STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24402

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted 10/23/18 through 10/25/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 170 bed facility was 165 at the time of the survey. The survey sample consisted of 33 current Resident reviews and 3 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Regulations for the Licensure of Nursing Facilities. 12VAC 5-371-250- (G) Cross Reference to F-Tag 655 12 VAC 5-371-250 (F) Cross Reference to F-Tag 657 12 VAC 5-371-370 (A) Cross Reference to F-Tag 700 12 VAC 5-371-250 (G) Cross Reference to F-Tag 744 12 VAC 5-371-300 (H) Cross Reference to F-Tag 758 12 VAC 5-371-300 (B) Cross Reference to F-Tag 761	F 001	12VAC 5-371-250- (G) Cross Referenced to F-Tag 655 Allegation of Compliance: 11/27/2018 12VAC 5-371-250 (F) Cross Referenced to F-Tag 657 Allegation of Compliance: 11/27/2018 12VAC 5-371-370 (A) Cross Referenced to F-Tag 700 Allegation of Compliance: 11/27/2018 12VAC 5-371-250 (G) Cross Referenced to F-Tag 744 Allegation of Compliance: 11/27/2018 12VAC 5-371-300 (H) Cross Referenced to F-Tag 758 Allegation of Compliance: 11/27/2018 12 VAC 5-371-300 (B) Cross Referenced to F-Tag 761 Allegation of Compliance: 11/27/2018	

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

Jeremiah T Davis — Executive Director LNHA — 11/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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) COMPLETE DATE
F 001	Continued From Page 1 12 VAC 5-371-180 (A) Cross Reference to F-Tag 880 12 VAC 5-371-370 (A) Cross Reference to F-Tag 909	F 001	12VAC 5-371-180 (A) Cross Referenced to F-Tag 880 Allegation of Compliance: 11/27/2018 12VAC 5-371-370 (A) Cross Referenced to F-Tag 909 Allegation of Compliance: 11/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/23/18 through 10/25/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/23/18 through 10/25/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 170 certified bed facility was 165 at the time of the survey. The survey sample consisted of 33 current resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F550 1. Education has been provided to documented staff member and staff members responsible for assisting resident #14 with meals in appropriate assistance/interaction promoting a dignified dining experience therefore maintaining/enhancing quality of life. This has been observed with appropriate staff interaction for Resident #14 during meal times.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremiah J. Davis
TITLE: Executive Director/LNHA
(X6) DATE: 11/13/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

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 550	Continued From page 2	F 550		

hypertension, aphasia, Non-Alzheimer's Dementia, non-traumatic intracerebral hemorrhage, abnormal posture, dysphagia, cognitive communication deficit, generalized muscle weakness, chronic atrial fibrillation chronic kidney disease, and vascular dementia with behavioral disturbance. According to the most recent Minimum Data Set a Quarterly Review with an Assessment Reference Date of 7/25/18 the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired with a Summary Score of 01 out of 15

Under Section G (Functional Status), at Item G0110(H) - Eating, the resident was assessed as being totally dependent with one person physical assist for eating.

Resident # 14's care plan, revised on 10/24/18, included the following problem, "Mrs (name of resident) has potential for imbalanced nutrition r/t (related to) self-care deficit dementia and altered nutrient utilization, requires mechanically altered diet and thickened liquics AEB (as evidenced by) dependent upon staff for provision of all nutrients and with diagnosis of poor dentition." The goal for the problem was, "Mrs (name of resident) will maintain acceptable nutritional parameters as evidenced by labs at base line or improved with no S/S (signs and symptoms) of malnutrition or dehydration through next review."

Interventions to the stated problem included, "Assist with feeding as needed; Up in wc (wheelchair) to dining room for all meals and fed by staff

At 8:00 a.m. on 10/24/18 during observation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24402

