Resident #3's wound wasn't drying and she was making the change to calcium alginate because it dries the wound out a little better than zinc.

On 7/6/17 at 5:15 p.m., ASM #1 (the executive director) and ASM #2 were made aware of the above concern.

On 7/7/17 at 9:47 a.m., an interview was conducted with ASM #3 (Resident #3's attending physician). ASM #3 stated nurses follow the wound care physician's recommendations and transcribes her recommendations onto the order forms. ASM #3 stated he will oversee a wound concern if the nurses can't get in touch with the wound care physician but other than that, he doesn't follow wounds. ASM #3 stated he has delegated wound care order decisions to the wound care physician and he doesn't have to "okay" each order.

On 7/7/17 at 12:10 p.m. an interview was conducted with RN #1. RN #1 was asked what process was in place to ensure nurses completed treatment orders. RN #1 stated, "I wound say on the TAR. That is where I go to find out what treatments I need to do."

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The facility policy titled, "Medical Consolations (sic)" documented, "Policy: Members of the medical staff will request a medical consultation when appropriate. Procedure: The member of the medical staff requesting a consultation will order the consultation and a Request For Consultation will be initiated by nursing to the consulting physician. The consultant will be qualified in the field in which the opinion is sought. The consultation will include the examination of the resident and the medical record. The consultant physician will complete the 'Report' section of the Request For Consultation or its equivalent.
Findings: Information gathered from examination.
Diagnosis: The resultant diagnosis per findings.
Recommendations: The plan of care recommended
Signature: Consultant physician's signature.
Upon completion of the consultation the charge nurse will notify the attending physician that the consult is complete and obtain any changes in plan of care or medications recommended by the consulting physician. The attending will need to note in his re-certification notes that consultation occurred and the outcome of this..."

No further information was presented prior to exit.

(1) "Venous leg ulceration is due to sustained venous hypertension, which results from chronic venous insufficiency. In the normal venous system, pressure decreases with exercise as a result of the action of the calf muscle pump. When the muscles relax, the valves in the perforating veins connecting the superficial to the deep venous circulation prevent reflux and the pressure remains low. The venous pressure

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F 309	Continued From page 10 remains high, however, in a system where the valves are incompetent" This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1363917/ (2) "ZINC OXIDE is a mild astringent and topical protectant with some antiseptic action. It is also used in bandages, pastes, ointments, dental cements, and as a sunblock." This information was obtained from the website: https://pubchem.ncbi.nlm.nih.gov/compound/zinc_oxide#section=Top (3) Calcium Alginate is a dressing used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/8954425	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 314	1. Resident #2 wound orders and wound physician recommendation were clarified, physician clarification order received and physician order wound treatment updated and rewritten on the Treatment Administration Records(TARs)	July 26, 2017

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F 314	Continued From page 11	F 314	2. DCS/designee completed a quality review on current Residents with wounds for physician orders. Physician orders for wound treatments clarified as indicated with wound physician, new physician clarification orders written as indicated and transcribed on the TAR.	

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the recommended pressure injury treatment for one of three residents in the survey sample, Resident #2.

The facility staff failed to provide Resident #2 left ischium (1) treatment as recommended by the wound care physician from 5/17/17 through 6/21/17. The facility staff also failed to provide Resident #2 right ischium treatment as recommended by the wound care physician from 5/17/17 through 7/5/17 and failed to provide Resident #2 sacrum (2) treatment as recommended by the wound care physician from 5/17/17 through 6/30/17.

The findings include:

Resident #2 was admitted to the facility on 8/31/16. Resident #2's diagnoses included but were not limited to: diabetes, high blood pressure and paraplegia (3). Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/7/17, coded the resident as being cognitively intact. Section M documented Resident #2 presented with two stage four pressure ulcers (4) and one unstageable pressure ulcer (4).

