STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 9/18/18 through 9/20/18. The facility's Emergency Preparedness Plan was found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000	This Plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared solely because it is required by state and federal law.	Allegation of Compliance 10/16/18
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/18/18 through 9/20/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Seven complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this seventy-seven certified bed facility was 73 at the time of the survey. The survey sample consisted of nineteen current resident reviews and three closed record reviews.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623	F623 1. Root Cause Analysis was completed on 9/21/2018 Ad. Hoc QAPI committee meeting was completed on 9/24/2018. The Ombudsman was not notified of resident #50's transfer from the facility to the hospital on 10/1/2018.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Division Exec Director — (X6) DATE: 10/1/18

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
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 1 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section, (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, 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	F 623	2. Quality review of resident discharged from the facility within the past 30 days was completed by the Director of Resident and Family Services to ensure Ombudsman notification. 3. The Director of Resident and Family Services was educated on the notification process for transfers and discharges by the Regional Director of Clinical Services on 9/27/2018. The interdisciplinary team will review transfers and discharges during the clinical meeting to ensure proper notification was made to the Ombudsman within 48 hours of discharge . 4. DON or designee to conduct a quality review weekly for 8 weeks to validate that notifications have been made any transfers and discharges. Findings will be reported to the QAPI committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 2 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 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the State ombudsman's office for a resident's discharge for one of 22 residents in the survey sample. Resident #50, discharged to the hospital and the State ombudsman's office was not notified of the discharge. The findings include: Resident #50 was admitted to the facility on 07/17/17 with a readmission on 08/04/18. Diagnoses for Resident #50 included: hypertension, anemia, acute kidney failure, dementia without behaviors, adult failure to thrive, abdominal swelling/pain, dysphasia, muscle weakness and hypokalemia. The most recent minimum data set (MDS) dated 08/26/18 assessed Resident #50 as being severely cognitively impaired and rarely making decisions. Resident #50's clinical record was reviewed on 09/19/18 at 8:36 a.m. A nursing progress note dated 08/26/18 with a timestamp of 22:22 (10:22 p.m.) documented "Resident was admitted to (Name) hospital." On 09/20/18 at 10:10 a.m., the social worker (SW) was interviewed concerning notifying the State Ombudsman's office regarding Resident #50 being discharged to the hospital on 08/26/18. The SW stated she notified Resident #50's responsible party and discussed the bed-hold authorization. The SW stated she did not notify the State ombudsman's office of Resident #50's discharge to the hospital because she was not	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 4 aware she was supposed to. These findings were reviewed with the administrator & director of nursing (DON) during a meeting on 09/20/18 at 12:10 p.m.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for three of 22 residents in the survey sample. 1. Resident #27's MDS inaccurately assessed the resident's oral/dental status. 2. Resident #34's MDS included an inaccurate weight. 3. Resident #1's MDS documented an inaccurate assessment of bladder function. The findings include: 1. Resident #27 was admitted to the facility on 10/11/17 with diagnoses that included schizophrenia, diabetes, chronic kidney disease, anxiety, peripheral vascular disease, bipolar disorder and pericarditis. The minimum data set (MDS) dated 7/21/18 assessed Resident #27 with moderately impaired cognitive skills. On 9/18/18 at 10:08 a.m., Resident #27 was	F 641	F641 1. Root Cause Analysis was conducted on 9/21/2018. Ad Hoc QAPI Committee meeting was held on 9/28/2018 Resident #27's MDS was modified on 9/20/2018 to accurately reflect oral status. Resident's #34 MDS was modified on 9/20/2018 to reflect accurate weight. Resident #1's MDS was modified on 10/1/2018to accurately reflect bladder function. 2.Quality monitor review will be conducted by Regional MDS Coordinator of assessments completed within the past 30 days to ensure accuracy of sections K and L.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 5 observed in his room. The resident's front teeth were missing with the remaining visible teeth chipped and discolored. The visible teeth had black and gray discoloration on the surface and along the gums Resident #27's clinical record documented the resident's teeth were in poor condition upon admission to the facility. Resident #27's admission nursing assessment dated 10/11/17 documented the resident had natural teeth that were chipped and/or broken. Resident #27's plan of care for nutrition (revised 4/20/18) listed the resident "has poor dentition and is on a mechanical soft diet for ease of chewing." Section L of Resident #27's admission MDS dated 10/18/17 inaccurately documented the resident with no dental issues and listed there were no obvious or likely cavities or broken natural teeth. On 9/19/18 at 8:35 a.m., the registered nurse (RN #1) responsible for MDS assessments was interviewed about Resident #27's dental status. RN #1 stated the resident had never complained about his teeth but had obvious missing and dark teeth. RN #1 stated the missing teeth with likely decay should have been included on the admission assessment. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page L-1 documents section L (Oral/Dental Status) is intended to record any dental problems present in the 7-day look-back period. Instructions for completion of this section include, "Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is	F 641	3. MDS coordinator and Regional Dietary Manager were educated on MDS accuracy according to the RAI manual to include completion of Sections K & L on 9/27/2018 by the Regional MDS Coordinator. Prior to submission of MDS assessments, the interdisciplinary team will review the assessment data to verify accuracy of Sections K & L. The DON or designee will complete a quality review weekly for 8 weeks to validate MDS assessment accuracy. 4. Findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 6	F 641		

edentulous/lacks all natural teeth or parts of teeth.." and to check item L0200D for "obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen" (1)

This finding was reviewed with the administrator and director of nursing during a meeting on 9/19/18 at 4:00 p.m.

(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.16, Centers for Medicare & Medicaid Services, Revised October 2018.

2. Resident # 34 was admitted to the facility on 6/10/16, and most recently readmitted on 6/27/18 with diagnoses that included hypertension, peripheral vascular disease, renal insufficiency, diabetes mellitus, hyperlipidemia, aphasia, Non-Alzheimer's Dementia, generalized muscle weakness, cognitive communication deficit, dysphagia, pyonephrosis, hypocalcemia, and status post left above the knee amputation. According to the most recent Minimum Data Set (MDS), an Annual with an Assessment Reference Date of 7/11/18, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 5 out of 15.

On the same Annual MDS, the resident was assessed under Section K (Swallowing/Nutritional Status) at Item K0200 (Height and Weight), as weighing 144 pounds. At Item K0300 (Weight Loss), the resident was assessed as having a weight loss of 5% or more in the last month, or a loss of 10% or more in the last six months, which was not part of a physician prescribed weight loss program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 7	F 641		

Review of the Weight Summary in Resident # 34's Electronic Health Record (EHR) revealed his weight on 7/11/18 was listed as 148.4 pounds Comparison of the resident's listed weight of 148.4 pounds on 7/11/18 with his Weight Summary listed weight of 144.6 pounds on 6/6/18, revealed a weight gain of 3.8 pounds, or a 2.6% weight gain in one month. Comparison of the resident's listed weight of 148.4 pounds on 7/11/18 with his Weight Summary listed weight of 156 pounds on 1/7/18, revealed a weight loss of 7.6 pounds, or a 5.13% weight loss in six months

At 9:45 a.m. on 9/19/18, the District Manager for Dietary Services was interviewed regarding the entries at Section K on the Annual MDS for Resident # 34. The District Manager said she entered the weight at Section K, and that she used the weight taken from a dietary assessment dated 8/4/18. The District Manger also said she entered the weight on the MDS on 8/4/18. A review of Resident # 34's EHR failed to reveal a dietary assessment dated 8/4/18.

According to Section Z (Assessment Administration) of the resident's Annual MDS, Section K was signed off as being complete by the District Manager on 8/4/18.

Further review of Resident # 34's EHR revealed a Consulate Nutritional Evaluation, dated 8/1/18. The "Summary and Progress" section of the evaluation listed the resident's weight as 143.6 pounds.

