tate of Vir atement of d plan of (rginia F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA VBER:	1, ,	LE CONSTRUCTION	(X3) DATE SI COMPLE	ETED
		495236		B. WING		04/17	7/2019
	OVIDER OR SUPPLIER THE MEADOWS		2715 DOC	DRESS, CITY, S TOWN ROA AND, VA 230)63		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	I S ' FULL	ID · PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X5) COMPLETE DATE
	Initial Comments			F 000	Preparation and submi	ission of this plan	
	Inspection was co 4/17/19. Correcti with the following Regulations for the	biennial State Licensionducted 4/14/19 throfons are required for consistency with the Virginia Rulene Licensure of Nursirus 84 certified bed facinaryey. The survey scurrent resident reviews.	ogn compliance is and ng Facilities ility was 75 sample	5.	of correction does not of admission or agreement of the truth of the facts corrections of the concon the statement of deformed of correction is preparately because of the runder the State and Formular of correction will facility's allegation of	at by the provider alleged or lusions set forth ficiencies, the planed and submitted equirements ederal law. This a serve as the	
F 001	Non Compliance			F 001	compliance.		
	following state lift following state lift This RULE: is reduced to the following state lift and employee reduced that the facility solding for prerequirements for records, OSM (#17, #3, #9, #1, #6, LPN #7, RN 1. The facility solding background characteristics of the facility solding state lift for the facility soldin	nterview, facility docurecord review, it was distaff failed to follow the screening prior to hire or ten of 25 reviewed cother staff members) 0, LPN (licensed pract) (registered nurse) # taff failed to obtain a ceck at the time of hire the failed to obtain retime of hire/transfer fo	by: lures - SEE ment reviet etermined e Code of employee # 15, #16, tical nurse) 1 and RN # criminal for OSM #	w,) :7.			
	3. The facility (staff failed to obtain O rdinator) reference ch	SM # 17's ecks.		-		(X6) DATE
LABORATO	DRY DIRECTOR'S OR F	PROVIDER/SUPPLIER REPRI	ESENTATIVE'S	SIGNATURE E	Xecutive Direct	tor 5/	23/19

State of V TATEMENT C ND PLAN OF	irginia OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA VBER:		E CONSTRUCTION	(X3) DATE S COMPL	ETED
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		495250	STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		1
	ROVIDER OR SUPPLIER		2715 DOGT	OWN ROAD			}
ENVOY A	T THE MEADOWS		GOOCHLAN	ND, VA 2306	53	SECTION	(X5)
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F 001	Continued From P	age 1		F 001			
	(social services di reference checks		, of the carrier				
5. The facility staff failed to obtain OSM # (environmental services), sworn statemer reference checks at the time of hire.		TICTIC CATA		·			
	(environmental state) time of hire.	ff failed to obtain OSI ervices) reference ch	CONS CE STE				
	practical nurse) and failed to obtain of hire.	ff failed to verify LPN #7's license at the tir ain reference checks	at the time				
	license and obta at the time of hir reference check		n complete			·	
	nurse) #7's licer background che	taff failed to verify RN nse and obtain a crim ack at the time of hire).				
	10. The facility reference check	staff failed to obtain F ks at time of hire.	₹N # 1's				
	The findings inc						
	background ch 15 (receptionis		0 101 00				
	Review of OSN OSM #15's cri	eptionist) was hired on the second of the se	eck complete			-	
	011 4/ 10/ 15 at		021199		DZVM11	lf c	ontinuation sheet 2

State of V	<u> 'irginia : : </u>			OVON MULITIPA	E CONSTRUCTION	(X3) DATE S	SURVEY
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	1	E CONSTRUCTION	COMPL	ETED
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	T THE MEADOWS	·	2715 DOGT	OWN ROAL)		ì
ENVOTA	I THE MEADONS	<u>.</u>	GOOCHLA	ND, VA 2300	03	DECTION	(VE)
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F 001	Continued From P	age 2		F 001			
	interview was condification of human process for screen OSM #4 stated, "A interview to gauge second interview, sure good fit. Offe the process, check good standing, do through Virginia S inspector general) results to come be company mails it barrier crimes. Se from previous em (potential employeresults of the back statement (sworn go into employee statement, criminal backgroup of the criminal backgroup rovided OSM #1 other employee fit additional information was informed of the criminal backgroup of the composed of the criminal backgroup of the model of the criminal backgroup of the back	ducted with OSM #4 (resources) regarding and hiring new expolicant first schedule them. Then if good sand meet administer, or the job discuss pay k license make sure criminal background tate police, do OIG (or, drug screen. Wait fack. If there is somethed to make sure there and off two reference ployer. During this time, and find the swor al background check then of statement). Should be file and find the swor al background check and OSM is 5's employee file aloues and asked to produce the could asked to produce the could (administrative staff of clinical services) urveyor. ASM #4 staff of clinical services and performance of clinical services o	mployees. e an schedule a to make Then start current, in check office of or the hing, the re no checks ne they g the obtain be able to n reference me OSM #15's #4 was ng with ovide any SM #4 stated locate. member) #4 asked to ted did QAP ng an audit ation, CPR (office of d education rtment staff. ssues es, ASM #4				
	stated, "For the	ones identified, suppo	sed to get		DZVM11	If cont	inuation sheet 3 of 1
			021199		ロケムバニュ		

State of V	/irginia		TD/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
TATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	MBER:	1 ' '		COMPI	_ETED
				B. WING		04/1	7/2019
		495236	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
	ROVIDER OR SUPPLIER T THE MEADOWS		2715 DOG	TOWN ROAD	•		
ENVOTA			L	ND, VA 2306	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	/SACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETE DATE
F 001	Continued From P	age 3		F 001			
	but did not docum	e checks, go back and ent it in the action pla	.n."				
	up interview OSM was 5/2/18, and w record it was note missing and it was time, OSM #4 was this could not be OSM #9 (environt date 3/14/19. Reversely revealed notes that the could not be considered as the could not be considered as the could not be considered as the could revealed notes as the could not be considered as the considered not be considered as the could not be considered as the considered not be considered not be considered as the considered not be consi	roximately 2:00 p.m., #4 stated OSM #15's hen reviewing the emd the background ches obtained on 4/14/19 informed of the findicited as past noncompental services) was view of OSM #9's emo sworn statement, a in the file and the factericiency.)	s nire date hployee eck was . At this ings. (Note, pliance as hired on ployee nd no				
	"Abuse, Neglect, documented in parapplying for employment of a history of the composition	und check appropriate licensing hire Statement prior to h f status of any discipl) licensing or registra	, titled, propriation" rsons er will be et, sident ed to: g board and lire linary ation boards e of 7 titled,				

State of V	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	ER/CLIA MBER:	I * '	E CONSTRUCTION	(X3) DATE S COMPL	
AND PLAN OF	CORRECTION	495236		B. WING		04/1	7/2019
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F 001	the following is do may be give a corpending the succe background check law. Under no circle begin work until the is completed and unless state requibegin employment check (please refrequirements)." No further inform 2. The facility statchecks at the time (business office of the background checks at the time (business office of the background checks at the time of the background checks of the time of the background checks of the time of the background checks of the time of time o	"Background Check cumented in part, "Conditional offer of employers and completion of the cumestance is a job can examinate to receive a positive report is represented at prior to receipt pf beer to your state specification was presented attended and sworn statements allows a ment prior to receipt pf beer to your state specification was presented attended and sworn statements and lack of reference and sworn statements and lack of reference and sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and lack of reference and saked of sworn statements and s	andidates loyment he rohibited by andidate to round check eceived, echanism to ackground iffic prior to exit. Frence OSM # 16 Ew of OSM eriminal ent were imployee ce checks. Imployee condition of the facility employees. In a could in could in could in could in could in could in a follow				
	up interview OS	SM #4 stated, "OSM #	#16 		DZVM11	If con	tinuation sheet 5 of