Review of Resident #2's clinical record revealed a wound care specialist evaluation signed by the wound care physician on 5/17/17. The evaluation documented, "STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM. Discontinue: Collagen Dressing (5) - Once Daily. Continue Calcium

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Alginate (6) - Once Daily, Foam- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 5/24/17 documented, "STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM. Continue: Calcium Alginate- Once Daily, Foam- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 5/31/17 documented, "STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM- IMPROVED EVIDENCED BY DECREASED SURFACE AREA, DECREASED DEPTH. Continue: Calcium Alginate- Once Daily, Foam- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/7/17 documented, "STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM. Continue: Calcium Alginate- Once Daily, Foam- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/21/17 documented, "STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM- IMPROVED EVIDENCED BY DECREASED NECROTIC TISSUE, INCREASED GRANULATION...Continue: Calcium Alginate- Once Daily, Foam- Once Daily..."

Further review of Resident #2's clinical record failed to reveal a physician's order for treatment to the left ischium from 5/17/17 until 6/21/17. A physician's order dated 6/21/17 documented, "Left ischium wound cleanse (with) NS (normal saline), apply calcium alginate, cover (with) foam dsg (dressing) q (every) day & prn (as needed)."

Resident #2's May 2017 and June 2017 TARs

3. Director of Clinical Services/designee met with wound physician and discussed plan to ensure recommendations are followed through to telephone orders. Using the 24 Hour chart check process orders to be checked for accurate transcription. DCS/designee provided re-education to the licensed nursing staff on policy and procedure for transcribing physician orders & chart check procedure to ensure physician orders are being transcribed correctly & documentation on the 24 hour report sheet of Provided education to the nursing staff on policy and procedure for transcribing physician orders & chart check procedure to ensure orders are being transcribed correctly & documentation on the 24 hour report sheet of any new orders.

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(treatment administration records) failed to document a treatment was provided for the left ischium from 5/17/17 until 6/21/17.

A wound care specialist evaluation signed by the wound care physician on 5/17/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT ISCHIUM. Discontinue: Collagen Dressing- Once Daily. Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 5/24/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT ISCHIUM. Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 5/31/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT ISCHIUM. Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/7/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT ISCHIUM. Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/21/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT ISCHIUM- IMPROVED EVIDENCED BY DECREASED DEPTH...Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/28/17 documented, "UNSTAGEABLE (DUE TO NECROSIS) OF THE

Physician orders to be reviewed in Daily Clinical meeting. Wound doctor recommendations and wound orders to be reviewed weekly after wound physician visit to ensure orders match the recommendations as well as in Weekly Clinical Meeting.

4. The Director of Clinical Services or designee to conduct Quality Monitoring 3 times per week for 4 weeks on each shift to ensure compliance with wound treatment orders then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations

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RIGHT ISCHIUM. Continue: Foam- Once Daily, Calcium Alginate- Once Daily..."

Further review of Resident #2's clinical record failed to reveal a physician's order for treatment to the right ischium from 5/17/17 until 7/5/17. A physician's order dated 7/5/17 documented, "Right Ischium- cleanse (with) chlorhexidine gluconate (hibiclens) (7), dry, apply calcium alginate. Cover (with) optifoam (dressing) QD (every day)."

Resident #2's May 2017, June 2017 and July TARs failed to document a treatment was provided for the right ischium from 5/17/17 until 7/5/17.

A wound care specialist evaluation signed by the wound care physician on 5/24/17 documented, "STAGE 4 PRESSURE WOUND SACRUM-IMPROVED EVIDENCED BY DECREASED SURFACE AREA...Continue: Foam- Once Daily, Collagen Dressing- Once Daily. Add: Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 5/31/17 documented, "STAGE 4 PRESSURE WOUND SACRUM...Continue: Foam, Once Daily, Collagen Dressing- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/7/17 documented, "STAGE 4 PRESSURE WOUND SACRUM-IMPROVED EVIDENCED BY DECREASED SURFACE AREA...Continue: Foam- Once Daily, Collagen Dressing- Once Daily, Calcium Alginate- Once Daily..."

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A wound care specialist evaluation signed by the wound care physician on 6/21/17 documented, "STAGE 4 PRESSURE WOUND SACRUM-IMPROVED EVIDENCED BY DECREASED DEPTH...Continue: Foam- Once Daily, Collagen Dressing- Once Daily, Calcium Alginate- Once Daily..."

A wound care specialist evaluation signed by the wound care physician on 6/28/17 documented, "STAGE 4 PRESSURE WOUND SACRUM-IMPROVED EVIDENCED BY DECREASED NECROTIC TISSUE, INCREASED GRANULATION...Continue: Foam- Once Daily, Collagen Dressing- Once Daily, Calcium Alginate- Once Daily. Add: Hibiclens rinse during dressing changes and showers..."