At 1:45 p.m. on 9/19/18, the facility's Registered Dietitian (RD) was interviewed regarding the weight listed on Section K of the Annual MDS. "I get the weights off the computer," the RD said. "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 8	F 641		

did not do this one, the District Manager did. She probably used the 143.6 weight and rounded it up to 144. It sounds like a coding error."

At 1:55 p.m. on 9/19/18, RN # 1 (Registered Nurse), one of three MDS Coordinators, was interviewed regarding the Annual MDS for Resident # 34. According to RN # 1, the MDS should be transmitted 14 days after the ARD. "All information on the MDS must be obtained from information available during the seven day look back period. We have up until midnight of the ARD to gather that information," RN # 1 said. RN # 1 went on to say that if no weights were done during the look back period, then the most recent weight prior to the look back period would be used. RN # 1 also said that information gathered after the ARD would not be included on the MDS.

The findings were discussed during a meeting at 4:00 p.m. on 9/19/18 that included the Administrator, Director of Nursing and the survey team.

3. Resident #1 admitted to the facility originally on 02/28/18. Diagnoses for Resident #1 included, but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia, DM (diabetes mellitus), Parkinson's disease, history of alcohol abuse, cardiomegaly, gout, anemia, thrombocytopenia, and BPH (benign prostatic hypertrophy) and urinary retention.

The most current full MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 03/05/18. This MDS was reviewed and documented the resident with a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 9 as requiring extensive assistance with most ADL's (activities of daily living) with assistance of at least one staff person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent upon one staff person for bathing. The resident was assessed as having an indwelling catheter on this MDS and triggered in the CAAS (care area assessment summary) section of this MDS for urinary incontinence and indwelling catheter. Resident #1 was observed multiple times during the survey process from 09/18/18 through 09/20/18. The resident had an indwelling Foley catheter in place during the entire survey process. During clinical record review the resident's physician's orders were reviewed from admission to present and documented in summary, that the resident was admitted with a Foley catheter on 02/28/18 and on 04/03/18 the Foley catheter was discontinued and intermittent catheterization twice daily was started. The resident had a hospitalization from 04/06/18 through 04/11/18. The resident was readmitted on 04/11/18, again with an indwelling catheter. On 08/28/18, the indwelling catheter was discontinued again. On 09/03/18 the resident was discharged to the hospital and readmitted to the facility on 09/10/18. The resident was readmitted again with an indwelling catheter on 09/10/18. The resident's MDS records were reviewed and revealed that on the discharge return anticipated dated 09/03/18, the resident was assessed as having intermittent catheterizations and no toileting program. The MDS dated 09/10/18 an entry tracking MDS did not document the resident	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 641	Continued From page 10 had an indwelling catheter and/or any intermittent catheterization, no toileting program and no information regarding urinary elimination On 09/20/18 at 10:50 a.m., the unit manger, also known as LPN (Licensed Practical Nurse) #1 was interviewed regarding Resident #1's MDS. The LPN was made aware that the MDS should reflect the correct status of the resident's urinary elimination. The LPN stated that the MDS coordinator completed the MDS and was not sure where the information came from. On 09/20/18 at approximately 11:00 a.m., the MDS coordinator was interviewed regarding Resident #1's MDS accuracy. The MDS coordinator stated that the resident's current information would be put on the readmission assessment. On 09/20/18 at approximately 1:30 p.m. the DON (director of nursing) and the administrator were made aware of the concerns regarding Resident #1's MDS and that the information did not reflect the residents current status. The DON agreed that the MDS is an assessment and should reflect the resident's status at the time of the MDS. No further information and/or documentation was presented prior to the exit conference on 09/20/18 at 2:00 p.m.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s) 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 11 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 656	1. Root Cause Analysis was conducted on 9/21/2018. Ad Hoc QAPI committee meeting was held on 9/21/2018. Resident #1 Care Plan was updated on 9/25/2018 to reflect use of indwelling catheter. Resident #21's Care Plan was updated on 10/1/2018 to reflect behaviors. Resident #27's Care Plan was updated on 10/1/2018 to reflect his dental concerns. 2. Quality review of care plans for residents with indwelling catheters, behaviors and dental concerns will be completed by the DON or designee to ensure that the comprehensive care plan is accurate. 3. On 9/24/2018 the MDS coordinator was educated on the development of comprehensive care plans to include accurate reflection of the resident by the Regional MDS coordinator. DON or designee to conduct quality review of new admissions and other random residents weekly for 8 weeks to validate implementation of the comprehensive care plan to reflect the residents current status. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 12	F 656		

review, the facility staff failed to develop a CCP (comprehensive care plan) for three of 22 residents in the survey sample (Resident #1, Resident #21, and Resident #27)

1. The facility staff failed to develop a CCP for Resident #1 for the use and care of an indwelling urinary catheter; the resident developed urethral erosion/trauma

2 The facility staff failed to develop a CCP for Resident #21 for behaviors.

3. The facility staff failed to develop a CCP for Resident #27 in the areas of ADL (activity of daily living) care and dental.

Findings include:

Resident #1 was admitted to the facility originally on 02/28/18. Diagnoses for Resident #1 included, but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia, DM (diabetes mellitus), Parkinson's disease, history of alcohol abuse, cardiomegaly, gout, anemia, thrombocytopenia, and BPH (benign prostatic hypertrophy) and urinary retention.

The most current full MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 03/06/18. This MDS documented the resident with a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance with most ADL's (activities of daily living) with assistance of at least one staff person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 13	F 656		

totally dependent upon one staff person for bathing. The resident was assessed as having an indwelling catheter on this MDS and triggered in the CAAS (care area assessment summary) section of this MDS for cognition, urinary, falls and nutrition.

Resident #1 was observed multiple times during the survey process from 09/18/18 through 09/20/18. The resident had an indwelling Foley catheter in place during the survey process.

During clinical record review, the resident's physician's orders were reviewed from admission to present and documented in summary, that the resident was admitted with a Foley catheter on 02/28/18. On 04/03/18 the Foley catheter was discontinued, and intermittent catheterization twice daily was started at that time. The resident had a hospitalization from 04/05/18 through 04/11/18. The resident was readmitted on 04/11/18 with an indwelling catheter. The catheter was again discontinued on 08/28/18. The resident had a hospitalization from 09/03/18 through 09/10/18. The resident was readmitted to the facility on 09/11/18 with an indwelling Foley catheter.

Resident #1's current CCP (comprehensive care plan) was reviewed and documented, ".. has altered bladder elimination related to bladder neck obstruction with intermittent catheterization [date initiated: 02/28/18] [Revision on: 09/04/18]..interventions in place to minimize risk of complications from intermittent catheter use through next review...intermittent catheter as ordered [date initiated: 08/29/18]..Monitor and report to MD [medical doctor] any signs/symptoms of UTI [urinary tract

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 14	F 656		

infection] ..obtain and monitor lab/diagnostic work as ordered ..apply barrier cream...Observe catheter for tension during transfers and repositioning [date initiated: 07/24/18]...observe and report to nurse any skin impairments noted during care [date initiated: 03/22/18] ..Observe skin areas around F/C [Foley catheter] strap and remove as needed to check skin condition [date initiated: 05/31/18 ..check [name of Resident #1] for incontinence and assist with toileting as needed.. "

The CCP did not address Resident # 1's history of or the current use of an indwelling Foley catheter. The CCP did not address any type of interventions for the prevention of complications related to the use of an indwelling Foley catheter. No interventions were listed regarding care and assessment of complications from the prolonged use of an indwelling catheter. The resident subsequently acquired penile erosion through the urethra, which left the resident with a wound measuring 3 cm (centimeters) in length, by 4 cm wide by 0.5 cm depth, and listed as a stage 2 pressure ulcer per LPN (Licensed Practical Nurse) #1 and RN (Registered Nurse) #1 wound/skin assessment dated 09/20/18.