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)	COMPLETION DATE
F 584	Continued From page 4 comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(j)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(j)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. §483.10(j)(3) Clean bed and bath linens that are in good condition. §483.10(j)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv). §483.10(j)(5) Adequate and comfortable lighting levels in all areas. §483.10(j)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 °F, and §483.10(j)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 584	2. Quality review of units 2NS, 2NW, 3NS, and 3NW during breakfast, lunch, and dinner to ensure residents residing on those units is provided a safe, clean, comfortable, and homelike environment. Follow up based on findings. 3. Nursing staff re-educated by the Staff Development Coordinator/designee to provide residents with a safe, clean, comfortable, and homelike environment. During meal service staff are to ask residents about their preference for setting up their meals, meals are not served on trays, meal items are to be removed from tray and set up according to resident preference, glasses and straws are to be provided on tray for each individual drink resident has, plate covers are not to be stacked up near residents while eating.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 584	Continued From page 6	F 584		

lunch. All 18 Residents were served lunch with trays left under their plates. Two surveyors were in the dining room at the time and did not hear any of the Certified Nursing Assistants (CNA) ask the residents if they wanted their tray removed. Two CNA's were interviewed separately after the observation. CNA # 3 verbalized the reason to leave the trays under the plates was to keep the food warm. CNA # 4 verbalized that she had worked there for almost 4 years and leaving the trays under the Resident's food is the way they (staff) have always done it.

3. At 8:00 a.m. on 10/24/18, the breakfast meal on Unit 2NW was observed. Five residents were seated at four tables in the unit Day Room/Dining area. All five received their meals on trays. None of the staff were heard to ask if any of the residents would like their meal removed from the tray. One resident was observed drinking two half pint cartons of milk directly from the carton.

4. On 10/25/18 at 7:40 a.m., the breakfast meal on Unit 2NS was observed. The seven residents in the dining area were served their meal with the meal items remaining on their individual trays. None of the staff serving the residents were heard to ask any of the residents if they would like their meal removed from the tray. CNA # 2, who was serving trays, was asked why meals were left on the trays. "Most of the residents don't like the dishes off the trays," she replied.

The meal observations were discussed during a meeting at 3:00 p.m. on 10/25/18, that included the Administrator, the Director of Nursing, and the survey team.

F 623	Notice Requirements Before Transfer/Discharge	F 623		

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
	495243	A. BUILDING ______ B. WING ______	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 623	Continued From page 8 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge. (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623	4. DON/Social Services/designee to conduct quality monitoring of written notification to residents responsible party and Ombudsmen following a transfer and/or discharge to the hospital, 5 times weekly x 2 weeks, 3x weekly x 4 weeks the 2x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance: 11/27/2018	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495243	A. BUILDING _____ B. WING _____	C 10/25/2018

(X1) NAME OF PROVIDER OR SUPPLIER	(X2) STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 623	Continued From page 10	F 623		

urinary tract infection. Resident #35's MDS assessment documented that Resident #35 returned to the facility on 6/27/18.

On 10/25/18 10:35 AM the director of nursing (DON) and administrator were interviewed in regards to notifying the responsible party the Ombudsman office in writing regarding the discharge. The DON and administrator both verbalized they did not notify RP or ombudsman in writing.

No other information was presented prior to exit conference on 10/24/18.

2. Resident #127 was most recently admitted to the facility on 9/1/18. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/1/18. Diagnoses for Resident #127 included heart failure, diabetes, failure to thrive and breast cancer. Resident #127 was assessed as having long and short-term memory problems with severe cognitive impairment.

Resident #127's medical record was reviewed on 10/24/18. A copy of hospital records documented that Resident #127 was admitted to the hospital on 8/10/18 for intestinal bleed and readmitted to the hospital on 9/12/18 for congestive heart failure. Resident #127 continues to reside in the facility.

On 10/25/18 10:35 AM the director of nursing (DON) and administrator were interviewed in regards to notifying the responsible party the Ombudsman office in writing regarding the discharge. The DON and administrator both verbalized they did not notify RP or ombudsman

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12	F 623		

the RP of the resident's transfer to the hospital. She stated "No. I don't think that's done for anyone... I know we always try to get in touch with the RP by telephone if someone goes out to the hospital, but nothing written is given."

The above findings were discussed with the administrator and DON during a meeting with facility staff 10/25/18 beginning at 2:55 p.m.

No further information was provided prior to the exit conference.

F 655 SS=D — Baseline Care Plan
CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission;
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders;
(B) Physician orders;
(C) Dietary orders;
(D) Therapy services;
(E) Social services;
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline

F 655

F 655

1. A copy of Resident #149's Baseline Care Plan has been provided to resident's responsible party.

2. Quality review of Current residents admitted in the last 30 days to ensure Baseline Care Plan is completed by nurse and resident/responsible party is provided with a copy. Baseline Care Plan is completed with nurse and resident/responsible party signatures/dates. Follow up based on findings.