Further review of Resident #2's clinical record revealed a physician's order dated 5/17/17 that documented, "D/C (Discontinue) wound orders to sacrum. New wound order to sacral wound: Clean wound with NS (normal saline). Pat dry. Apply collagen dressing. Cover with optifoam once daily and prn (as needed)." The order failed to include the recommended calcium alginate. The following sacral wound care order was dated 6/21/17 and documented, "Sacral wdx (wound treatment): Clean (with) NS, pat dry; apply collagen dsg (dressing), calcium alginate, cover (with) foam dsg Q (every) day & prn." Another physician's order dated 6/28/17 documented, "D/C previous sacrum orders. Sacrum Cleanse (with) hibiclens 3 x (times) a week; apply collagen & cover (with) DD (dry dressing). Sacrums (sic) cleanse (with) normal saline 4 x a week; apply collagen & cover (with) DD."

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Resident #2's May 2017 TAR documented, "5-17-17 Sacrum Clean wound (with) NS. Pat dry; apply collagen dressing. Cover (with) optifoam once daily & PRN..." Resident #2's June 2017 TAR documented "5/17/17 SACRAL WOUND: CLEAN WOUND WITH NS; PAT DRY; APPLY COLLAGEN DRESSING, COVER WITH OPTIFOAM ONCE DAILY AND AS NEEDED..." The June 2017 TAR failed to document the 6/21/17 physician's order for a collagen dressing, calcium alginate and a foam dressing. The June 2017 TAR also failed to document the 6/28/17 sacrum treatment orders.

Resident #2's comprehensive care plan initiated on 12/4/16 documented, "The resident has impaired skin integrity...Interventions: Administer treatments as ordered and monitor for effectiveness..."

On 7/6/17 at 11:05 a.m., an interview was conducted with RN (registered nurse) #1 (the unit manager). RN #1 stated a nurse conducts rounds with the wound care physician every week but the same nurse doesn't always conduct the rounds. RN #1 stated usually she, the assistant director of clinical services or a particular staff nurse conducts rounds. When asked the facility process for ensuring the wound care physician's recommendations are implemented, RN #1 stated the wound care physician makes recommendations and dictates her notes then the director of clinical services prints out the recommendations and nurses write the orders based on the recommendations. RN #1 was asked if nurses always follow the wound care physician's recommendations. RN #1 stated, "I would say yes. If we had a question we wound call but she (the wound care physician) gives the

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orders." RN #1 was asked why the wound care physician's recommendations documented for Resident #2 in May 2017 and June 2017 were not implemented. RN #1 stated sometimes the wound care physician verbalizes a different recommendation than the recommendation she writes in her notes. RN #1 stated she reads the wound care physician's documented recommendations after the director of clinical services prints out the notes. RN #1 was asked what should happen if the wound care recommendation documented in the note is different than the recommendation the wound care physician verbalizes. RN #1 stated, "She (the wound care physician) needs to be called."

On 7/6/17 at approximately 2:40 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services). ASM #2 was asked what the facility process was for ensuring the recommendations dictated in the wound care physician's notes are implemented. ASM #2 stated she receives the wound care physician's dictated notes the same day the notes are dictated. ASM #2 stated she prints off the notes and gives them to the treatment nurse who rounded with the wound care physician. ASM #2 stated the treatment nurse is supposed to look at the written recommendations and write an order to change the treatment as recommended. ASM #2 was asked what should happen if the dictated recommendation is different than the verbal recommendation given during rounds. ASM #2 stated, "There should be clarification."

On 7/6/17 at 3:15 p.m., a telephone interview was conducted with ASM #4 (the wound care physician). ASM #4 stated sometimes she verbalizes different recommendations than the

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recommendations she documents in her notes. ASM #4 stated if the nurses ever have a question they can reach out and call her. ASM #4 stated the nurses are good about calling her. ASM #4 stated it's not fair to the nurses when she says one thing and writes another in her note. ASM #4 stated sometimes the computer may not capture her change or she puts the recommendation in the computer wrong. ASM #4 was asked if the recommendations written in her notes should be followed or if the treatment orders written should be followed. ASM #4 stated, "I want to say my note is more accurate but they are doing what they are supposed to. The wounds are improving."