On 09/20/18 at 10:50 a.m., the unit manger, also known as LPN # 1 was interviewed regarding Resident #1's CCP. The LPN was made aware that the resident's indwelling catheter and/or interventions related the the use of an indwelling catheter were not on the resident's CCP. The current CCP still had the resident as receiving intermittent catheterization's

The LPN stated that anyone can update the CCP, but normally is done when MDS assessments are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 15 completed. On 09/20/18 at approximately 1:30 p.m. the DON (director of nursing) and the administrator were made aware of serious concerns with Resident #1's prolonged use of an indwelling catheter and the fact that the resident's CCP did not address the current status of the resident and did not include interventions for the prevention of complications. The DON agreed that the CCP is what drives the resident's care and agreed that he CCP should be up to date to reflect the resident's current interventions and status and is the plan of care for that resident. No further information and/or documentation was presented prior to the exit conference on 09/20/18 at 2:00 p.m. 2. Resident #21 was admitted to the facility on 6/28/18 with diagnoses including, cerebral vascular accident, urine retention with Foley catheter, hemiplegia affecting right side, anemia, and current urinary tract infection. The most recent MDS (minimum data set) assessment was a quarterly with an ARD (assessment reference date) of 7/15/18. Resident #21 had a cognitive score of 3 indicating severe cognitive impairment. Section G of the current MDS documented that Resident #21 needs extensive two person assist with personal hygiene. On 9/19/19 at 10:35 AM license practical nurse (LPN #4) was observed performing Foley catheter care. Prior to catheter care Resident #21 was observed with blood on the left hand LPN #4 made the comment that Resident #21 digs and scratches at himself around his pubic	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 16	F 656		

area. LPN #4 removed Resident #21's brief and blood was observed around the penis and scrotal area; there were no lacerations or abrasions observed. Resident #21's finger nails were long, thick, and yellowed and did not appear clean or well kept. When asked about nail care LPN #4 verbalized that she has asked for Resident #21 to be seen by podiatry but podiatry only does toe nails. LPN #4 also verbalized that the facility does not have clippers that will work on the resident's finger nails because they are so thick and that the physician would be contacted regarding Resident #21's nails. When asked about resident scratching and digging around his genital area LPN #4 verbalized that she felt like it was behavioral because when he can't access his genital area he will pick at inanimate objects such as his wheel chair.

On 9/19/18 Resident #21's care plan was reviewed and did not evidence any care plan regarding behaviors or any interventions regarding scratching.

09/19/18 04:26 PM Informed DON (director of nursing) and administrator regarding the above finding. The DON was asked, should a care plan be put in place regarding behaviors related to scratching at the Resident's genital area to the point of making himself bleed. The DON verbalized that resident should be care planned for behaviors regarding scratching.

No other information was presented prior to exit on 9/20/18.

3. Resident #27 was admitted to the facility on 10/11/17 with diagnoses that included schizophrenia, diabetes, chronic kidney disease, anxiety, peripheral vascular disease, bipolar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 17	F 656		

disorder and pericarditis. The minimum data set (MDS) dated 7/21/18 assessed Resident#27 with moderately impaired cognitive skills. This MDS assessed Resident #27 to require cueing and set up help with personal hygiene.

On 9/18/18 at 10:08 a.m., Resident #27 was observed in his room. The resident's front teeth were missing with the remaining visible teeth chipped and discolored. The visible teeth had black and gray discoloration on the surface and along the gums. Resident #27's fingernails on both hands were long and uneven. The fingernails were dirty with black/gray substance under all the nails.

Resident #27's clinical record documented the resident's teeth were in poor condition upon admission to the facility. Resident #27's admission nursing assessment dated 10/11/17 documented the resident had natural teet.. that were chipped and/or broken. The clinical record also documented the resident frequently refused baths, showers and daily hygiene. Resident #27's activity of daily living records for the past 30 days documented the resident refused personal hygiene daily from 8/26/18 through 9/3/18 and on 9/9/18 and 9/13/18. Nursing notes documented multiple attempts to get the resident to bathe and/or shower.

Resident #27's plan of care (revised 7/16/18) included no problems, goals and/or interventions regarding the resident's teeth or activities of daily living. The plan of care for nutrition listed the resident "has poor dentition and is on a mechanical soft diet for ease of chewing" but included no interventions regarding dental care or services. The care plan made no mention of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 656	Continued From page 18 resident's refusals of baths/showers On 9/19/18 at 2:14 p.m., the licensed practical nurse (LPN #2) caring for Resident #27 was interviewed. LPN #2 stated the resident's fingernails were long and dirty but the resident refused nail care and daily baths frequently. LPN #2 stated the resident frequently did not take a bath unless you bargained with him regarding cigarettes. LPN #2 stated she documented in nursing notes the resident's refusals and their attempts to get him to bathe. On 9/19/18 at 8:34 a.m., the registered nurse responsible for care plan development (RN #1) was interviewed about Resident #27. RN #1 reviewed the care plan and stated the broken and missing teeth were not listed but should have been addressed. On 9/19/18 at 3:42 p.m., RN #1 was interviewed about Resident #27's personal hygiene refusals. RN #1 reviewed the care plan and stated she did not see anything concerning activities of daily living or dental concerns. RN #1 stated the resident's refusals of daily hygiene should have been addressed under behaviors. These findings were reviewed with the administrator and director of nursing during a meeting on 9/19/18 at 4:00 p.m.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment (ii) Prepared by an interdisciplinary team, that	F 657	F657 1. Root Cause Analysis was conducted on 9/21/2018.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 19 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 22 residents in the survey sample. Resident #1. The facility staff failed to review and revise the CCP for Resident #1 in the areas of urinary and nutrition. Findings include: Resident #1 admitted to the facility originally on 02/28/18. Diagnoses for Resident #1 included, but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia, DM (diabetes mellitus), Parkinson's disease, history	F 657	Ad Hoc QAPI committee meeting was held on 9/21/2018. Resident #1 Care Plan was updated on 9/25/2018 to reflect use of indwelling catheter and nutritional status. 2. Quality review of care plan for residents with indwelling catheters and nutritional needs will be reviewed to ensure care plan is accuracy. 3 9/24/2018 the clinical management team was educated by the Regional MDS coordinator on reviewing and revising care plans in a timely manner to reflect the resident's current status. The DON or designee will educate the licensed nursing staff on reviewing and revising care plans in a timely manner. DON/designee to conduct quality review of random care plans weekly for 8 weeks to validate accurate reflection of the resident. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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	F 657		

of alcohol abuse, cardiomegaly, gout, anemia, thrombocytopenia, and BPH (benign prostatic hypertrophy) and urinary retention.

The most current full MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 03/06/18. This MDS was reviewed and documented the resident with a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance with most ADL's (activities of daily living) with assistance of at least one staff person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent upon one staff person for bathing. The resident was assessed as having an indwelling catheter on this MDS and triggered in the CAAS (care area assessment summary) section of this MDS for cognition, urinary, falls and nutrition.

Resident #1 was observed multiple times during the survey process from 09/18/18 through 09/20/18. The resident had an indwelling Foley catheter in place during the survey process.