State of \	/irginia	_		<u> </u>			2000
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	:R/CLIA MBER:	1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-UADT EXILO	Commedia			A. BUILDING			
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F 001	Continued From Pa	age 5		F 001			!
·	The background cl completed prior to of hire, but there a	e hire date with us is a neck and sworn state her transfer at the or re no reference check f the findings at this t	ment were iginal time ks." OSM				
	1/10/2018, and effer "Employment Appling in part the following individuals interest company must company must company must composite and satisfactory representative must be reference from at I prior to the applications for incretained in the emplicationed in the emplications for incretained in the emplication for incretained in the emp	with a revision date of ective date of 11/30/1 ication Procedure" dog: "Policy: It is the poled in an open position mplete and sign an erovide reference. All elemant upon successful contupon successful contupon successful contupon successful contupon a favorable least two of the reference that starting work. Recombet the employment applicatividuals who are hire ployee's personnel fill tion was presented.	4 titled, cumented licy that all n with the mployment ompletion and ree or neutral ences listed ords of all or not, must ation.				
	3. The facility staff	failed to obtain OSM ator) reference check	l # 17's s.				
	#17's employee re	ed on 5/16/18. Revie cord failed to reveal prior to or at the time	any				
	interview was condirector of human process for screen OSM #4 stated, "S from previous em	roximately 10:40 a.m ducted with OSM #4 resources) regarding ning and hiring new e Send off two referenc ployer. During this times se) stay home pending	(regional I the facility mployees. e checks ne they				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING O4/17/201 NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING O4/17/201 STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	
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ENVOY AT THE MEADOWS 2715 DOG TOWN ROAD GOOCHLAND, VA 23063	
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PROVIDER'S PLAN OF CORRECTION	(X5)
WALID SUMMARY STATEMENT OF DEFICIENCES FACH CORRECTIVE ACTION SHOULD BE CO	DMPLETE DATE
F 001 Continued From Page 6 F 001	
results of the background check then obtain statement (sworn statement). Should be able to go into employee file and find the sworn statement, criminal background check, reference checks and license checks." At this time, OSM #4 was informed of the above regarding OSM #17's lack of references in the employee file. OSM #4 was provided OSM #17's employee file along with other employee files and asked to provide any additional information /clarification. OSM #4 stated she would look to see what she could locate. On 4/17/19 at approximately 2:00 p.m., in a follow up interview OSM #4 stated, "Accurate we do not have reference checks." No further information was presented prior to exit. 4. The facility staff failed to obtain OSM #3's (social services director) sworn statement, and reference checks. OSM # 3 (social services director) was hired on 10/31/18. Review of OSM #3's employee record failed to reveal a sworn statement, or reference checks. On 4/16/19 at approximately 10:40 a.m., an interview was conducted with OSM #4 (regional director of human resources) regarding the facility process for screening and hiring new employees. At this time, OSM #4 was informed of the above regarding OSM #3's employee file. OSM #4 was provided OSM #3's employee file. OSM #4 was provided OSM #3's employee file along with other employee files and asked to provide any additional information /ciarification. OSM #4 stated she would look to see what she could locate. On 4/17/19 at approximately 2:05 p.m., in a follow up interview OSM #4 brought OSM #3's employee	

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F 001	Continued From Page 7		F 001				
	file to this surveyor. OSM #4 was observed looking through OSM #3's employee record. OSM #4 then stated, "There is no sworn statement and no reference checks."				,		
	No further information was presented prior to exit.						
	5. The facility staff (environmental ser reference checks.	failed to obtain OSM vices), sworn statem	#9's ent and			·	
	date 3/14/19. Rev	nental services) was liew of OSM #9's emposworn statement, and the file.	oloyee				
	interview was condification of human process for screer At this time, OSM regarding OSM #9 reference checks was provided OSM other employee file additional informations.	roximately 10:40 a.m. ducted with OSM #4 resources) regarding ning and hiring new e #4 was informed of the lack of sworn state in the employee file. If #9's employee file are and asked to provise what she could be see what she could lead to the lack of the l	(regional) I the facility Imployees. The above The above The and The above The facility				
	(Regional director speak with this su (quality assurance improvement) on of nineteen emploreferences, and by (cardiopulmonary inspector general) on facility policy of When asked what identified in the ninetesker with the ninetesker in the ninetesker with the ninetes	(administrative staff r of clinical services) a rveyor. ASM #4 state and performance 2/22/19 by completin yee files for: applicat ackground checks Cl resuscitation), OIG (n ASM #4 stated did in 2/22/19 with depart t was done for the iss meteen employee file nes identified, suppos	asked to ed did QAP g an audit ion, PR office of education ment staff. sues s, ASM #4				

State of \	/irginia			OVON NATIONAL PROPERTY.	LE CONCTRUCTION	(X3) DATE S	JRVEY
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F 001	Continued From Pa	age 8		F 001			
-	but did not docume However, review o revealed OSM #10	checks, go back and ent it in the action pla f OSM #10's employe was hired on 3/14/1 d completed the QAF	n." ee file 9 after the				
	up interview regard	roximately 2:05 p.m., ding OSM #9's missir erence checks, OSM n statement and no re	ng sworn #4 stated,				
:	No further informa	tion was presented p	orior to exit.				
: 	6. The facility staff (environmental se	failed to obtain OSM rvices) reference che	1 # 10's ecks.				
	3/15/19 review of	nmental services) hir OSM #10's employe re no reference chec	e record		,		
	interview was condirector of human process for screet At this time, OSM regarding OSM # the employee file. #10's employee file information /clarifi	roximately 10:40 a.m ducted with OSM #4 resources) regarding and hiring new e #4 was informed of the 10's lack of reference OSM #4 was provide along with other er provide any addition that she could location.	(regional g the facility employees. the above e checks in ed OSM mployee al			•	
	(Regional director speak with this su	(administrative staff of clinical services) rveyor. ASM #4 state and performance 2/22/19 by completir	asked to ted did QAP	i			

State of \	Virginia			<u> </u>				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		' '	LE CONSTRUCTION	(X3) DATE S COMPL		
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F 001	references, and ba (cardiopulmonary r inspector general). on facility policy on When asked what identified in the nin stated, "For the on OIG and reference but did not docume addition, review of revealed OSM #10 date the facility had education of staff. On 4/17/19 at appr up interview regard reference checks, reference checks, reference checks." No further informat 7. The facility staff practical nurse) #7 and failed to obtain of hire. LPN #7 was hired employee record reference of the control	ree files for: application (ckground checks CF) resuscitation), OIG (checks) ASM #4 stated did (checks) and the first checks and the first checks, go back and the first checks are checks and the first checks and the first checks are checks	office of education ment staff. Les and #4 ed to get dorrect it n." In e file 9, after the el and in a following o not have rior to exit. licensed e of hire, the time f LPN #7's	F 001				
	background check the license verifical On 4/16/19 at apprinterview was condificator of human process for screen At this time, OSM regarding LPN #75	was completed on 6 tion was obtained on tion was obtained on toximately 10:40 a.m ducted with OSM #4 resources) regarding and hiring new e #4 was informed of the criminal records of	., an (regional) the facility mployees. he above					
	license verification reference checks i	at the time of hire a in the employee file. employee file for LPN	nd lack of OSM #4	9 9 9 9 9				

State of \	/irginia					<u> </u>	
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·	asked to provide a	nployee files. OSM #- ny additional informat #4 stated she would d locate.	tion [
	up interview regard background check missing reference (LPN #7) is agency Criminal backgrout the agency. They provide reference	roximately 2:05 p.m., ding LPN #7's crimina, license verification a checks, OSM #4 state, she (LPN #7) camend was done when hiverified her license buchecks. We should her should not."	and ed, "She e 4/1/19. red with ut did not ave				
	No further informat	tion was presented p	rior to exit.				
	license and obtain	failed to verify LPN # a criminal back grout and failed to obtain c	nd check				
ļ	employee record redated, 4/14/19. LF	on 8/23/18. Review of evealed a background the solution of the second the second the second the second only ons could be located	d check ip vone of two				
	interview was condification of human process for screen At this time, OSM regarding LPN #6's license verification two reference chee #4 was provided the addition to other estimates.	roximately 10:40 a.m. ducted with OSM #4 (resources) regarding ing and hiring new er #4 was informed of the criminal records cheat the time of hire arcks in the employee file for Lemployee files. OSM #.ny additional informa	regional the facility mployees. ne above neck, nd lack of le. OSM PN #6, in				