3. Licensed nurses re-educated by the Staff Development Coordinator/designee related to Baseline Care Plans, BCP is to be developed within 48 hours of a resident's admission. BCP must be developed and implemented for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. BCP is to be signed and dated by resident/responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

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)	COMPLETION DATE

F 655 Continued From page 14

in daily decision makings skills

Observed during clinical record review was the resident's baseline care plan completed on 10/09/18 (seven days after admission). The baseline care plan also had an area that documented, " .below are completion signatures and dates of those participating in the initial baseline care plan development summary ." A space was provided for the nurse's signature, along with date (dated 10/09/18) and a space for the representative's signature and date, which was blank. The nursing notes were reviewed for this resident, no documentation was found to evidence the resident's representative was provided a copy

The unit manger was interviewed on 10/24/18 at approximately 10:00 a.m. regarding the baseline care plan and was asked what the nurse's signature represented. The unit manger stated that was the date of completion and stated that the resident's representative should also sign

At approximately 10:45 a.m., the DON (director of nursing) stated that the baseline care plan for Resident #149 was completed on 10/02/18 (the date of admission), but the nurse that completed the baseline care plan did not sign it, so when the unit manager noticed that it was not signed, the unit manger signed it and did not back date it to the original date. The DON was asked if the residents's representative was given a copy, the DON stated that she would find out.

On 10/25/18 at approximately 11:00 a.m. the DON stated that she could not find where the resident's representative was given a copy. The DON further stated that the baseline care plan

F 655

3. Licensed nurses re-educated by the Staff Development Coordinator/designee related to Baseline Care Plans, BCP is to be developed within 48 hours of a resident's admission. BCP must be developed and implemented for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. BCP is to be signed and dated by resident/responsible party.

4. DON/UM/designee to conduct quality monitoring of Baseline Care Plans, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	_____ BLDG. _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 657	Continued From page 18 Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 36 residents in the survey sample. 1. Resident #14's care plan was not revised to include use of a specialized "Broda" chair. 2. Resident #15's care plan was not revised with interventions for fall/injury prevention. The findings include: 1. Resident #14 was admitted to the facility on 12/26/16 with a re-admission on 6/27/18. Diagnoses for Resident #14 included encephalopathy, urinary tract infection, chronic kidney disease and dementia with behaviors. The minimum data set (MDS) dated 7/25/18 assessed Resident #14 with severely impaired cognitive skills. On 10/23/18 at 12:30 p.m. Resident #14 was observed seated in a specialized "Broda" chair in the dining room. The resident was observed again on 10/23/18 at 1:50 p.m. in her room seated in the Broda chair (a special positioning wheel chair). Resident #14's plan of care (revised 10/10/18) made no mention of the resident's use of a Broda chair. The care plan listed the resident was at risk of injury due to confusion, poor communication/comprehension, poor safety awareness and psychoactive drug use. Care plan interventions for injury prevention referenced use of a standard wheelchair and did not include the Broda chair.	F 657	4. DON/UM/designee to conduct quality monitoring of Comprehensive care plans, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance: 11/27/2018 **12 VAC 5-371-250** **1. Resident #14's comprehensive care plan has been reviewed by the Interdisciplinary team and revised to include use of a specialized "Broda" chair. Resident #15's comprehensive care plan has been reviewed by the Interdisciplinary team and revised to included person centered individualized interventions for fall/injury prevention.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	_____ WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 657	Continued From page 18	F 657		

assessed the resident as having short and long term memory impairment with severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for most all ADL's (activities of daily living). The resident was also coded as having one fall without injury.

The resident's clinical record was reviewed and in summary, the resident resided on the dementia/locked unit of the facility. The resident was ambulating independently and had a fall with no apparent injury in early July 2018. On July 09, 2018 the resident complained of pain and was examined by the nurse and found to have an abnormal assessment. The resident was sent to the hospital and diagnosed with a fracture of the right femur (unknown origin). The resident's fracture was repaired, the resident was placed on non weight bearing status and returned to the facility. The resident was seen by OT (occupational therapy) upon return to the facility and discharged from OT on 08/01/18. The OT discharge summary documented "...fall risk, nonweightbearing right lower leg...hip fracture...patient and caregiver training...provided instruction...safe task completion and functional maintenance program specifically in order to increase safety and reduce the risk of further medical complications that may result from impairments/condition and enhance functional performance in the presence of reduced cognitive abilities...discharge recommendations...caregiver support, equipment recommended upon discharge...wheelchair and hospital bed...discharge functional status...bed mobility = supervision."