The resident's physician's orders were reviewed from admission to present and documented in summary, that the resident was admitted with a Foley catheter on 02/28/18. On 04/03/18 the Foley catheter was discontinued, and intermittent catheterization twice daily was started at that time. The resident had a hospitalization from 04/05/18 through 04/11/18. The resident was readmitted on 04/11/18 with an indwelling catheter. The catheter was again discontinued on 08/28/18. The resident had a hospitalization from 09/03/18 through 09/10/18. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 21 was readmitted to the facility on 09/11/18 with an indwelling Foley catheter Resident #1's current CCP (comprehensive care plan) also documented, "...has altered bladder elimination related to bladder neck obstruction with intermittent catheterization [date initiated: 02/28/18] [Revision on: 09/04/18] ..interventions in place to minimize risk of complications from intermittent catheter use through next review. ..intermittent catheter as ordered [date initiated: 08/29/18] ..Monitor and report to MD [medical doctor] any signs/symptoms of UTI [urinary tract infection]...obtain and monitor lab/diagnostic work as ordered...apply barrier cream...Observe catheter for tension during transfers and repositioning [date initiated: 07/24/18]...observe and report to nurse any skin impairments noted during care [date initiated: 03/22/18] ..Observe skin areas around F/C [Foley catheter] strap and remove as needed to check skin condition [date initiated: 05/31/18...check [name of Resident #1] for incontinence and assist with toileting as needed..." The CCP did not address Resident # 1's current indwelling Foley catheter. During clinical record review, the resident's weight records were reviewed and revealed the resident had a substantial weight loss from admission on 02/28/18 through September 2018. The resident had a total weight loss of 18.61 % and a total of 43 lbs (pounds) during that time The resident's physician orders were reviewed from admission to present regarding interventions for weight loss and documented in summary, that the resident had med pass 60 ml BID [twice daily]	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 22 ordered on 03/16/18, puree diet ordered on 04/06/18, fortified foods on 05/12/18 and med pass change of 120 ml TID [three times a day] on 07/30/18. The resident's current CCP (comprehensive care plan) documented, "...assist with feeding when needed...observe for s/sx [signs/symptoms] of dysphagia...observe for s/sx of malnutrition...observe for s/sx of oral/dental problems...evaluate and make diet change recommendations as needed..." The CCP did not list the resident's weight loss and d d not list any type of nutritional interventions in place for the prevention of weight loss. On 09/20/18 at 10.50 a.m., the unit manger, LPN (Licensed Practical Nurse)# 1 was interviewed regarding Resident #1's CCP. The LPN was made aware that the CCP did not include the resident's nutritional interventions or the resident's current indwelling catheter. The LPN stated that anyone can update the CCP, but normally is done when MDS assessments are completed. On 09/20/18 at approximately 1:30 p.m. the DON (director of nursing) and the administrator were made aware major concerns with Resident #1's CCP not including the resident's current indwelling catheter and did not include any weight loss interventions. The DON agreed that the CCP is what drives the resident's care and agreed that he CCP should be up to date to reflect the resident's current interventions and status and is the plan of care for that resident. No further information and/or documentation was	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 23 presented prior to the exit conference on 09/20/18 at 2:00 p.m.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide nail care for two of 22 residents. Resident #21 and Resident #23 1. Resident #21 was observed with long, thick, yellow finger nails. 2. Resident #23, dependent upon staff for assistance with personal hygiene, had long, dirty fingernails. Findings were: 1. Resident #21 was admitted to the facility on 6/28/18 with diagnoses including, cerebral vascular accident, urine retention with Foley catheter, hemiplegia affecting right side, anemia, and current urinary tract infection. The most recent MDS (minimum data set) assessment was a quarterly with an ARD (assessment reference date) of 7/15/18. Resident #21 had a cognitive score of 3 indicating severe cognitive impairment. Section G of the current MDS documented that Resident #21 needs extensive two person assist with personal	F 677	F677 1.Root cause analysis was completed on9/24/2018. Ad hoc QAPI committee meeting was held on 9/28/2018. Resident #21 is receiving treatment for nail fungus. Resident #22's nails were cleaned and trimmed on 9/20/2018. 2. Quality review of residents residing in the facility will be completed by the Unit Manager or designee ensure nail care is being provided. 3. The licensed nursing staff and certified nursing staff will be educated on providing ADL care to include cleaning and trimming finger nails as needed. DON or designee to conduct quality review to validate that residents are being provided nail care as needed. This will be completed 5 times weekly for 8 weeks. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 677	Continued From page 24	F 677		

hygiene.

On 9/19/19 at 10:35 AM, license practical nurse (LPN #4) was observed performing Foley catheter care. Prior to catheter care Resident #21 was observed with blood on the left hand. LPN #4 made the comment that Resident #21 digs and scratches at himself around his pubic area. LPN #4 removed Resident #21's brief and blood was observed around the penis and scrotal area; there were no lacerations or abrasions observed. Resident's #21's finger nails were long, thick, and yellowed and did not appear clean or well kept. When asked about nail care LPN #4 verbalized that she has asked for Resident #21 to be seen by podiatry but podiatry only does toe nails. LPN #4 also verbalized that the facility does not have clippers that will work on the resident's finger nails because they are so thick and that the physician would be contacted regarding Resident #21's nails.

09/19/18 04:26 PM Informed DON (director of nursing) and administrator regarding the above finding.

No other information was presented prior to exit on 9/20/18.