STATE FORM

DZVM11

State of Virginia (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WING 04/17/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 Continued From Page 11 F 001 /clarification, OSM #4 stated she would look to see what she could locate. On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding LPN #6's criminal background check, license verification and missing reference check, OSM #4 stated, "The criminal records check and license check were not completed at the time of hire. I did not see it so redid it on 4/14/19." No further information was provided. 9. The facility staff failed to verify RN (registered nurse) #7's license and obtain a criminal background check at the time of hire. RN #7 was hired on date 2/15/19. Review of the employee file revealed the criminal background check was dated 12/19/17, and RN #7's license verification was dated 12/14/17. On 4/16/19 at approximately 10:40 a.m., an interview was conducted with OSM #4 (regional director of human resources) regarding the facility process for screening and hiring new employees. At this time, OSM #4 was informed of the above regarding RN #7's criminal records check, and license verification in the employee file. OSM #4 was provided RN #7's employee file and was asked to provide any additional information /clarification, OSM #4 stated she would look to see what she could locate. On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding RN #7's criminal background check, and license verification, OSM #4 stated, "The sworn statement has two different dates (2/28/18 and 10/15/17) can't explain that. License verification was done on a different date altogether, if rehire or transfer we are provided,

State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING ___ 495236 04/17/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From Page 12 F 001 F 001 that information, we also do it again. I do not have anything to back that up." OSM #4 was informed of the findings at this time. No further information was provided. 10. The facility staff failed to obtain RN # 1's reference checks at time of hire. RN # 1's hire date was 8/31/18. Review of RN #1's employee record revealed there were no reference checks in the record. On 4/16/19 at approximately 10:40 a.m., an interview was conducted with OSM #4 (regional director of human resources) regarding the facility process for screening and hiring new employees. At this time, OSM #4 was informed of the above regarding RN #1's lack of reference checks in the employee file. OSM #4 was provided RN #1's employee file and was asked to provide any additional information /clarification. OSM #4 stated she would look to see what she could locate. On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding RN #1's reference checks at the time of hire, OSM #4 stated, "No reference checks and she (RN #1) does still work here as needed (PRN)." OSM #4 was informed of the findings at this time. No further information was provided. 12 VAC 5 - 371 - 220 H - cross references to Federal Deficieny - 580 12 VAC 5 - 371 - 360 B - cross references to Federal Deficiency - 583 12 VAC 5 - 371 - 250 F, G - cross references to Federal Deficiency - 656

PRINTED: 04/30/2019 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495236 B. WING_ 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 001 Continued From Page 13 F 001 12 VAC 5 - 371 - 220 B - cross references to Federal Deficiency - 684 There is no cross reference for Federal Deficiency - 689 12 VAC 5 - 371 - 300 A - cross references to Federal Deficiency - 755 12 VAC 5 - 371 - 220 B - cross references to Federal Deficiency - 759 12 VAC 5 - 371 - 180 C.9 - cross references to Federal Deficiency - 925 12VAC5-371-110, Management and Administration. Cross reference to F607 and F610. 12VAC5-371-140. Policies and Procedures. Cross reference to F607, F610, F622, and F623. 12VAC5-371-150. Resident Rights. Cross reference to F622 and F623. Resident Assessment & Care Planning. 12VAC5-371-250F cross reference F657 Nusrsina Services 12VAC5-371-220A cross reference F758 12VAC5-371-170. Quality Assessment and Assurance cross reference to F868. 12VAC5-371-180. Infection Control

cross reference to F880.

cross reference to F686.

12VAC5-371-220. Nursing Services

12VAC5-371-220. Nursing Services

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495236 B. WING _ 04/17/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 001 Continued From Page 14 F 001 cross reference to F695. 12VAC5-371-260, Staff Development and Inservice Training cross reference to F730. 12VAC5-371-260. Staff Development and Inservice Training cross reference to F947. 12VAC5-371-300. Pharmaceutical Services cross reference to F761. 12VAC5-371-140 Policy and Procedures Cross referenced to F550 and F804 12VAC5-371-140 Policy and Procedures 12VAC5-371-360 Clinical Records Cross referenced to F583 12VAC5-371-360 Clinical Records 12VAC5-371-370 Maintenance and Housekeeping Cross referenced to F584 12VAC5-371-110 Management and Administration 12VAC5-371-140 Policy and Procedures Cross referenced to F607, F609, and F610 12VAC5-371-140 Policy and Procedures 12VAC5-371-150 Resident Rights 12VAC5-371-360 Clinical Records Cross referenced to F622 12VAC5-371-250 Resident Assessment and Care Planning Cross referenced to 656 12VAC5-371-220 Nursing Services Cross referenced to 695 12VAC5-371-180 Infection Control

If continuation sheet 16 of 16

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WING _ 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ENVOY AT THE MEADOWS** 2715 DOGTOWN ROAD GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 001 Continued From Page 15 F 001 Crossed referenced for F812 Fed code 803 was cross reference: 12VAC35-46-860, Nutrition Fed code 812 was state cross reference with the following: 12VAC5-450-120. Garbage and Refuse Disposal. 12VAC5-421-1100. Food-Contact Surfaces: Cleanability. 12VAC5-431-440, Food Services STATE FORM DZVM11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AH A" FORM

	FOR MEDICARE & MEDICAID SERVICES								
NO HARM V	T OF ISOLATED DEFICIENCIES WHICH CAUSE WITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING:	DATE SURVEY COMPLETE:					
FOR SNFs A	ND NPs	495236	B. WING	4/17/2019					
NAME OF PI	ROVIDER OR SUPPLIER		, CITY, STATE, ZIP CODE						
	T THE MEADOWS	2715 DOGTOW GOOCHLAND,							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES							
F 804	Nutritive Value/Appear, Palatable/Pref CFR(s): 483.60(d)(1)(2)	er Temp							
	§483.60(d) Food and drink Each resident receives and the facility I	provides-							
	§483.60(d)(1) Food prepared by metho	ds that conserve nu	tritive value, flavor, and appearance;						
	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:								
	Based on observation, resident interview, staff interview, clinical record review, and facility document review it was determined the facility staff failed to provide palatable food for two of 41 residents in the survey sample; Resident #9 and Resident #10.								
	The facility staff failed to provide palatable food during the breakfast meal; as the biscuits served to Resident #9 and Resident #10 were undercooked.								
	The findings include:								
	Resident #9 was admitted to the facility on 12/5/18, with the diagnoses including, but not limited to, depression, high blood pressure, type 2 diabetes mellitus, and anxiety. The most recent MDS (Minimum Data Set), a quarterly Medicare assessment, with an ARD (Assessment reference date) of 2/7/19, coded the resident as scoring a 13 on the BIMS (Brief interview for mental status) score, indicating the Resident has no cognitive impairment for daily decision making. The resident required setup and supervision for eating.								
	Resident #10 was admitted to the facility on 11/5/18 with the diagnoses of but not limited to high blood pressure, type 2 diabetes mellitus, depression, and gastro-esophageal reflux disease. The most recent MDS (Minimum Data Set), an annual Medicare assessment, with an ARD (Assessment reference date) of 1/11/19, coded the resident as scoring a 3 on the BIMS (Brief interview for mental status) score, indicating the Resident has severe cognitive impairment for daily decision making. The resident required setup and supervision for eating.								
	Resident #9 and Resident #10 were aske	On 4/114/19 at 7:58 a.m., an observation was made in the dining room during the breakfast meal. When Resident #9 and Resident #10 were asked about how their meal was, Resident #9 and Resident #10 stated, "The biscuits are doughy in the center." Resident #10 then placed her finger in the center of the biscuit and lifted the dough up with her finger.							
	A biscuit tasting was conducted by this s tasted undercooked. OSM #7 tasted a bi	On 4/15/19 at 8:20 a.m., an interview was conducted with OSM (Other staff member) #7 (Cook Supervisor). A biscuit tasting was conducted by this surveyor and revealed, the biscuit tasted had a mushy texture and tasted undercooked. OSM #7 tasted a biscuit and stated, "Sometimes with the oven you have to keep turning it (the biscuit tray) around. The biscuit tastes a little mushy. I was rushed. It takes 30 minutes to bake."							
	A review of the facility's policy "Food Pr	oduction/Preparation	on" with a revision date of 7/27/18 doc	cumented in					