The resident's nursing notes were reviewed and

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
496243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 657	Continued From page 20 (9/6/17) maintain clear path (6/14/18) staff to assist while ambulating as she allows (8/7/18) " No new interventions were implemented after the resident returned from the hospital with the diagnosis of a fracture to right femur. The resident had additional falls after the right hip fracture repair and was ordered to be non weight bearing, but no new interventions were implemented in an attempt to keep the resident non weight bearing, to prevent the resident from falling and/or ambulating without assistance On 10/25/18 at approximately 11:00 a.m. the DON (director of nursing) and administrator were made aware of concerns regarding Resident #15's continuous attempts to ambulate unassisted and continued falls and that the resident did not have interventions in place for supervision and safety for the pattern of falls At approximately 4:00 p.m., the DON presented nursing notes and stated "we did stuff. I don't want you to think we didn't do anything." The nursing notes provided information regarding diagnostic testing and/or standard nursing care after the falls, such as xrays and neurological checks, no actual interventions were found to prevent additional falls in the resident's plan of care No further information and/or documentation was presented prior to the exit conference on 10/25/18	F 657		
F 700 (5/8/17)	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails	F 700		

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

PRINTED: 10/31/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING ______ B. WING ______	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 700	Continued From page 22 kidney disease and dementia with behaviors. The minimum data set (MDS) dated 7/25/18 assessed Resident #14 with severely impaired cognitive skills. This MDS indicated Resident #14 was totally dependent upon staff for bed mobility, transfers, dressing, eating and hygiene and had daily physical behaviors that included hitting, kicking, pushing and/or grabbing. On 10/23/18 at 12:03 p.m., Resident #14's roommate (Resident #266) was interviewed about life in the facility. Resident #266, assessed by the facility as cognitively intact, stated that several days ago she used her call bell to summon staff regarding her roommate. Resident stated Resident #14 got her legs caught in the side rails on her bed during the night. Resident #260 stated Resident #14 was frequently "restless" when in the bed. Resident #266 stated staff responded promptly and repositioned the resident from the rail. Resident #266 stated the resident's legs were tangled in the raised bed rail positioned in the middle section of the bedside. On 10/23/18 at 7:30 a.m. Resident #14 was observed in bed. The resident's bed was against the wall on one side. A grab type rail was in the raised position on the wall side near the head of the bed. A quarter length bed rail was raised on the room side of the bed along the middle portion of the bedside. On 10/23/18 at 7:35 a.m., accompanied by the certified nurses' aide (CNA #1) caring for Resident #14, the resident was observed in bed with the bed rails in the up position. CNA #1 was interviewed at this time about the bed rails. CNA #1 stated the bed rails were routinely used with Resident #14 in bed along with the low bed	F 700	3. Nursing and Maintenance staff re-educated by the Staff Development Coordinator/designee related to bedrails, facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Assess the resident for risk of entrapment from bed rails prior to installation. Review the risks and benefits of bed rails with the resident/responsible party and obtained informed consent prior to installation. Ensure that he beds dimensions are appropriate for the resident's size and weight. Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails. 4. DON/UM/designee to conduct quality monitoring of side rail evaluations for completion, correct installation, use, and maintenance of side rails, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings 5. Allegation of Compliance: 11/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 700	Continued From page 24	F 700		

On 10/24/18 at 9:11 a.m., the licensed practical nurse (LPN#2) unit manager was interviewed about Resident #14's bed rail use and assessment. LPN #2 stated she completed the quarterly nursing assessment dated 9/28/18 and indicated the resident used quarter length rails when in bed. When asked about the reference to the additional side rail assessment, LPN #2 stated she did not notice the requirement for the additional assessment form. LPN #2 stated she did not complete the additional side rail assessment for Resident #14. LPN #2 stated the quarterly assessment form was new and she was not familiar with the additional side rail assessment. LPN #2 stated Resident #14 was not able to use the rails independently for repositioning or turning in bed.

On 10/25/18 at 2:00 p.m., the director of nursing (DON) was interviewed about Resident #14's bed rail use. The DON reviewed the record and stated there was no physician's order or informed consent from the resident's family regarding bed rail use.