2. Resident #23 was admitted to the facility on 2/8/08 with diagnoses that included cervical spinal cord injury, high blood pressure, glaucoma and contractures of the left and right hand. The minimum data set (MDS) dated 7/8/18 assessed Resident #23 as cognitively intact. The MDS listed the resident had limited functional range of motion of upper and lower extremities on both sides and required the extensive assistance of one person for personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 677	Continued From page 25 On 9/18/18 at 9:30 a.m., Resident #23 was observed in bed in his room. The resident had contracted fingers on both hands with his fingertips resting on his palms. The resident's fingernails on both hands were long, extending beyond the ends of his fingers. The pinky nails on both hands were longer than the other nails. Both thumbnails were dirty with a black substance and were jagged. Resident #23 was interviewed at this time about his long nails. The resident stated his fingernails were cut "about a month ago" and stated he wanted his nails cut and cleaned. Resident #23 stated his nails were hard to cut because his fingers were contracted. Resident #23's plan of care (revised 7/9/18) documented the resident had ADL (activities of daily living) deficits due to his limited mobility. Goals to meet ADL care needs included, ".. will receive a staff support with ADLs through the review date..." Interventions to meet ADL needs included, "...requires extensive assist of 1 staff regarding bathing, dressing, Toileting .." On 9/19/18 at 2:05 p.m., the certified nursing aide (CNA #1) caring for Resident #23 was interviewed about the fingernails. CNA #1 stated nails were usually cut during baths and/or showers "whenever they need cutting." CNA #1 stated Resident #23 usually received his bath and ADL (activities of daily living) care on the 11:00 p.m. to 7:00 a.m. shift. CNA #1 stated she did not know why his nails had not been cut. On 9/19/18 at 2:12 p.m., the licensed practical nurse (LPN #2) working on Resident #23's living unit was interviewed about nail care. LPN #2 stated nails were supposed to be cut and cleaned as needed during ADL care.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 677	Continued From page 26 These findings were reviewed with the administrator and director of nursing during a meeting on 9/19/18 at 4:00 p.m.	F 677	F684 1. Root cause analysis was conducted on 9/21/2018. Ad hoc QAPI committee meeting was conducted on 9/28/2018. Resident#50 is receiving medication according to Physician orders for bowel regimen.	AOC 10/16/18
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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 This REQUIREMENT is not met as evidenced by: Based on clinical record review, document review and staff interview, the facility failed to implement interventions for bowel management. Resident #50 did not have a bowel movement for 5 consecutive days and the facility did not implement bowel management interventions. The findings include: Resident #50 was admitted to the facility on 07/17/17 with a readmission on 09/04/18. Diagnoses for Resident #50 included: hypertension, anemia, acute kidney failure, dementia without behaviors, adult failure to thrive, abdominal swelling/pain, dysphasia, muscle weakness and hypokalemia. The most recent minimum data set (MDS) dated 08/26/18 assessed Resident #50 as being severely cognitively impaired and rarely making decisions The MDS assessed Resident #50 as being	F 684	2. Quality review of residents at risk for constipation will be reviewed by the DON or designee to ensure that interventions are in place and are being implemented as needed. 3. The licensed nursing staff and certified nursing staff will be educated on documentation of bowel movements and the bowel protocol. The clinical team will review documentation daily to identify residents who have not had a bowel movement within 3 days and follow protocol. DON or designee to conduct quality review weekly for 8 weeks to ensure that interventions are being implemented when deemed necessary for no bowel movement 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 684	Continued From page 27 always incontinent of bowel. Resident #50's clinical record was reviewed on 09/19/18 at 8:36 a.m. A review of the bowel and bladder report documented that Resident #50 did not have a bowel movement for 5 consecutive days for the period of 08/12/18 through 8/16/18. There was no documentation that the facility implemented bowel management interventions during these days. Resident #50's plan of care in place during August 2018 included no interventions regarding constipation or bowel management. On 09/19/18 at 8:30 a.m., the licensed practical nurse (LPN #4) who routinely provides care for Resident #50 was interviewed regarding the bowel management interventions. LPN #4 stated the facility's protocol is to notify the attending physician when a resident does not have a bowel movement for 3 consecutive days. LPN #4 stated based on the resident's orders he or she is given a laxative or suppository depending on the physician orders. On 09/19/18 at 4:00 p.m. the director of nursing (DON) was interviewed about the bowel management procedure. The DON stated after 3 consecutive days of a resident not having a bowel movement, the nurse is to contact the physician to discuss interventions. The DON was advised that Resident #50 did not have a bowel movement for 5 consecutive days for the period of 08/12/18 through 08/16/18 and the clinical record did not document any interventions. The DON stated she would review the information and provide an update the next morning (09/20/18). On 09/20/18 at 8:35 a.m., the DON stated she	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 684	Continued From page 28 reviewed Resident #50's records and there were no bowel management interventions for the period of 08/12/18 through 08/16/18. The DON stated the certified nursing assistants (CNA) document if the resident does or does not have a bowel movement. The DON stated the CNA also verbally reports to the lead nurse those residents who have triggered for no bowel movement in 3 days. The DON stated the nurses use the electronic clinical dashboard to identify those residents who are at risk for constipation. The DON stated she did not know why there were no bowel management interventions for Resident #50 completed during this period. A review of the facility's Bowel Movement Worksheet Policies and Procedures (revised 9/1/2017) documents the following procedure steps: "The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions." "If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident's order sheet making sure there is a laxative or suppository order." No additional information and/or documentation was provided to the survey team prior to the exit conference on 09/20/18 at 2:00 p.m.	F 684		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 29 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure	F 690	F690 1. Root cause analysis was completed on 9/21/18. The Physician ordered the indwelling catheter due to Neurogenic bladder. Resident #1 was assessed and found to have penile trauma related to usage of the catheter. The Physician desired to continue the indwelling catheter and treatment was initiated to address the penile trauma. Ad hoc QAPI committee meeting was conducted 9/28/18. . Resident #1 was seen by Physician on 9/19/2018 and the indwelling catheter remains in place. The plan of care being reviewed for possible supra-pubic catheter placement. 2. Quality review of residents with indwelling catheters will be completed by the DON or designee to ensure that they are free from complications related to the device.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 30 one of 22 residents (Resident #1) was assessed and provided care and services for the prevention of urethral trauma related to the prolonged use of an indwelling Foley catheter. As a result the resident developed trauma to the urethra (urethral tear/erosion) constituting harm to the resident Findings include Resident #1 admitted to the facility originally on 02/28/18. Diagnoses for Resident #1 included, but were not limited to: COPD (chronic obstructive pulmonary disease), dysphagia, DM (diabetes mellitus), Parkinson's disease, history of alcohol abuse, cardiomegaly, gout, anemia, thrombocytopenia, and BPH (benign prostatic hypertrophy) and urinary retention. The most current full MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 03/06/18. This MDS documented the resident with a cognitive score of 6, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance with most ADL's (activities of daily living) with assistance of at least one staff person for bed mobility, transfers, dressing, toileting and personal hygiene. The resident was totally dependent upon one staff person for bathing. The resident was assessed as having an indwelling catheter on this MDS and triggered in the CAAS (care area assessment summary) section of this MDS for cognition, urinary, fall's and nutrition. The resident additionally triggered for pressure in the CAAS area of this MDS, but it was not marked to address this area in the careplan.	F 690	3. The licensed nursing staff and the certified nursing staff will be educated on proper securement of indwelling catheters and completion of skin assessments to include documentation. Unit manager or designee will conduct quality review of catheter care weekly for 8 weeks to ensure procedure is appropriate and device is properly secured. DON or designee to conduct quality review of catheter care weekly for 8 weeks to ensure the resident is free from trauma and that the care is being provided adequately. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 31 During clinical record review, a consult from the urologist dated 04/03/18 documented, ".. This patient had incomplete voiding with + [positive] UA [urinalysis], decreased renal function and negative UC [urine culture] 2/18. Foley passed in ER [emergency room] and has had hematuria and urethral trauma twice since then. Flomax d/c'd [discontinued] but on proscar AODM [adult onset diabetes mellitus]. Parkinson's and BPH [benign prostatic hyperplasia]. Paraphimosis* reduced 1. atonic neurogenic bladder with incomplete voiding and trauma to urethra secondary to catheter manipulation. 2. paraphimosis Recommendations: D/C Foley catheter Intermittent cath BID [twice daily] if RU [residual urine] < [less than] 250 ml [milliliters] then intermittent cath QD [every day] RT [refer to] urology PRN [as needed]...signature of urologist." Paraphimosis occurs when the foreskin of an uncircumcised male cannot be pulled back over the head of the penis. Website: https://medlineplus.gov/ency/article/001281.htm The resident's physician's orders were reviewed for April 2018 and included an order to: "...d/c Foley catheter [04/03/18]...intermittent catheterization, if urine output is less than 250 ml two times a day for urine retention...May D/C intermittent catheterization if urine output is 250 ml or more consistently..." A physician's progress note dated 04/04/18 at 10:08 p.m. documented, "...COPD and history of falling, at baseline...stable...agree with plan of care..." The note made no mention of the resident's Foley catheter or care of the catheter. Nursing notes were reviewed and documented	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 32	F 690		

the following:

04/03/18 at 3:00 p.m., "...resident back in facility...new order to D/C Foley catheter, intermittent catheterization BID if residual urine 250 ml then intermittent cath QD...called doctors office for clarification on how long to cath BID... Awaiting call back from doctors office..."

04/04/18, "...Foley d/c'd per MD [medical doctor] orders. Voiding without difficulty. Saturated three brief [sic] on this shift..."

On 04/06/18 the resident was admitted to the hospital and returned on 04/11/18. Resident #1 was readmitted with an indwelling catheter in place.

The resident's physician's orders did not reveal a physician's order was in place for the indwelling catheter present on readmission of 04/11/18; physician's orders documented an order for an 18 french Foley catheter on 06/07/18.

On 06/27/18 nursing notes documented that "Nystatin" was ordered for "penis irritation/scrotum" and that the attending physician was in the facility [06/27/18] and had been made aware, and wanted to continue with the treatment as ordered and the resident required a follow up of condition.

No information was found in the resident's clinical record regarding any follow up for the above condition. No physician's progress notes were found regarding concerns related to the resident's indwelling catheter.