On 7/6/17 at 4:30 p.m. another telephone interview was conducted with ASM #4. ASM #4 was made aware there were discrepancies between her written recommendations, the physician's orders written and the TARs for Resident #2. ASM #4 stated, "They have done what I have ordered." ASM #4 stated Resident #2 has the appropriate treatment on when she evaluates him on a weekly basis.

On 7/6/17 at 5:15 p.m. ASM #1 (the executive director) and ASM #2 were made aware of the above concern.

On 7/7/17 at 9:47 a.m., an interview was conducted with ASM #3 (Resident #2's attending physician). ASM #3 stated nurses follow the wound care physician's recommendations and transcribes her recommendations onto the order forms. ASM #3 stated he will oversee a wound concern if the nurses can't get in touch with the wound care physician but other than that, he doesn't follow wounds. ASM #3 stated he has

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delegated wound care order decisions to the wound care physician and he doesn't have to "okay" each order.

On 7/7/17 at 12:10 p.m. an interview was conducted with RN #1. RN #1 was asked what process was in place to ensure nurses completed treatment orders. RN #1 stated, "I wound say on the TAR. That is where I go to find out what treatments I need to do."

The facility policy titled, "Medical Consolations" documented, "Policy: Members of the medical staff will request a medical consultation when appropriate. Procedure: The member of the medical staff requesting a consultation will order the consultation and a Request For Consultation will be initiated by nursing to the consulting physician. The consultant will be qualified in the field in which the opinion is sought. The consultation will include the examination of the resident and the medical record. The consultant physician will complete the 'Report' section of the Request For Consultation or its equivalent. Findings: Information gathered from examination. Diagnosis: The resultant diagnosis per findings. Recommendations: The plan of care recommended
Signature: Consultant physician's signature. Upon completion of the consultation the charge nurse will notify the attending physician that the consult is complete and obtain any changes in plan of care or medications recommended by the consulting physician. The attending will need to note in his re-certification notes that consultation occurred and the outcome of this..."

No further information was presented prior to exit.

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(1) The ischium is the lower and back part of the hip bone. This information was obtained from the website: https://medlineplus.gov/appendixa.html

(2) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis..." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(3) "Paralysis of the lower half of your body, including both legs, is called paraplegia." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=paraplegia&_ga=2.165315772.246107152.1499704680-139120270.1477942321

(4) Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur.

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F 314	Continued From page 21 Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (5) Collagen dressings are used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3601889/ (6) (3) Calcium Alginate is a dressing used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/8954425 (7) Hibiclens (chlorhexidine) is an antiseptic antibacterial agent used to clean the skin. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009564/?report=details	F 314		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional	F 514	1. The nurses that were assigned to residents # 2 & # 3 were contacted to verify the treatments had been completed. Residents #2 and #3 receive wound treatments per physician orders.	July 26, 2017

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standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of three residents in the survey sample, Residents #2 and #3.

2. DCS/designee completed a Quality Review on curren. resident s' MAR & TAR to ensure medications and treatments are being signed off.

3. Director of Clinical Services(DCS) /designee met with wound physician and discussed plan to ensure recommendations are followed through to telephone orders.
During report at the end of the shift the oncoming and the off-going nurse will check the TARs to ensure the treatment(s) have been completed and signed off by the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	C 07/07/2017

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

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1. The facility staff failed to sign off wound care treatment was administered to Resident #2 on 6/11/17, 6/16/17, 6/19/17, 6/22/17 and 6/23/17.

2. The facility staff failed to sign off wound care treatment was administered to Resident #3 on 6/15/17, 6/16/17, 6/19/17 and 6/25/17.

The findings include:

1. The facility staff failed to sign off wound care treatment was administered to Resident #2 on 6/11/17, 6/16/17, 6/19/17, 6/22/17 and 6/23/17.

Resident #2 was admitted to the facility on 8/31/16. Resident #2's diagnoses included but were not limited to: diabetes, high blood pressure and paraplegia (1). Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/7/17, coded the resident as being cognitively intact.