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AH "A" FORM

	SISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	"A" FC				
	ONLY A POTENTIAL FOR MINIMAL HARM	,	A. BUILDING:	COMPLETE:				
FOR SNFs AND NFs		495236	B. WING	4/17/2019				
IAME OF PROV	IDER OR SUPPLIER		CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·				
NVOY AT T	THE MEADOWS		2715 DOGTOWN ROAD GOOCHLAND, VA					
D REFIX 'AG	SUMMARY STATEMENT OF DEFICIE	NCIES						
7 8 04	Continued From Page 1							
	part, "Policy: Food will be prepared Food Code using methods that conserv	e nutritive value, qu	ality, flavor and appearance."	·				
	On 4/16/19 at 3:15 p.m., ASM (Admin Director of Clinical Services), and ASI findings. No further information was p	M #2 (Interim Direc	tor of Clinical Services) were made av	(Regional vare of the				
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PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495236	B. WING_			04	/17/2019
	PROVIDER OR SUPPLIER			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	An unannounced Em survey was conducted was in substantial cor 483.73, Requirement Facilities. No compla during the survey. INITIAL COMMENTS An unannounced Med survey was conducted Corrections are requirements. The Life will follow. The census in this 84 at the time of the surve consisted of 37 currenciosed record reviews Resident Rights/Exerce CFR(s): 483.10(a)(1)(3) §483.10(a) Resident Fine resident has a right self-determination, and access to persons and outside the facility, incitations section. §483.10(a)(1) A facility with respect and dignit resident in a manner a	dicare/Medicaid standard 4 4/14/19 through 4/17/19. ed for compliance with 42 Long Term Care a Safety code survey/report certified bed facility was 75 ey. The survey sample at resident reviews and four dise of Rights 2/(b)(1)(2) tights. at to a dignified existence, at communication with and a services inside and auding those specified in a must treat each resident by and care for each and in an environment that a or enhancement of his or gnizing each resident's by must protect and	F 00	00	Preparation and submission of the of correction does not constitute a admission or agreement by the prof the truth of the facts alleged or corrections of the conclusions set to the statement of deficiencies, the of correction is prepared and subsciency because of the requirements under the State and Federal law. I plan of correction will serve as the facility's allegation of substantial compliance.	n ovider forth ne plan mitted s This	
		IDDITED DEDDECENTATION OCNATION			THE		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MB5W11

Facility ID: VA0162

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495236	B. WING		04/	17/2019
	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	2	BTREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	§483.10(a)(2) The factorises to quality care severity of condition, of must establish and mapractices regarding traprovision of services unresidents regardless of \$483.10(b) Exercise of The resident has the mights as a resident of or resident of the United §483.10(b)(1) The factorise of the facility. §483.10(b)(1) The factorise of the facility. §483.10(b)(2) The resident can exercise of the facility rights and to be supposed exercise of his or her risubpart. This REQUIREMENT by: Based on observation, record review, and factorise determined the factorise determined the factorise determined the factorise sample, Resided The facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the Resident's indwelling the several supposition of the facility staff failed the several supposition of the severa	ility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ensfer, discharge, and the under the State plan for all f payment source. If Rights. ight to exercise his or her the facility and as a citizened States. Ility must ensure that the his or her rights without discrimination, or reprisal dent has the right to be ercion, discrimination, and in exercising his or her red by the facility in the ghts as required under this is not met as evidenced staff interview, clinical lity document review, it citity staff failed to ensure one of 41 residents in the nt #69. In ensure and promote as it was observed that	F 550	1. Resident # 69 continues to require the of an indwelling urinary catheter collebag. The current urinary catheter collebag system used contains an attached occlusive cover that provides privacy a enhances dignity for resident. 2. Residents with physician orders for indwelling urinary catheters or a visib collection drainage system /device have assessed for providing privacy as of 5/No other residents were affected. 3. Licensed nursing staff will be re eduly Director of Nursing (DON) or designesident's right to privacy with respect Foley catheter drainage/collection bag managed to maintain or enhance dignit DON /designee will conduct quality reweekly for eight weeks to ensure priva drainage system are in place for reside with indwelling catheters and other detection. 4. The results of the quality monitoring to be reviewed by the quality assurance committee team monthly for review, a and further recommendations.	ction ection und le e been 9/2019. cated nee on to being ty. views cy ents vices. g data e	5-28-2019

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	1/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN HOAD GOOCHLAND, VA 23063		71774010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 550	Resident #69 was 3/28/19 with the dia obstructive and refl prostatic hyperplas tract symptoms, acretention of urine. (Minimum Data Seassessment, with a date) of 4/4/19, coon the BIMS (Brief score, indicating the cognitive impairment The MDS coded Reextensive assistant transfers, and eating In Section H - Bladd was coded as having active as a having an indwelling urinary catheter during the #69's care plan date potential for bladde physical limitations, having an indwelling urinary catheter during the bed frame and/cobserved uncovered the bed frame and/cobservation, urine with bag was visible on 4/14/19 at 4:00 per conducted with Reshis catheter bag bei others, Resident #6 bothers me."	admitted to the facility on agnoses of but not limited to lux uropathy (2), benign ia (BPH) (3) with lower urinary ute kidney failure, and The most recent MDS i), a five day Medicare in ARD (Assessment reference led the resident as scoring a 9 interview for mental status) is resident has moderate int for daily decision making. It is for hygiene, dressing, ig; total assistance for bathing. It is for hygiene, dressing, ig; total assistance for bathing. It is for and Bowel, the resident ing an indwelling urinary look back period. Resident incontinence related to BPH, and renal failure and as ig urinary catheter. D.m., and on 4/15/19 at 8:00 is 12:15 p.m., Resident #69's atheter collection bag was id, exposed, and hanging on or on the floor. During each was observed in the bag and	F 5.	50			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	X3) DATE SURVEY COMPLETED	
		495236	B. WING	i		n/	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			2	ETREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 07	1112013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	for residents with incollection bags, CN, them up in the wheel (indwelling urinary care to be covered at up in the wheelchair it is to be covered. I hall, she is going to should be covered awindow." On 4/16/19 at 10:28 conducted with LPN #2. When asked ab to ensure and promound welling urinary cakeep the Foley (indwelling urinary cakeep the Foley (indwedvered at all times, A review of the facility and Responsibilities' nursing facility reside existence A facility the rights of each restreated in a manner amaintains or enhance in full recognition of yprivacy." On 4/16/19 at 3:15 p Staff Member) #1 (E: (Regional Director of #2 (Interim Director of made aware of the file	about the process staff follows dwelling urinary catheter A #10 stated, "When I get elchair, I am to cover them atheter collection bag). They all, times when residents are If the bag is facing the door, if my boss comes down the tell me to cover it. They even if they are facing the a.m., an interview was (Licensed Practical Nurse) out the process staff follows out the process staff follows out dignity for residents with theters, LPN #2 stated, "We welling urinary catheter) bag unless emptying it." by's policy "Residents' Rights documented in part, "Each ent has a right to a dignified must protect and promote sidentPrivacyTo be and in an environment that the syour dignity, and respect your individuality and .m., ASM (Administrative executive Director), AMS #3 Clinical Services), and ASM of Clinical Services) were	F	550	,			
	(1) An indwelling cath	neter is a tube that drains						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		11720	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 558 SS=D	body. This informate website: https://medlineplus.io.100140.htm (2) obstructive and representation of the website: normal urine flow, so dysfunction (obstruction of the website: https://www.merckmtourinary-disorders/ove-uropathy (3) benign prostation men in which the proportion of the website: https://www.niddk.nilogic-diseases/prostate. https://www.nidkl.nilogic-diseases/prostate. https://www.nidkl.nilogic-diseases/pros	der to a bag outside of the ion was obtained from the gov/ency/patientinstructions/0 reflux uropathy: Obstructive all or functional hindrance of ometimes leading to renalitive nephropathy) The sined from the website: ranuals.com/professional/geniobstructive-uropathy/obstructive-uropathy/obstructive-uropathy/obstructive-proper and information was obtained information was obtained information was obtained inchyperplasia modations Needs/Preferences with reasonable esident needs and when to do so would or safety of the resident or is not met as evidenced on, staff interview, resident record review, it was acility staff failed to provide esident needs for one of 41	F 5				
	residents in the surve	ey sample, Resident # 73.					