The facility's policy titled Side Rail/Bed Rail (dated 4/19/18) documented, "The Center will attempt alternative interventions and document in the medical record prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to: Side rails, bed rails, safety rails, grab bars and assist bars. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. Review the risk and benefits with the resident and/or resident representative. Obtain consent from the resident and/or resident representative. Obtain physician order for side rail/bed rail. Update the care plan

3. Nursing and Maintenance staff re-educated by the Staff Development Coordinator/designee related to bedrails, facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Assess the resident for risk of entrapment from bed rails prior to installation. Review the risks and benefits of bed rails with the resident/responsible party and obtained informed consent prior to installation. Ensure that he beds dimensions are appropriate for the resident's size and weight. Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	812 HOUSTON STREET STAUNTON, VA 24402

(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 700	Continued From page 26	F 700		

unaware of safety limitations or resistant? No Safety (continued) Side Rail Evaluation ..resident is non ambulatory has a history of falls demonstrated poor bed mobility.. poor trunk control..and takes medications that require safety precautions.." There were no interventions marked in this section which included low bed to floor, provide frequent staff monitoring at night, periodic assisted toileting, or visual and verbal reminders to use the call bell. There was a section for recommendations, such as, left, right, bilateral, half rails, quarter rails, other, or that the side rails are indicated to provide safety, or not indicated for this resident. None of the area were marked

On 10/24/18 at approximately 3:45 p.m., the unit manager was asked about the side rail assessment for this resident. The unit manager was made aware that this assessment was not complete and did not provide information regarding the resident's ability to safely use the side rails. The unit manager stated that the resident was "due" a side rail assessment, as they are completed quarterly and the last one done was on 07/12/18. The unit manager stated that she would see if the resident had any other side rail assessments.

The unit manager later presented a quarterly data collection assessment dated 07/20/18 which documented the resident was unaware of safety limitations due to dementia and that the resident had an alteration in safety awareness, had poor bed mobility, and took medications that require safety precautions. No interventions were listed for low bed, frequent monitoring, etc. The recommendations were marked for the resident to have quarter rails and that the side rails are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

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 744	Continued From page 28 diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement individualized person centered interventions for dementia for one of 36 residents in the survey sample, Resident #149. Findings included: Resident #149 was admitted to the facility on 10/02/18. Diagnoses for the resident included, but were not limited to: dementia, major depressive disorder, anxiety disorder, and high blood pressure. The most current MDS (minimum data set) was an admission assessment dated 10/09/18. This MDS assessed the resident with a cognitive score of 6, indicating the resident was severely impaired in daily decision makings skills. This resident also triggered in the CAAS (care area assessment summary) section of this MDS for cognitive loss/dementia, behavioral symptoms, and psychotropic drug use. Resident #149 was observed throughout the survey process from 10/23/18 through 10/25/18. On 10/23/18 at approximately 11:30 a.m. the resident was observed in the dining room and asked this surveyor to call her daughter and have her come pick the resident up, she wanted to go home. The resident was not angry, but was anxious/distressed and wanted to go home. A	F 744	F 744 1. Resident #149's comprehensive care plan has been reviewed by interdisciplinary team and revised to reflect behaviors, triggers, and person centered individualized interventions. 2. Quality review of current residents with the diagnosis of Dementia to ensure resident has appropriate behavior care plan to reflect behavioral symptoms/triggers, psychotropic drug use, and person centered individualized interventions. Follow up based on findings. 3. Licensed nurses and interdisciplinary team re-educated by the Staff Development Coordinator/designee related to treatment and services for residents with Dementia, Residents who display or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Comprehensive care plan is reviewed and revised to reflect resident's current status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) COMPLETION DATE
F 744	Continued From page 30 DON and administrator were made aware in a meeting with the survey team, of the above observations of Resident #149'ws desire to go home. The DON was made aware that this information was not identified anywhere on the resident's CCP and there were no specific individualized interventions for an attempt to decrease and/or manage this behav or for Resident #149. The facility staff would at times attempt to distract the resident, but the concern was not identified or documented, did not include the development of interventions to address an individualized plan with person centered approaches for this resident with dementia. The DON and administrator agreed No further information and/or documentation was presented prior to the exit conference.	F 744	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories (i) Anti-psychotic, (ii) Anti-depressant, (iii) Anti-anxiety, and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that: §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758	