On 07/09/18 a nursing note documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 33 "Irritated area on tip of penis has small amount of improvement, treatment to area is continued ..scrotum is completely healed...Catheter strap is needed on catheter/leg at all times to prevent pulling on catheter..." The resident's MARs/TARs [mediation administration records/treatment administration records] were reviewed from admission 02/28/18 through 09/20/18 and did not reveal any documentation that a leg strap was implemented or being tracked or monitored for placement, to ensure tension was not being placed on the catheter. On 07/14/18 a nursing note documented that the irritation to the resident's penis had improved. No other documentation, skin records, or wound records were located to indicate that the area had been assessed by nursing or the physician, or that the area of concern was being followed and monitored to evidence actual improvement or deterioration On 07/20/18 a nursing note documented, "Spoke with [name of attending physician] and he is aware of meatus tearing. I advised him of interventions in place and he wanted to know when resident was scheduled for next urologist appointment, if he has none scheduled appointment [sic]. Spoke with wife while she was in facility and made aware of reeducation to staff and needing to check on next urologist appointment " On 07/25/18 a physician's progress note documented, "pain with movement of patient Foley catheter...Foley repositioning alleviates discomfort..." There was no documentation in the	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 34 physician progress notes that evidenced he was aware of the resident's "meatus tearing." Further review of the nursing notes revealed the following: 07/29/18, "...treatment of nystatin ointment continues to resident penis due to excoriation at Foley catheter insertion site...area has improved...skin at insertion site of resident's penis is pink in color, with no drainage or blood noted... [name of attending physician] in facility 07/25/18 and did see this resident no new orders given, would like this treatment to continue." 07/30/18, "Continues with nystatin cream to...penis...no drainage/bleeding noted. Instructed resident not pull on catheter. Pain upon manipulation or movement of catheter. ." 08/01/18, "Some excoriation noted at Foley catheter insertion site. [Name of physician] in to see resident... " 08/08/18 , "...improvement at Foley catheter site...Another leg strap placed on resident Foley catheter tubing for stability. [Name of physician] in tonight, no new orders given." 08/24/18, "Very little progress to penile meatus site, will ask for reevaluation of site R/T [related to] treatment." 08/25/18, "Very little progress noted to penile meatus. Treatment continue [sic] as ordered." There were no physician progress notes for 08/01/18 or 08/08/18.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 35	F 690		

A urology consult dated 08/28/18 documented, "....Report Requested Regarding catheter problem...Findings: atrophic urethral necrosis at the distal phallus from chronic indwelling Foley, no significant acute cellulitis, being treated with topical creams, patient also manipulating the Foley, atrophic distal penile necrosis secondary to chronic indwelling Foley. Recommendations: 1 continue lubricating penile meatus with KY jelly BID. 2. avoid excess catheter tension. These are the problems that occur with chronic indwelling Foley and why I recommended intermittent catheter on 04/18 See Note...signature of physician."

A physician's order documented to, "Discontinue Foley catheter [08/29/18]..."

On 09/02/18 a nursing note documented, "d/c Foley catheter, intermittently catheterize twice daily if his residual urine are less than 250 cc he then can be catheterized once a day. Indwelling catheter should be avoided due to high likelihood of urethral trauma two times a day for urine retention. Intermittently catheterize twice daily If residual urine are less than 250 cc then he can be catheterized once a day. Indwelling Foley catheter should be avoided due to high likelihood of urethral trauma. Foley catheter in place [sic]"

On 09/03/18 the resident was admitted to the hospital and returned on 09/10/18. Resident #1 was readmitted with a Foley catheter in place.

Resident #1's current CCP (comprehensive care plan) was reviewed and documented, "...has impaired cognition...assist with decision making ..has altered bladder elimination related to bladder neck obstruction with intermittent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 36	F 690		

catheterization [date initiated: 02/28/18] [Revision on: 09/04/18].. interventions in place to minimize risk of complications from intermittent catheter use through next review...intermittent catheter as ordered [date initiated: 08/29/18]..Monitor and report to MD [medical doctor] any signs/symptoms of UTI [urinary tract infection]...obtain and monitor lab/diagnostic work as ordered...apply barrier cream...Observe catheter for tension during transfers and repositioning [date initiated: 07/24/18]...observe and report to nurse any skin impairments noted during care [date initiated: 03/22/18]...Observe skin areas around F/C [Foley catheter] strap and remove as needed to check skin condition [date initiated: 05/31/18...check [name of Resident #1] for incontinence and assist with toileting as needed ..has impaired skin integrity to the left gluteal area related to impaired mobility.. apply barrier cream...assess/record/monitor wound healing weekly Measure length, width, and depth where possible...[dated initiated: 09/14/18] . "

The CCP did not address Resident # 1's current Foley catheter, did not address the resident's penile erosion/urethral tear and did not include any type of interventions for the prevention of complications related to the use of a Foley catheter

On 09/19/18 at 11:00 AM, the DON (director of nursing) was made aware of concerns regarding Resident # 1's indwelling catheter and possible complications and was asked to observe care of the resident's catheter. The DON stated that she would get the Unit Manager, LPN (Licensed Practical Nurse) # 1, to assist with the observation.
The DON was asked for skin and/or wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 37 assessment records for Resident #1. On 09/19/18 at 11:10 AM, LPN #1 took Resident #1 to his room via wheelchair. The LPN explained to the resident concerns regarding the catheter and was asked if an observation could take place. The resident agreed. The resident was sitting in his wheelchair. The LPN had a flashlight for observation and applied gloves. The LPN pulled the front of the resident's sweat pants down, exposing his genital area. The resident had an indwelling catheter in place. The resident's tip of the penis (glans penis) was red and raw. The LPN moved the penis to view the underside, the resident's penis was torn/ripped from the tip of the penis (the urethral opening) to the bottom of the glans penis (below the frenulum), the entire underside of the penis is open and raw. The resident had a leg strap on the left leg upper thigh. The LPN stated, "It didn't look like that the last time I seen it." The LPN was asked when was the last time she had seen it. The LPN stated, "The last time I seen it was, well I've been gone for three weeks." The LPN did not provide a date of when the resident's penis was last observed or any other information regarding the condition of the resident's penis. The resident stated, "Tell my wife." The LPN stated that the resident's wife makes his appointments for him and that the resident has one coming up, but she [LPN] was not aware of when it was. The LPN was made aware that the resident just had an appointment on 08/31/18. The LPN stated, "What did they say, what did they order?" The resident was asked if the area hurt or was painful. The resident stated, "Sometimes it burns and hurts all the time." The LPN was asked when was the resident's next urology appointment. The LPN stated that she	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 38	F 690		

wasn't sure, but would find out.

On 09/19/18 at approximately 4:00 p.m., the survey team met with the administrator and DON and informed of concerns regarding Resident #1. The DON was asked when a resident has a catheter, are the nurses supposed to be providing Foley catheter care and tracking output of the resident's catheter. The DON stated, "Yes, anytime anyone has a catheter they [the nurses] should be documenting." The DON further stated that resident's with Foley catheters have an order set for care. The DON was asked if that was a standing order set or was the order set individualized. The DON stated that it was individualized for each resident. The DON was asked for a copy of Resident #1's urinary catheter order set regarding care and instructions, along with any policies and procedures for catheter care, the resident's kardex, and any voiding trials attempted with documentation.

Admission assessments and skin assessments/wound records were presented and reviewed for Resident #1 from admission to present.

An admission assessment dated 03/05/18 documented the resident had a indwelling catheter and with no skin impairments to any area of the body.

An admission assessment dated 03/29/18 documented no skin impairments to any area of the body

An admission assessment dated 09/10/18 documented the resident had a catheter (did not specify type), and that the resident had "penile,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 39	F 690		

meatus tear from Foley catheter"; no measurements or any other description was documented for this area.