Review of Resident #2's clinical record revealed a physician's order dated 5/17/17 that documented, "D/C (Discontinue) wound orders to sacrum. New wound order to sacral wound: Clean wound with NS (normal saline). Pat dry. Apply collagen dressing. Cover with optifoam (dressing) once daily and prn (as needed)."

Resident #2's June 2017 TAR (treatment administration record) documented, "05/17/17 SACRAL WOUND: CLEAN WOUND WITH NS; PAT DRY; APPLY COLLAGEN DRESSING, COVER WITH OPTIFOAM (dressing) ONCE DAILY AND AS NEEDED." The treatment was initialed (indicating the treatment was administered) each day except for 6/11/17,

DCS/designee provided re-education to the licensed nursing staff on policy and procedure for transcribing physician orders & chart check procedure to ensure physician orders are being transcribed correctly, TARs are signed off when treatment (s) are completed & documentation on the 24 hour report sheet of any new orders.
Physician orders to be reviewed in Daily Clinical meeting.
Wound doctor recommendations and wound orders to be reviewed weekly after wound physician visit to ensure orders match the recommendations as well as reviewed weekly in Weekly Clinical Meeting

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F 514	Continued From page 24	F 514	4. The Director of Clinical Services or designee to conduct Quality Monitoring 3 times per week for 4 weeks on each shift to ensure compliance with wound treatment orders then 1 time weekly for 1 month then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations	

6/16/17, 6/19/17, 6/22/17 and 6/23/17.

On 7/6/17 at 11:05 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how nurses indicate treatments are done. RN #1 stated the nurses sign the treatment off on the TAR. RN #1 was asked what a blank space on the TAR with no initials meant. RN #1 stated, "If it's not charted it wasn't done but I would like to think it was done but they didn't get time to sign off."

On 7/7/17 at 9:45 a.m. an interview was conducted with Resident #2. The resident confirmed nurses had changed his dressing every day.

On 7/7/17 at 12:25 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. A policy regarding TAR documentation was requested.

On 7/7/17 at 12:40 p.m., ASM #2 presented a policy titled, "Medications- Oral Administration Of." ASM #2 stated she thought the policy was also applicable to treatments. The policy documented, "Chart on MAR (medication administration record) according to policy..."

No further information was presented prior to exit.

(1) "Paralysis of the lower half of your body, including both legs, is called paraplegia." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=paraplegia&_ga=2.165315772.246107152.1499704680-139120270.14

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2. The facility staff failed to sign off wound care treatment was administered to Resident #3 on 6/15/17, 6/16/17, 6/19/17 and 6/25/17.

Resident #3 was admitted to the facility on 5/20/17. Resident #3's diagnoses included but were not limited to: diabetes, seizures and acute kidney failure. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/30/17, coded the resident as being cognitively intact.

Review of Resident #3's clinical record revealed a physician's order dated 6/14/17 that documented, "D/C (Discontinue) previous wound orders to left calf. Cleanse left calf wound (with) NS (normal saline), apply calcium alginate (1) & cover (with) a dry protective drsg (dressing) once daily."

Resident #3's June 2017 TAR (treatment administration record) documented, "6/14/17 Left calf- cleanse (with) Normal saline, apply Calcium alginate cover (with) DD (dry dressing) QD (every day)." The treatment was initialed (indicating the treatment was administered) each day except for 6/15/17, 6/16/17, 6/19/17 and 6/25/17.

On 7/6/17 at 11:05 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how nurses indicate treatments are done. RN #1 stated the nurses sign the treatment off on the TAR. RN #1 was asked what a blank space on the TAR with no initials meant. RN #1 stated, "If it's not charted it wasn't done but I would like to think it was done but they didn't get time to sign off."

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On 7/6/17 at 1:37 p.m. an interview was conducted with Resident #3. The resident confirmed nurses had changed his dressing every day.

On 7/6/17 at 1:52 p.m. RN #1 stated she spoke to the nurses who cared for Resident #3 on 6/15/17, 6/16/17, 6/19/17 and 6/25/17. RN #1 stated those nurses stated they did the treatment but didn't sign the treatment off.

On 7/7/17 at 12:25 p.m. ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

(1) Calcium Alginate is a dressing used to treat wounds. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmed/8954425