3. Licensed nurses and Interdisciplinary team re-educated by the Staff Development Coordinator/designee related to treatment and services for residents with Dementia, Residents who display or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Comprehensive care plan is reviewed and revised to reflect resident's current status.
4. DON/UM/designee to conduct quality monitoring of behavior care plans, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018

F 758

1. Resident #149 is no longer prescribed Haldol. Resident #88 has a Physician order dated 10/30/2018 to Discontinue PRN Ativan in 14 days.
2. Quality review of current residents receiving PRN psychotropic medications for necessary use. 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
	495243	A. BUILDING _____ B. WING _____	C 10/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24402

(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 756	Continued From page 32	F 756		

1. The facility staff administered a PRN dose of Haldol to Resident #149 on two separate occasions without a diagnosed specific consult or without clear indications for use and without documentation in the resident's clinical record.

2. The facility staff failed to ensure Resident #88 was not prescribed PRN (as needed) Lorazepam (Ativan) for greater than 14 days.

Findings included:

1. Resident #149 was admitted to the facility on 10/02/18. Diagnoses for the resident included but were not limited to: dementia, major depressive disorder, anxiety disorder, and high blood pressure.

The most current MDS (minimum data set) was an admission assessment dated 10/09/18. This MDS assessed the resident with a cognitive score of 8, indicating the resident was severely impaired in daily decision makings skills. This resident also triggered in the CAAS (care area assessment summary) section of this MDS for cognitive loss/dementia, behavioral symptoms, and psychotropic drug use.

During clinical record review it was observed that the resident was admitted to the facility originally on 10/02/18 and the physician ordered the medication Haldol 2 mg (milligrams) by mouth or injection every 4 hours as needed for five days for agitation.

On 10/06/18 the physician again ordered Haldol 2 mg by mouth or injection every 4 hours as needed for 2 weeks. This order did not include any information regarding the indication for use or

4. DON/UM/designee to conduct quality monitoring use of psychotropic medications, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings
5. Allegation of Compliance: 11/27/2018

12 VAC 5-371-300

1. Resident #149 is no longer prescribed Haldol. Resident #88 has a Physician order dated 10/30/2018 to Discontinue PRN Ativan in 14 days.
2. Quality review of current residents receiving PRN psychotropic medications for necessary use. 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
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 758 Continued From page 34

increased agitation

On 10/25/18 at approximately 11:00 a.m., the DON and administrator were made aware of the above information and that the resident was prescribed an antipsychotic without indications for use and no documentation regarding an assessment to support the use of this medication. The DON was also made aware that the resident was administered the medication on two separate occasions without any documentation, other than "increased agitation." The DON was made aware of concerns of lack of assessment documentation regarding the administration of this drug. The DON stated that a note should have been written.

No further information and/or documentation was presented prior to the exit conference.

2. Resident #88 was originally admitted to the facility on 07/02/18 with a readmission on 08/29/18. Diagnoses for Resident #88 included anxiety disorder, hypertension, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), hypoxia, and status post left hip fracture surgery. The minimum date set (MDS) dated 09/06/18 assessed Resident #88 as severely cognitive impaired, having long-term and short-term memory loss.

Resident #88's clinical record was reviewed on 10/24/18 at 10:15 a.m. Included in this resident's physician's orders sheet was an order dated 09/15/18 for Lorazepam (Ativan) 0.5 mg (milligrams) tablet. 1 tablet by mouth every 4 hours as needed for anxiety.

A review of the Medication Regimen Review form documented the following: "DC (discontinue)

F 758

4. DON/UM/designee to conduct quality monitoring use of psychotropic medications, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) COMPLETION DATE
F 758	Continued From page 36 On 10/25/18 at 9:10 a.m., the pharmacist was interviewed by telephone. The pharmacist stated she was aware of the 14 day PRN rule for psychotropic medications and she just documented that the medication had not been used in 30 days because she has had some challenges with some facility physicians not wanted to discontinue PRN medications especially if a resident is on hospice. She continued and said she has discussed with the facilities that the Lorazepam is located in the STAT box, therefore if a resident should need a one-time dose it is readily available rather than having a PRN order. The DON was asked if the Lorazepam was included in the facility's STAT box and she said yes it was. The DON stated it would be best practice to discontinue the PRN Lorazepam order and have a continuous order based on the resident's needs No other information was received prior to the exit conference on 10/25/18 at 4:30 p.m.	F 758
F 761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761