Skin assessments were located in the clinical record dated 04/18/18, 04/25/18, 05/02/18, 05/09/18, 05/16/18, 05/23/18, 05/30/18, 06/06/18, and 06/20/18. Each skin assessment documented the resident's skin was intact without any impairments to any area of the body.

A skin assessment dated 09/14/18 documented that the resident had "excoriation on penile meatus, treatment progress [sic]"; no other information or details were found.

On 09/20/18 at approximately 9:40 a.m., the DON was interviewed regarding skin and/or wound records for Resident #1's penis. The DON stated that she has looked and seen the same thing as the surveyor. The DON stated that was all the assessment information for Resident #1 regarding skin/wound assessments.

On 09/20/18 at 10:50 a.m., the unit manger, LPN # 1 was interviewed regarding Resident #1 and the observation of the resident's penis on 09/19/18. LPN # 1 was asked if she called the attending physician. The LPN stated, "No, I didn't call [name of attending physician]." The LPN was asked, who is responsibly for skin/wound assessments. The LPN stated that the nurse's do their own skin and wound assessments. The LPN was then asked if she thought a skin or wound assessment should have been done on Resident #1 based on the observation on 09/19/18. The LPN stated that the nurse assigned on that shift should have done some type of skin assessment, because the nurse's are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 40	F 690		

providing catheter care. The LPN was asked if she thought a skin assessment or some documentation should have been completed for Resident #1 based on the findings of the observation on 09/19/18. The LPN stated, "I guess I should have probably did it since I was the one who seen it." The LPN stated that it should have been completed on a "nonpressure" skin/wound assessment and that she was going to do it now. The LPN stated that she would include measurements.

On 09/20/18 at 11:45 a.m., LPN #1 presented a "non pressure" skin assessment, which documented, "...09/20/18 10:57 a.m....present upon admission: yes....penis meatus tear from prolonged use of catheter. red. no drainage, denies pain, measurements done.." No measurements were included on this assessment.

An attached nursing note dated 09/20/18 at 11:29 a.m "...penis remains tor [sic] measurements done w-4, l-3, d-.5...area that is beefy red and some areas are pink. He does exhibit some discomfort, it appears inflamed, [name of attending physician] office called and made aware of appearance."

On 09/20/18 at approximately 12:00 p.m. noon, the DON and administrator were made aware of the serious concerns regarding Resident #1 in meeting with the survey team. The DON was asked if LPN #1 was qualified to do wound assessments and complete measurements and provide staging for wounds. The DON stated yes and went on to say that the ADON (assistant director of nursing), RN (registered nurse) #1 completed the assessment with the LPN. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 41	F 690		

DON was made aware that the LPN completed the assessment as "non pressure", that the area was documented by the LPN as being present upon admission, and that the measurements were not included on the actual assessment. The DON was informed that clarification was needed regarding the measurements and if the area was present upon admission, where was that documentation.

The DON presented a policy titled, "Catheter care, urinary", which documented the care of a catheter for cleaning and did not provide interventions regarding concerns and/or complications.

The current kardex for Resident #1 was presented and documented, "...check for incontinence and assist with toileting as needed...provide peri care after each incontinent episode...observe skin areas around F/C strap and remove as needed to check for skin condition..."

At approximately 1:20 p.m. a "pressure ulcer wound" assessment dated 09/20/18 and timed 1:10 p.m. documented, that the area was not present upon admission and "...site: groin [did not identify the penis as the wound site] type: pressure 3 cm [centimeters] length 4 cm width .5 cm depth Stage: 2...red ..pain around penile meatus..."