			X3) DATE SURVEY COMPLETED			
		495236	B. WING			04/17/2019
•	ROVIDER OR SUPPLIER T THE MEADOWS		2	STREET ADDRESS, CITY, STATE, ZIP C 1715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	The facility staff failed call bell (a device with pushed to alert staff was within the reside observation, Resident the floor underneath freach. The findings include: Resident # 73 was ac 08/06/12 with a re-ad diagnoses that included mentia (1), heart fa and diabetes mellitus Resident # 73's most set), a quarterly asses (assessment reference Resident # 73 as scor interview for mental staff - 15, 3 (three) - being cognition for making of 73 was coded as required activities of daily "Functional Limitation Resident # 73 as "No of her upper extremitic hand). On 04/14/19 at 2:30 p	It to ensure Resident # 73's in a button that can be when assistance is needed), nt's reach. During an it #73's call bell was lying on his bed out of the residents. Imitted to the facility on mission of 04/27/15 with ed but were not limited to illure (2), atrial fibrillation (3) (4). In recent MDS (minimum data issment with an ARD edate) of 03/22/19, coded ing a 3 (three) on the brief atus (BIMS) of a score of 0 severely impaired of faily decisions. Resident # iring supervision with setup of living. Section G0400 in Range of Motion" coded impairment" on both sides its (shoulder, elbow, wrist,	F 558	F558 1. Resident # 73 has a call hand it is kept within reach call for assistance as needed. 2. Residents who reside in a provided with a call bell dein reach to alert staff when need. A quality review has as of 5-9-2019 by the interctorence call bells were wiresidents in the facility. Nowere affected. 3. Nursing staff will be reached device that needs to be resident's utilization. Quabe conducted five times we interdisciplinary team to oplacement of call bell device usage to allow the request. 4. The results of the quality data to be reviewed by me quality assurance committed for review, analysis and fur recommendations.	pell at the bedsid to allow him to d. the facility are exice that is place assistance is been conducted disciplinary team thin reach for oother residents educated by DON a resident with ce within reach folity reviews will the been conducted by the beserve for propect for assistance. y monitoring too mbers of the tee team meeting	ed N/ all r
	edge of his bed. Obse revealed it was lying o bed. When asked if hi Resident #73 stated,	ervation of the call bell In the floor underneath his In could locate his call bell It's over there" and pointed The privacy curtain toward				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING	9	04	/17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		,,,,,	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 558	observation reveale to reach for the call The comprehensive dated 02/07/2019 de (Resident # 73) is al has clear speech, vi adequate without de assistance with ADL due to impaired cog ambulatory and user as eat on it. He sits he is out of bed. He handrails on each si he use's them to help in the bed. Date Init "Interventions" it door resident to use bell to Initiated: 02/07/2019	d Resident # 73 was unable bell under his bed. care plan for Resident # 73 ocumented, "Focus. ole to make his needs known, sion and hearing are vices. He does need is (activities of daily living) intive status. He is a wheeled walker [sic] with on a chair by his bed when has 2 ¼ (two and a quarter) de of the bed and he reports of transfer and move around liated: 02/07/2019." Under umented, "Encourage the ocall for assistance. Date	F 5	558			
	Resident # 73 reveal next to his bed. Obs revealed it was attac rail. When Resident and press his call be observed to reach fo button independently. On 04/16/19 at 9:00 conducted with CNA 5. When asked to de placement of a reside stated, "The call bell resident." When ask of the call bell is checyou go into the room	r the call and depress the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		0.	1/17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		H1172019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFIGIENCIES 'MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD BE	(X5) COMPLETION DATE	
	conducted with LPN 4. When asked to a care plan, LPN # 4 a of the resident and a living." When asked on the care plan to and it is not followed implemented, LPN about Resident # 73 the floor under his bedocumenting Reside encouraged to use a "The care plan is not encouraged to use a treach. On 04/06/19 at appreciation (administrative staff director, and ASM # services, were made to the services and the services are made to the services are a services and the services are made to the services are se	is p.m., an interview was I (licensed practical nurse) # describe the purpose of the stated, "Monitor the progress to maintain a healthy level of diff something is documented be followed or implemented is the care plan was being # 4 stated, "No." When asked is call bell being observed on ed and the care plan ent # 73 should be nis call bell, LPN # 4 stated, to being followed. He can't be he call bell if it is not within eximately 3:43 p.m., ASM member) #1, the executive example aware of the above findings. On was provided prior to exit. Inction that occurs with certain nemory, thinking, language, vior. This information was ebsite: Incomplete the proposed prior able blood to the rest of the body es symptoms to occur. This information was	F 5	558			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING		n ₄	/17/2019	
1	PROVIDER OR SUPPLIER AT THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			1 0 111/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	the website: https://www.nlm.nih on.html. (4) A chronic diseas regulate the amoun information was obt https://www.nlm.nih 001214.htm. Notify of Changes (I CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must improve the consistent with his consult with the resi consistent with his consults in injury and physician intervention (B) A significant chamental, or psychosodeterioration in healt status in either life-thelinical complications (C) A need to alter the aneed to discontinu treatment due to advommence a new form the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informat	commation was obtained from gov/med/ineplus/atrialfibrillating of in which the body cannot to for sugar in the blood. This ained from the website: .gov/med/ineplus/ency/article/ Injury/Decline/Room, etc.) Injury/Decline/Roo	F 558				
, '	-						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	i	495236	B. WING_			04/	17/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/	1772019
ENVOY A	T THE MEADOWS				15 DOGTOWN ROAD DOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 580	when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must reupdate the address (mphone number of the representative(s). §483.10(g)(15) Admission to a composite dis §483.5) must disclose its physical configurati locations that comprise part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on staff interviere review, and clinical recidetermined the facility physician that medicat not administered per the of 41 residents in the site #52. The facility staff failed when the medication A to Resident #52 per the	lso promptly notify the ent representative, if any, or roommate assignment O(e)(6); or ent rights under Federal or as as specified in paragraph ecord and periodically halling and email) and esident site distinct part. A facility tinct part (as defined in in its admission agreement on, including the various enthe composite distinct the policies that apply to in its different locations is not met as evidenced every, it was staff failed to notify the lons were unavailable and the physician's order for one urvey sample, Resident enthe one was not administered enthe one was not available for	F 5	580	1. The MD was notified on 4-15-2019 of medication omission of Ativan and Methadone for resident #52. An order given to administer once received from Pharmacy, later that same evening resi #52 received her Ativan and Methadone Resident #52 is receiving her Ativan and Methadone as prescribed. 2. Residents with physician orders for Ativan have been reviewed for medical availability and administration as of 5/9/2019, no residents noted to be affect No other residents in the facility are prescribed Methadone. 3. Licensed nursing staff will be re educion following physician orders to include physician must be notified for any char in condition to include medication omis by DON/designee. Random medication administration observations will be conducted weekly for eight weeks by the DON or designee to ensure medications available and medication administratio completed in accordance with physician order. 4. The results of the quality monitoring be presented to the quality assurance committee monthly for review, analysis further recommendations.	was ident ident ite. id tion tted. cated e; the iges ssion i	5-28-2019