F761

1. The Tuberculin multi-dose vial has been discarded. The bottle of over the counter Aspirin and Natural Fiber powder has also been discarded.
2. Quality review of facility medication rooms, medication refrigerators, medication and treatment carts, and Central Supply to ensure no medications are expired and all necessary items are labeled and dated appropriately when opened. Follow up based on findings.
3. Licensed nurses-educated by the Staff Development Coordinator/designee related to labeling and storage of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Drugs and biologicals are to be discard prior to or at the time of expiration. Central Supply Manager-educated by the Staff Development Coordinator/designee related to the storage of drugs and biologicals. Drugs and biologicals are to be discard prior to or at the time of expiration.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495243		C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) COMPLETION DATE

F 761 Continued From page 38 F 761

On 10/24/18 at 9:31 AM, LPN #3 was interviewed regarding the opened container and verbalized Tuberculin multi-use vial should be labeled when opened and is good for 30 days after being opened. LPN #3 verbalized that night shift were supposed to go through to check for expired medication's and correct labeling.

Review of a policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

The above finding was brought to the attention of the director of nursing and the administrator on 10/25/18 at 3:30 PM.

No other information was provided prior to exit conference on 10/25/18.

2. On 10/24/18 at 2:45 p.m. an inspection of the main distribution center (central supply) for OTC (over the counter)medications was conducted with the manager of the central supply. A bottle of Gericare Aspirin 325 mg (milligrams), 100 tablets was observed with an expiration date of 07/18 (July 2018). A bottle of 10 oz (ounces) Natura Fiber Powder was observed with an expiration date of August 2018. The manager was observed placing the 2 bottles of expired medications in box to discard them. The manager of central supply was asked about how often she checked expiration dates. She stated she normally checks them on the fifteenth of each month and then again when new stock comes in. She stated she rotates the medications using the first in first out rule. She was asked if there was

3. Licensed nurses-educated by the Staff Development Coordinator/designee related to labeling and storage of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Drugs and biologicals are to be discard prior to or at the time of expiration. Central Supply Manager-educated by the Staff Development Coordinator/designee related to the storage of drugs and biologicals. Drugs and biologicals are to be discard prior to or at the time of expiration.
4. DON/UM/designee to conduct quality monitoring of facility medication rooms, medication refrigerators, medication and treatment carts, and Central Supply to ensure no medications are expired and all necessary items are labeled and dated appropriately when opened., 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING ______ B. WING ______	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 880	Continued From page 40 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; §483.80(a)(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; (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	2. Quality review of current nurse's handwashing competency skills by Staff Development Coordinator. Follow up based on findings. 3. Licensed nurses re-educated by the Staff Development Coordinator/designee related to hand hygiene as cleaning hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel) to reduce spread of germs in the healthcare setting. Hand Hygiene should be performed before initiating a clean procedure, before and after resident care, after contact with inanimate objects (including medical equipment) in the immediate resident vicinity, after glove removal. 4. DON/UM/designee to conduct quality monitoring of proper hand hygiene, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance: 11/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 880 Continued From page 42

On 10/24/18 at 8:35 a.m. LPN #1 was interviewed about hand hygiene between residents during the medication pass. LPN #1 stated, "That's my fault." LPN #1 stated hand sanitizer was available in each room and with all the medications and "hovering," he forgot.

On 10/25/18 at 9:49 a.m., the director of nursing (DON) was interviewed about hand hygiene during medication administration. The DON stated it was her understanding that hand hygiene was supposed to be done between residents. The DON stated LPN #1 said he was very nervous during the medication pass observation.

The facility's policy titled Hand Hygiene (revised 8/29/17) documented, "The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). To reduce the spread of germs in the healthcare setting. Hand hygiene should be performed. Before initiating a clean procedure. Before and after patient care. After contact with inanimate objects (including medical equipment) in the immediate patient vicinity. After glove removal."

These findings were reviewed with the administrator and DON during a meeting on 10/25/18 at 3:00 p.m.