The DON and administrator were again informed in a meeting with the survey team on 09/20/18 at approximately 1:30 p.m. of the serious concerns with Resident #1 including the lack of physician's orders for the indwelling catheter, lack of assessment by the nursing staff, not developing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 690	Continued From page 42 CCP for the indwelling catheter and the lack of interventions for the care and maintenance of the indwelling catheter. A indwelling Foley catheter order set was never presented for Resident #1. An order set was presented for another resident, but not Resident #1. The DON stated that the order sets were basically the same, but one was not provided for Resident #1. No documentation and/or information regarding any type of voiding trials/bladder retraining and/or toileting program was presented for Resident #1. No further information and/or documentation was presented prior to the exit conference on 09/20/18 to evidence the facility staff provided appropriate care and services for the prevention of complications related to the prolonged use of a Foley catheter, which resulted in actual harm to the resident.	F 690		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) 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 and clinical record review, the facility staff failed to ensure dialysis services were provided as ordered by the physician for one of 22 residents in the survey sample. Resident #29 missed a scheduled dialysis treatment due to lack of transportation	F 698	F698 1. Root cause analysis was completed on 9/21/2018. Ad hoc committee meeting was held QAPI on 9/28/2018. Resident #29 is receiving dialysis treatments as scheduled Facility administrator will review contract with Logisticare by 10/16/2018 regarding cancellation process.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 698	Continued From page 43 and failed to report the missed session to the physician. The findings include: Resident #29 was admitted to the facility on 3/9/11 with a re-admission on 7/2/18. Diagnoses for Resident #29 included chronic kidney disease with hemodialysis, heart failure, osteoarthritis, atherosclerosis epilepsy and cerebrovascular disease. The minimum data set (MDS) dated 7/9/18 assessed Resident #29 as cognitively intact. Resident #29's clinical record documented a physician's order dated 7/2/18 for hemodialysis on Tuesday, Thursday and Saturday each week The resident's plan of care (revised 8/13/18) documented the resident required dialysis due to chronic renal failure Interventions to ensure dialysis treatments as scheduled included communicating with dialysis center as needed and notify physician of any complications. A nursing note dated 7/10/18 documented the resident missed a dialysis treatment due to lack of transportation. The note on 7/10/18 documented, "Resident didn't go to dialysis today d/t [due to] no transportation issues. [Transport service] has not set up her standing order for her dialysis and facility van in the shop. I called [transport service] and filed a complaint because I sent in all necessary forms and they were supposed to transport today. Attendant advised me to call back today to ensure it has been done Resident was very upset and I reassured her it was a mistake on [transport service]. she has to be at dialysis tomorrow at 12:30."	F 698	2. Quality review of scheduled transportations within the past 30 days will be completed by the DON or designee to ensure no appointments were missed. 3. The DON will educate workforce manager on transportation process The licensed nursing staff will be educated on notification to the Physician for missed appointments to dialysis. DON or designee to conduct quality review of scheduled transportation to include dialysis appointments, weekly for 8 weeks to ensure no appointments are missed related to transportation. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 698	Continued From page 44 The record documented no attempts at obtaining alternate transportation for Resident #29 on 7/10/18. There was no notification to the physician concerning the missed dialysis treatment on 7/10/18. On 9/19/18 at 9.26 a.m., the social worker was interviewed about Resident #29's lack of transportation to dialysis. The social worker stated they frequently had issues with the routine transport service and stated, "Sometimes they [transport service] don't show." The social worker stated the previous administrator spoke with the transport service supervisor about problems with transport vans not showing up as scheduled. The social worker stated the facility had a van and transported residents if need but the van was not available on 7/10/18 because it was in the shop for repair. When asked if there were other transport services available, the social worker stated the contracted transport service was supposed to contact alternate services if they could not show up. Concerning Resident #29's missed dialysis treatment on 7/10/18, the social worker stated no alternate services were provided. On 9/19/18 at 2.38 p.m., the director of nursing (DON) was interviewed about Resident #29's missed dialysis treatment. The DON stated there was a list of back-up agencies if the contracted transport service was not available for some reason. The DON stated facility staff were required to contact the alternate services if needed. The DON stated, "We could get another transport service." The DON stated the transport companies sometimes do not like last minute transports but were supposed to be contacted if standard transportation was not available	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 698	Continued From page 45 On 9/20/18 at 9:20 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about notifying Resident #29's physician concerning the missed dialysis treatment on 7/10/18. LPN #1 stated, "if I didn't put a note in about notification I didn't do it. I put a note in for everything." These findings were reviewed with the administrator and DON during a meeting on 9/19/18 at 4:00 p.m.	F 698		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by. Based on staff interview and facility document review the facility staff failed to ensure RN (registered nurse) coverage for 8 hours on 9/16/18. Findings include	F 727	F727 1. Root cause analysis was completed on 9/21/2018. Ad hoc QAPI committee meeting was held on 9/28/2018. The facility has RN coverage 7 days a week. 2. Quality review will be completed by the DON or designee to ensure	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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) COMPLET ON DATE
F 727	Continued From page 46 On 09/20/18 at 09:43 AM the staffing "as worked" schedule for the survey timeframe was reviewed. On 9/16/18, a Sunday, no RN coverage was identified on the schedule. CNA (certified nursing assistant) # 3, who was identified as the scheduler, was interviewed at 9:00 a.m. about the coverage. CNA # 3 stated "Let me go back in the book to see who was here." At 9:30 a.m. CNA # 3 informed this surveyor "There was no RN coverage that day. No one called the on-call nurse, who was the ADON (assistant director of nursing), that coverage was needed that day." The administrator and DON (director of nursing) were informed of the above findings during a meeting 9/20/18 at 12:15 p.m. The DON stated "So, the RN can't be on call? They have to be here in the building?" The survey team stated "yes." No further information was provided prior to the exit conference	F 727	RN staffing 7 days weekly for 8 hours daily 3. The Executive Director and DON will be educated by the Regional Director of Clinical Services on the regulation for RN coverage. The Executive Director, DON and Workforce Manager will meet at least 3 times weekly to review staffing to ensure RN coverage 7 days weekly. DON or designee to conduct quality review of staffing schedule daily for 8 weeks to ensure RN coverage. 4. The findings will be reported to the quality improvement committee monthly and will be revised as necessary.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered	F 791	F791 1. Root Cause Analysis was conducted on 9/21/18 Ad hoc QAPI committee meeting was conducted on 9/28/2018. Resident #27 will be seen on the next dental visit on 10/4/17	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 COMPLET ON DATE
F 791	Continued From page 47 under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to offer and/or provide routine dental services for one of 22 residents in the survey sample. Resident #27, with visible missing and deteriorated teeth, was not offered or provided a dental assessment for repair/maintenance of his teeth	F 791	2. Quality review of residents' oral status will be completed by the Unit Manager or designee to identify residents with the need for dental services. 3. The DON or designee will educate nursing staff on completing oral care daily and notification of changes in dental condition. DON or designee to conduct quality review of residents weekly for 8 weeks to identify the need for dental services and schedule visits if needed. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 791	Continued From page 48 The findings include: Resident #27 was admitted to the facility on 10/11/17 with diagnoses that included schizophrenia, diabetes, chronic kidney disease, anxiety, peripheral vascular disease, bipolar disorder and pericarditis. The minimum data set (MDS) dated 7/21/18 assessed Resident#27 with moderately impaired cognitive skills. On 9/18/18 at 10:08 a.m., Resident #27 was observed in his room. The resident's front teeth were missing with the remaining visible teeth chipped and discolored. The visible teeth had black and gray discoloration on the surface and along the gums. Resident #27's clinical record documented the resident's teeth were in poor condition. Resident #27's admission nursing assessment dated 10/11/17 documented the resident had natural teeth that were chipped and/or broken. Resident #27's plan of care for nutrition (revised 4/20/18) listed the resident "has poor dentition and is on a mechanical soft diet for ease of chewing." The clinical record documented no plan of care regarding the resident's poor dental condition and included no referral to a dental provider for assessment and/or treatment. Social worker notes made no mention of the resident's dental condition. On 9/19/18 at 9:12 a.m., the social worker was interviewed concerning Resident #27's teeth The social worker stated a dental provider came to the facility once per month for assessments and provision of needed dental services. The social worker stated all residents were screened	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 791	Continued From page 49 by the dental service to determine any needed dental services. The social worker stated dental services were also provided if requested from nursing regarding any specific dental need. When asked if Resident #27 had been referred or had an initial assessment by the dental provider, the social worker stated, "I don't see anything." The social worker stated Resident #27 had not been initially screened and had not been referred by nursing regarding his deteriorated teeth. These findings were reviewed with the administrator and director of nursing during a meeting on 9/19/18 at 4:00 p.m.	F 791		
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities (i) This may include food items obtained directly from local producers subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812	F812 1. Root cause analysis was completed on 9/21/2018. Ad hoc QAPI committee meeting was held on 9/28/18. Expired foods were discarded immediately. Pans were washed and dried immediately. Foods are being stored properly. Dishes are being dried appropriately.	AOC 10/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 812	Continued From page 50 Based on observation, facility document review and staff interview, the facility staff failed to store and prepare food in a sanitary manner. Food items, with expired discard dates, were stored and available for use in the reach- refrigerator. Five baking/serving pans, identified as ready to use, were stored nested and wet. The findings include. On 9/18/18 at 8:39 a.m., accompanied by the dietary manager, the facility's main kitchen was inspected. Stored in the reach-in refrigerator were the following foods with expired discard dates: a plastic container of cheese sauce, loosely covered with plastic wrap, opened on 9/11 with discard date of 9/14; a plastic container of pears opened on 9/14 with discard date of 9/17; a plastic bag of deli meat labeled as 9-10 2-10; a plastic bag of house made macaroni salad made on 9/12 with discard date of 9/15; another plastic bag of deli meat opened on 9/10 with discard date of 9/13. The deli meats, macaroni salad, pears and cheese sauce were not in their original containers but were stored in Ziploc type plastic bags or plastic containers On 9/18/18 at 8:56 a.m., the stored prep/serving pans were inspected. The dietary manager identified the pans as ready to use. There were five large serving pans (three 4 inch deep, two 2 inch deep) stored nested and wet. Water droplets were visible along the pan edges and the flat pan surfaces were wet On 9/19/18 at 7:47 a.m., the dietary manager was interviewed about the out of date food items and wet pans. The dietary manager stated the food items were supposed to be labeled with a dated	F 812	2. The Executive Director will complete a quality review of food items in the kitchen ensure no items are expired as well as validate dishes are being dried properly. 3.Dietary Manger was in serviced by the Regional Food Manager on wet-nesting and discarding expired foods on 9/20/2018 The Executive Director or designee will complete a quality review of the kitchen weekly for 8 weeks to validate that foods are not expired and that dishes are being dried properly. 4. The findings will be reported to the quality improvement committee monthly and the plan will be revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 812	Continued From page 51 opened and a discard date. The dietary manager stated the discard date was typically 3 days after opening or preparing the food and foods were supposed to be discarded after this date. The dietary manager stated the deli meat labeled "9-10 2-10" was not labeled correctly and she did not know what the numbers/dates written on that bag meant. The dietary manager stated kitchen employees were supposed to review opened food items daily and discard as needed. The dietary manager stated there was a dry rack available for pans and serving pans were supposed to air dry prior to stacking. The facility's policy titled Food Storage: Cold Foods (revised 4/2018) documented, "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. All foods will be stored wrapped or in covered containers labeled and dated, and arranged in a manner to prevent cross contamination ." The facility's policy titled Manual Warewashing (revised 9/2017) documented, "All cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed and sanitized ..All serviceware and cookware will be air dried prior to storage. ." These findings were reviewed with the administrator and director of nursing during a meeting on 9/19/18 at 4:00 p.m.	F 812		