LAND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495236	B. WING_		04.	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		117,300 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 10 dmitted to the facility on	F 58	0		
	9/17/18 with diagnoral limited to lung cance pulmonary disease nonreversible lung of combination of emp	ses that included but were not er, COPD [chronic obstructive - general term for chronic, lisease that is usually a hysema and chronic. (1)],				
	depression.	, anxiety, chronic pain and	,			
	assessment, a quar assessment referen resident as scoring a interview for mental resident is severely cognitive decisions. having periods of discomes and goes. Re	DS (minimum data set) terly assessment, with an ce date of 3/13/19, coded the a "1" on the BIMS (brief status) score, indicating the impaired to make daily The resident was coded as corganized thinking that esident #52 was coded as flucinations and delusions.				
	The resident was co assistance of one sta activities of daily livir	ded as requiring limited aff member for most of her ng. In Section N - ident was coded as receiving				
	"Reduce am (mornin treat anxiety) (2), to (dated, 2/14/19, documented, g) dose of Ativan (used to 0.5 mg (milligram), cont ng) dose of Ativan @ (at) 1				
	physician medication scheduled for 2/15/19 nurse's initials with a was nothing docume	2019 (medication I) documented the above orders. The Ativan dose 9 at 9:00 a.m. had the circle around them. There nted on the reverse side of also documented the Ativan 1	·		,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	mg dose to be adminurse's initials circle 2/19/19, and 2/24/1 MAR documented of "Pending arrival from 5:00 p.m., the rever documented, "Sleep notes on the reverse the circled doses of The comprehensive documented in part, anti-anxiety medicated disorder." The "Inter "Administer ANT-AN ordered by physiciar effectiveness Q-SHI Review of the nurse and times, failed to ewhy the medication on the phenomena of the phenomena of the process stordered medication in administration, RN # a circle around their on the back of the M giving it. If it's not avail they can't get it to notify the doctor and something else in the the facility has an em#1 stated that there were and their on the stated that there we are the stated that the sta	inistered at 5:00 p.m. with the ed on 2/14/19, 2/15/19, 9. The reverse side of the on 2/14/19 at 5:00 p.m. m pharmacy." On 2/14/19 at se side of the MAR oing." There were no other e side of the MAR regarding Ativan listed above. I care plan dated, 3/26/19, "Focus: The resident uses tions r/t (related to) Anxiety eventions" documented in part, IXIETY medications as n. Monitor for side effects and FT (every shift)." I's notes for the above dates evidence documentation of was not administered, and or ysician. Inducted with RN (registered of at 4:07 p.m. When asked aff follows if a physician	F 58				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04/	17/2019
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	MG (milligram) Table three times daily at p.m.), 2200 (10:00 p.m.), 22	dated, 12/31/18, adone* HCL (hydrochloride) 5 et; 3 tabs (tablets) by mouth 0600 (6:00 a.m.) 1400 (2:00 o.m.) for pain." I to relieve severe pain in ected to need pain medication a long time and who cannot r medications (3). ary 2019 MAR (medication d) documented the above 1/14/19 at 2200 (10:00 p.m.) be medication and circled their wasn't given. There was no ne reverse side of the MAR d dose of Methadone. Is notes failed to evidence	F5	80		
	physician order. The not administered on at 10:00 p.m., 2/18/1 at 10:00 p.m. The reto evidence docume medication was not at the physician. Review of the nurse and times, failed to emedication was not at the physician. The March 2019 MA physician order. The not administered on	MAR documented the above Methadone was circled as 2/9/19 at 10:00 p.m., 2/10/19 9 at 6:00 a.m., and 2/21/19 everse side of the MAR failed ntation regarding why the administered as ordered by s notes for the above dates evidence the reason why the administered or notification to Methadone was circled as 3/8/19 at 6:00 a.m. and 2:00 p.m. and 3/13/19 at 2:00				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495236		B. WING		04/17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
p.m. There was not reverse side of the I doses. The physician order "Methadone HCL (h tabs (20 mg) PO (by day) for pain." The March 2019 MA physician order. The administration of the 3/17/19 and 3/18/19 side of the MAR faile documentation. Review of the nurse failed to evidence domedication was not anotification to the ph The physician order "Methadone HCL 20 mouth) TID (three tir The March 2019 MA order. On 3/26/19 at the medication was con 3/28/19, the 6:00 as not administered. documented, "3/26/1 Medication - Methadin from pharmacy."	dated, 3/14/19 documented, ydrochloride) 5 mg; give 4 mouth) TID (three times a AR documented the above MAR failed to document the Methadone on 3/16/19, at 2:00 p.m. The reverse ed to evidence any some some for the above dates ocumentation of why the administered, and or ysician. dated, 3/26/19, documented, mg tab (tablet) PO (by nes a day)." R documented the above 2:00 p.m. and 10:00 p.m., circled as not administered. a.m. dose was documented The reverse side of the MAR 9 - 1400 (2:00 p.m.), one - meds (medications) not some some process of the above dates cumentation of why the	F 5	, , , , , , , , , , , , , , , , , , ,		
medications were no notification to the phy	t given as ordered, and or sician.	•			
	PROVIDER OR SUPPLIER AT THE MEADOWS SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LE Continued From page p.m. There was nother reverse side of the flooses. The physician order "Methadone HCL (he tabs (20 mg) PO (by day) for pain." The March 2019 MA physician order. The administration of the 3/17/19 and 3/18/19 side of the MAR failed documentation. Review of the nurse failed to evidence do medication was not a notification to the physician order "Methadone HCL 20 mouth) TID (three tires the medication was con 3/26/19 at the medication was con 3/26/19 at the medication - Methadoin from pharmacy." Review of the nurse's failed to evidence do medication - Methadoin from pharmacy."	PROVIDER OR SUPPLIER AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 p.m. There was nothing documented on the reverse side of the MAR regarding the missed doses. The physician order dated, 3/14/19 documented, "Methadone HCL (hydrochloride) 5 mg; give 4 tabs (20 mg) PO (by mouth) TID (three times a day) for pain." The March 2019 MAR documented the above physician order. The MAR failed to document the administration of the Methadone on 3/16/19, 3/17/19 and 3/18/19 at 2:00 p.m. The reverse side of the MAR failed to evidence any documentation. Review of the nurse's notes for the above dates failed to evidence documentation of why the medication was not administered, and or notification to the physician. The physician order dated, 3/26/19, documented, "Methadone HCL 20 mg tab (tablet) PO (by mouth) TID (three times a day)." The March 2019 MAR documented the above order. On 3/26/19 at 2:00 p.m. and 10:00 p.m., the medication was circled as not administered. On 3/28/19, the 6:00 a.m. dose was documented as not administered. The reverse side of the MAR documented, "3/26/19 - 1400 (2:00 p.m.), Medication - Methadone - meds (medications) not	A BUILD 495236 B. WING PROVIDER OR SUPPLIER AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 p.m. There was nothing documented on the reverse side of the MAR regarding the missed doses. The physician order dated, 3/14/19 documented, "Methadone HCL (hydrochloride) 5 mg; give 4 tabs (20 mg) PO (by mouth) TID (three times a day) for pain." The March 2019 MAR documented the above physician order. The MAR failed to document the administration of the Methadone on 3/16/19, 3/17/19 and 3/18/19 at 2:00 p.m. The reverse side of the MAR failed to evidence any documentation. Review of the nurse's notes for the above dates failed to evidence documentation of why the medication was not administered, and or notification to the physician. The physician order dated, 3/26/19, documented, "Methadone HCL 20 mg tab (tablet) PO (by mouth) TID (three times a day)." The March 2019 MAR documented the above order. On 3/26/19 at 2:00 p.m. and 10:00 p.m., the medication was circled as not administered. On 3/28/19, the 6:00 a.m. dose was documented as not administered. The reverse side of the MAR documented, "3/26/19 - 1400 (2:00 p.m.), Medication - Methadone - meds (medications) not in from pharmacy." Review of the nurse's notes for the above dates failed to evidence documentation of why the medications were not given as ordered, and or	PROVIDER OR SUPPLIER A STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 p.m. There was nothing documented on the reverse side of the MAR regarding the missed doses. The physician order dated, 3/14/19 documented, "Methadone HCL (hydrochloride) 5 mg; give 4 tabs (20 mg) PO (by mouth) TID (three times a day) for pain." The March 2019 MAR documented the above physician order dated, 3/16/19, 3/17/19 and 3/18/19 at 2:00 p.m. The reverse side of the MAR failed to evidence any documentation. Review of the nurse's notes for the above dates failed to evidence documentation of why the medication was not administered, and or notification to the Physician. The physician order dated, 3/26/19, documented, "Methadone on 3/26/19 at 2:00 p.m. and 10:00 p.m., the medication was circled as not administered. The reverse side of the MAR documented the above order. On 3/26/19 at 2:00 p.m. and 10:00 p.m., the medication was circled as not administered, On 3/26/19 at 2:00 p.m. and 10:00 p.m., the medication was circled as not administered. The reverse side of the MAR documented as not administered. The reverse side of the MAR documented, "3/26/19 - 1400 (2:00 p.m.), Medication - Methadone - meds (medications) not in from pharmacy." Review of the nurse's notes for the above dates failed to evidence documentation of why the medications were not given as ordered, and or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	l/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	N SHOULD BE COMPLÉ E APPROPRIATE DATE	
	The comprehensive documented in part acute/chronic pain in pain to right ankle will (cancer)." The "Interpart, "Administer and An interview was conurse) #1 on 4/15/1 about the process sordered medication administration, RN # a circle around their on the back of the Migiving it. If it's not avill they can't get it to notify the doctor and something else in the facility has an er #1 stated that there room that contains a narcotics." When as nurse's initials indicathat nurse did not give asked if a nurse sho medication is not give can either document MAR or in a nurse's medication is not give should the physician "Absolutely and a not The box of emergence medication room was 4:16 p.m. accompan #2. The narcotics endocument the storage.	care plan dated, 3/14/19, Focus: The resident has It (related to) complaints of Ith warmth/swelling/ CA rventions" documented in algesics as per orders." Inducted with RN (registered 9 at 4:07 p.m. When asked taff follows if a physician is not available for It stated, "I first circle it (draw initials) on the front and write IAR what the reason for not railable, I'd call the pharmacy. In a timely manner, I'd I see if they want to give I see if they want to give I see meantime." When asked if I nergency medication box, RN I was a box in the medication Intibiotics, diuretics and some I ked what a circle around the I tet, RN #1 stated it means I tet medication. When I to the reverse side of the I note. When asked if a I e, refused or not available, I be notified, RN #1 stated, I te should be documented." I tey medications stored in the I sobserved on 4/15/19 at I ied by RN (registered nurse) I regency box failed to	F 58			