F 883 Influenza and Pneumococcal immunizations
SS=E CFR(s): 483.80(d)(1)(2)

§483.80(d) Influenza and pneumococcal

F 880 3. Licensed nurses re-educated by the Staff Development Coordinator/designee related to hand hygiene as cleaning hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel) to reduce spread of germs in the healthcare setting. Hand Hygiene should be performed before initiating a clean procedure, before and after resident care, after contact with inanimate objects (including medical equipment) in the immediate resident vicinity, after glove removal.
4. DON/UM/designee to conduct quality monitoring of proper hand hygiene, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018

F 883

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	495243	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(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 883	Continued From page 44 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (v)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to correctly assess and document the pneumococcal vaccine status for one of 5 records reviewed. Resident # 85. Resident # 85 had a signed informed consent form signed that the vaccine had been received outside the facility. Findings include: Resident # 85 was admitted to the facility 8/9/18 with a readmission date of 10/22/18. Diagnoses for Resident # 85 included, but were not limited to: multiple fractures, high blood pressure, and GERD (gastroesophageal reflux diswase). The most recent MDS (minimum data set) was a quarterly review dated 9/6/18 and had the resident coded as cognitively intact with a total summary score of 14 out of 15. On 10/25/18 at 8:47 a.m. during review of the clinical record, it was noted that Resident # 85 did not have documentation of the pneumococcal vaccine.	F 883	3. Licensed nurses re educated by the Staff Development Coordinator/designee related to Pneumococcal Immunizations. Resident/responsible party receives education regarding the benefits and potential side effects of the immunizations. Offer a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. Resident/responsible party has the opportunity to refuse immunization. The medical record includes documentation that indicates that the resident/responsible party was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	517 HOUSTON STREET STAUNTON, VA 24402

(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	(X5) COMPLETION DATE
F 883	Continued From page 46 facility staff 10/25/18 beginning at 2:55 p.m. No further information was provided prior to the exit conference. F 909 Resident Bed SS=F CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by Based on observation, staff interview and facility document review, the facility staff failed to implement routine inspections of all bed frames mattresses and bed rails to identify areas of possible entrapment. There was no documented inspection or maintenance program for resident beds, mattresses and/or bed rails to identify and minimize possible areas of entrapment. The findings include: Resident #14 and Resident #15 were observed during the current survey with bed rails in use without a prior assessment regarding possible entrapment risks, an informed consent from the residents' representative or any attempted alternatives to the bed rails. In addition, several types of bed rails were observed in use on resident beds including grab rails, half bed length rails and quarter length rails.			

F 909

F 883

1. **Resident #14 had a new side rail evaluation completed on 10/24/2018; at that time the Interdisciplinary team reviewed side rail evaluation and determined side rails are no longer appropriate, side rails removed at that time. Resident #15 had a new side rail evaluation completed on 10/24/2018; at that time the Interdisciplinary team reviewed side rail evaluation and determined side rails are no longer appropriate, side rails removed at that time.**
2. **Quality review of facility beds to identify areas of possible entrapment. Follow up based on findings.**
3. **Maintenance staff re-educated by the Staff Development Coordinator/designee related to bedrails. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Ensure that the beds dimensions are appropriate for the resident's size and weight. Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails. Conduct regular inspections of bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattresses, and bed frame are compatible.**

F 909

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

OMB NO. 0938-0391

495243

10/25/2018

ENVOY OF STAUNTON, LLC

[illegible] HOUSTON STREET
STAUNTON, VA 24401

F [illegible] Continued From page 48

Rails" (dated 10/2/18) documented "Inspect connections on rails and tighten as necessary. Check for any burrs or rough edges to prevent injury. Also [illegible] [illegible] is [illegible]. Check for missing or faulty [illegible]. The inspection sheet included the room and/or bed number, and [illegible] information regarding entrapment zones, mattress evaluations or gap measurements indicating possible entrapment risks.

There was no evidence of a maintenance program that included inspections of beds, mattresses and bed rails for the identification of entrapment risks. It was unclear if the general inspections in place were actually performed on all beds, rails and/or mattresses, as there was no documentation or tracking of these inspections by room number or bed number.

These findings were reviewed with the administrator and director of nursing during a meeting on 10/25/18 at 2:30 p.m.

F [illegible]

3. Maintenance staff re-educated by the Staff Development Coordinator/designee related to bedrails. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. Ensure that the beds dimensions are appropriate for the resident's size and weight. Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails. Conduct regular inspections of bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattresses, and bed frame are compatible.
4. Maintenance/designee to conduct quality monitoring of resident beds, 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.
5. Allegation of Compliance: 11/27/2018