A95236 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD	7/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	772010
ENVOY AT THE MEADOWS GOOCHLAND, VA 23063	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 Continued From page 15 executive director, ASM #2, the interim director of clinical services and ASM #3, the regional director of clinical services were made aware of the above concern on 4/15/19 at 4:58 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682134.html. F 582 CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged, (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495236	B. WING			04	/17/2019
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD OOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	§483.10(g)(18) The resident before, or a periodically during the available in the faciliservices, including a covered under Medifacility's per diem ra (i) Where changes in and services covered Medicaid State plan notice to residents or reasonably possible (ii) Where changes a items and services the facility must inform the 60 days prior to implicate facility must refund the representative, or esting demonstrates of charges and per diem rate, for the resided or reserved of facility, regardless of discharge notice requived the resident within 30 date of discharge from (v) The terms of an abehalf of an individuate facility must not confit these regulations. This REQUIREMENT by: Based on staff intervand clinical record rethe facility staff failed	facility must inform each at the time of admission, and he resident's stay, of services ity and of charges for those any charges for services not care/ Medicaid or by the te. In coverage are made to items d by Medicare and/or by the the facility must provide if the change as soon as is are made to charges for other that the facility offers, the the resident in writing at least ementation of the change. In or is hospitalized or is a not return to the facility, the other resident, resident that, as applicable, any lready paid, less the facility's endays the resident actually or retained a bed in the any minimum stay or uirements. In or in the resident or we any and all refunds due of days from the resident's method the facility. Indicated the redirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the is not met as evidenced in the requirements of the resident review view, it was determined that	F 5				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495236		1,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING		04	/17/2019		
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	the survey sample, In Resident #228's last Part A services was failed to notify Resid resident's representation and the right to appear The findings include: Resident #228 was a 11/4/18. Resident #28's most data set) (prior to disassessment with an adate) of 11/17/18, co as severely impaired On 4/15/19at 10:40 a conducted with OSM director of social services was anothave a notice of resident #228's last Part A services was not have a notice of resident #3 stated in Novemband the business office departments were becompleting the notice stated the responsibilater transitioned to the department and it was Resident #228's notice #3 stated training reg provided after she resissued.	Resident #228. It covered day of Medicare 11/28/18. The facility staff ent #228 (and/or the ative) of the last covered day eal. It admitted to the facility on 226's diagnoses included but fuscle weakness, high blood depressive disorder. It recent MDS (minimum ficharge), a 14 day Medicare ARD (assessment reference ded the resident's cognition It a.m., an interview was (other staff member) #3 (the vices). OSM #3 confirmed covered day of Medicare 11/28/18 and stated she did non-coverage on file. OSM for 2018, she was in training, for and the social services for the social services for issuing the notices the social services the staff member of the social services the staff non-coverage. OSM #3 lity of issuing the notices the social services the that she realized the was not provided. OSM farding the notice was not	F 58	1.Resident #228 was discharge 2.Social Services Director or I review resident discharge from services within past 60 days to Medicare Non-Coverage notif provided. Follow-ups will be dindings. 3.Social Services Director will by Vice President of Revenue ensuring residents are notified care needed does not meet Mc coverage requirements. Exect or Designee to conduct quality ABN notification weekly x 8 v needed. 4. The results of the Quality M reviewed at the monthly Qual Performance Improvement (effor review, analysis, and further recommendations)	d on 11/28/19. Designee will in skilled censure form ication was lone based on be educated Cycle on it timely when edicare itive Director y monitoring of weeks and as fonitoring to be lity Assurance QAPI) meetings	5.28.19	
	On 4/15/19 at approx	imately 2:00 p.m., review of					

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495236	B. WING			04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			27	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD OOCHLAND, VA 23063	· · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	a facility plan of cornection (advance beneficiar non-coverage forms point of the plan of configuration (times) 4 weeks and ASM #2 (the interim were made aware of and ASM #2 were as the monitoring as do of correction. On 4/16/19 at approximate the monitoring pieces she knew a former effective the monitoring pieces she could not provide facility) Advance Bernotice of Medicare Focumented, "The Soutification (SNF ABNon-Coverage will be Medicare Part A resident of the clinical team of longer meets the MeservicesSNFs must Medicare Provider NaBN to Medicare berdays (48 hours) befend of the coverage will be ending"	rection regarding ABNs y notices)/ Medicare was conducted. The third correction documented, or Designee to conduct ABN notification weekly x as needed" a.m., ASM (administrative nee executive director) and director of clinical services) the above concern. ASM #1 sked to provide evidence of acumented in the above plan eximately 10:35 a.m., ASM #3 of clinical services) stated executive director completed of the plan of correction but the ethe evidence. ed, "SNF (Skilled nursing neficiary Notification (ABN) & Provider Non-Coverage" NF Advance Beneficiary	F 5	82			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 583 \$S=D	CFR(s): 483.10(h)(-1) §483.10(h) Privacy The resident has a confidentiality of his records. §483.10(h)(l) Person accommodations, matelephone communiand meetings of familiand meeting me	and Confidentiality. right to personal privacy and or her personal and medical hal privacy includes hedical treatment, written and cations, personal care, visits, hily and resident groups, but the facility to provide a sh resident. acility must respect the rsonal privacy, including the	F 58				
	written, and electron the right to send and mail and other letter materials delivered to including those delivithan a postal service §483.10(h)(3) The read confidential personal and medical personal and medical personal and medical or state laws (ii) The facility must a Office of the State Letto examine a resider administrative record law. This REQUIREMENT	esident has a right to secure sonal and medical records. the right to refuse the release lical records except as (i)(2) or other applicable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
		495236	B. WING_			04/17/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		-H 1112013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
	confidentiality of persod 41 residents in the sur #60, #74 and #45. 1. Personal information and #74 was observed cart on the 100 hall, not anyone passing by the 2. Resident #45's private medication reorder stick crusher handle on the hall of the facility. The people walking past the The findings include: 1. Personal information and #74 was observed cart on the 100 hall, not anyone passing by the Resident #5 was admitted 11/14/18 with diagnoses not limited to: COPD [cipulmonary disease - genonreversible lung disease in the people walking the pulmonary disease in the people walking both memory difficulties and on make daily cognitive of the people walking both memory difficulties and on make daily cognitive of the people walking both memory difficulties and on make daily cognitive of the people walking both memory difficulties and on make daily cognitive of the people walking both memory difficulties and on make daily cognitive of the people walking the	cility staff failed to maintain and information for four of vey sample, Residents #5, and for Residents #5, #60, and top of the medication of covered, visible to medication cart. It information on a ker was left on the pill medication cart on the 100 label was easily visible to emedication cart. In for Residents #5, #60, on top of the medication cart. In for Residents #5, #60, on top of the medication to covered, visible to medication cart. In the facility on the strain included but were medication cart. In the facility on the strain included but were medication cart. In the facility on the facility on the strain included but were medication cart. In the facility on the facility on the strain included but were medication cart. In the facility on the facility on the strain included but were medication cart. In the facility on the facility on the strain included but were medication cart. In the facility on the facility on the strain included but were medication cart. In the facility on the facility	F5	F583 1. The personal information fo # 60, # 74, and # 45 is being manner to provide privacy and confidentiality. 2. The personal information of been reviewed via observation nurses' practice of inappropripersonal information not cover to public. A folder has been policensed nurses with reorder for pharmacy communication requests. 3. Facility licensed nurses will on "Notice of Privacy Practice designee. The medication reorder for until the information is submit pharmacy for medication renequality review observations will conducted by quality assurance members on privacy practices to information collected and mabout residents, weekly for eig 4. The results of the quality medication review, further recommendations.	residents has for licensed ate placing red and visible rovided to orms enclosed of medication be re educated by DON / der labels will or privacy ted to wal. Random ll be e committee with respect aintained ht weeks.	5.28.19	
	Resident #60 was admit 2/22/19 with diagnoses t	ted to the facility on that included but were not					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	limited to: atrial fibri characterized by ray the atria of the hear the ventricles and re output and frequent (2)], and COPD. The data set) assessme assessment, with an of 3/22/19, coded the on the BIMS (brief in score, indicating the making daily cognitive. Resident #74 was a 9/28/18 with diagnost limited to: high blood dementia. The most set) assessment referent resident as having be memory difficulties a make daily cognitive. An observation was for the 100 hall on 4, was no staff membe white paper was sitting cart. On that piece of reordering medication for Residuretic used to treat and heart disease (3) Resident #60 was Visupplement for defice	lation [a condition oid and random contraction of t causing irregular beats of esulting in decreased heart by clot formation in the atria. The most recent MDS (minimum ont, a Medicare 30 day of assessment reference date of resident as scoring a "15" of terview for mental status) of resident was capable of the decisions. Indicate the facility on sees that included but were not of the pressure, low back pain and recent MDS (minimum data quarterly assessment, with an oce date of 3/26/19, coded the oth short and long-term and as severely impaired to decisions. Indicate the medication cart of 15/19 at 8:07 a.m. There is near the cart. A piece of ong on top of the medication of paper were three labels for on for the residents. The lined the names and dents #5, #60 and #74. The lent #5 was furosemide [a edema, high blood pressure of the medication for tamin D [used as a liency and to help the body of the medication for Resident is sufficient to the medication for Resident in the paper were three body of the medication for Resident in the paper were three body of the medication for Resident in the medication for Resident in the paper were three body.	F 5	83			

STATEMEN' AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	An interview was copractical nurse) #1, asked about the piemedication cart, LPI to reorder medication the sticky off the measked to review the LPN #1 was asked in of paper should be a pass by the medicate Ma'am. It should be the facility policy, "Notice of Privacy Promedical information used and disclosed access to this inform is responsible to: maresident health inform with a copy of this not responsibilities and promise information we concern on 4/15/19 and for clinical services and of clinical services we concern on 4/15/19 and Non-Medical Reader Chapman, page 55. (2) Barron's Dictional Non-Medical Reader Chapman, page 55.	onducted with LPN (licensed on 4/15/19 at 8:16 a.m. When ce of paper on the top of the N #1 stated, "It's when I have one from the pharmacy. I pulledication card." LPN #1 was list. After reviewing the list, if the information on that piece exposed for others to see that tion cart. LPN #1 stated, "No, covered." Notice of Privacy Practice" "Policy: The intent of the actices is to describe how about the resident may be and how the resident can get nation. Procedure: The facility aintain the privacy of the mation. Provide the Resident office (policy) of our privacy practices with respect elect and maintain about the he terms of this notice member (ASM) #1, the SM #2, the interim director of ASM #3, the regional director ere made aware of the above	F 58	33			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019
İ	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Chapman, page 12-(3) This information following website: https://medlineplus.tml (4) This information following website: https://vsearch.nlm.meta?v%3Aproject=medlineplus-bundle.729367.334979157.8851256 2. Resident #45's pr medication reorder scrusher handle on thall of the facility. T people walking past Resident #45 was at 11/29/18 with the diahigh blood pressure, depressive disorder Resident #45's Minimaterly review assing Reference Date (AR #45 with a BIMS (Bri Status) of 14 indicati impairment in her abdecisions. The residlimited assistance fo transfers, and eating incontinent of bladded bowel. On 4/14/19 at 4:10 p 100 hall's medication reorder sticker for Ri	was obtained from the gov/druginfo/meds/a682858.h was obtained from the mih.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources=&query=Vitamin+D&_ga=2.75 1555434117-938173006.146 ivate information on a sticker was left on the pill ne medication cart on the 100 he label was easily visible to the medication cart. dmitted to the facility on agnoses of but not limited to the medication cart. dmitted to the facility on agnoses of but not limited to dementia, anxiety, and with psychotic symptoms. The properties of t	F 58	33		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495236	B. WING_		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1772013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 583	medication cart in treasily visible to peomedication cart. A review of the clinic physician order, dating tablet, one tab (topsychosis/delusional further review of the MAR (medication acresident #45 that do 0.5 mg tablet was acred 4/14/19. On 4/16/19 at 9:41 a was conducted with observation. LPN #3 label on the pill crust sticker there and I streorder sticker]. The	ne hallway. The label was pole walking past the cal record revealed a ged 1/4/19, for Risperidone 0.5 tablet) by mouth twice daily for I disorder. The clinical record revealed a diministration record) for commented the Risperidone diministered at 9:00 a.m., on L.m., a telephone interview LPN #3, regarding the above 3 stated, "I recall a reorder ner. I did not place the nould have removed it [the preorder label discloses	F 58	,			
	patient information a Insurance Portability violation." A review of the facility and Responsibilities" Confidentiality To medical records treated to the facility of	nd is a HIPAA (Health and Accountability Act) y's policy "Residents' Rights documented in part, " have your personal and ted confidentially" m., ASM (Administrative Recutive Director), AMS #3 Clinical Services), and ASM of Clinical Services) were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495236	B. WING		04/17/2019	
ł	AT THE MEADOWS		. [:	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	0.7.772010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 583	medications called a works by changing t substances in the bi retrieved from https://medlineplus.o	atypical antipsychotics. It he activity of certain natural rain. This information was gov/druginfo/meds/a694015.h	F 583			
	S483.10(i) Safe Envi The resident has a recomfortable and hon but not limited to rec supports for daily livi The facility must prov \$483.10(i)(1) A safe, homelike environmenuse his or her persor possible. (i) This includes ensureceive care and semphysical layout of the independence and do (ii) The facility shall e the protection of the ror theft. \$483.10(i)(2) Housek services necessary to and comfortable inter-	ronment. ight to a safe, clean, nelike environment, including eiving treatment and ng safely. vide- clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the facility maximizes resident pes not pose a safety risk. exercise reasonable care for resident's property from loss eeping and maintenance maintain a sanitary, orderly,	F 584	1.Maintenance Director and Housekeepi Services Director completed repairs #9 b removing the old caulking ring on floor, cleaning the green blue discoloration insi tub, and removing the unconnected show hose on 4/22/2019. 2.Executive Director will conduct facility inspection to include resident rooms to identify areas for environmental improvement. Follow-ups will be done based on findings. 3.Quality assurance committee team members and maintenance team will be educated by Executive Director on provide residents a safe/clean/comfortable environment and reporting of any finding that require repair. Executive Director of Designee to conduct quality monitoring of facility environment weekly x 8 weeks to identify areas in need of environmental improvement. 4.The results of the Quality Monitoring to	ding gs or	
	§483.10(i)(4) Private or resident room, as spe	closet space in each cified in §483.90 (e)(2)(iv);		reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetifor review, analysis, and further recommendations.	ce	

CTATEMENT	TOT STEIGHTNOISE					אלו פועוי	<i>J.</i> 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NINE OF		495236	B. WING	·		04	1/17/2019
ENVOY	PROVIDER OR SUPPLIER AT THE MEADOWS	-		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1715 DOGTOWN ROAD BOOCHLAND, VA 23063	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BF	(X5) COMPLETION DATE
. F 584	levels in all areas;	ate and comfortable lighting	F 5	584			
	levels. Facilities initia	rtable and safe temperature ally certified after October 1, a temperature range of 71 to					
	sound levels. This REQUIREMENT by: Based on observation record review, and fawas determined the faclean, comfortable,	maintenance of comfortable is not met as evidenced on, staff interview, clinical cility document review, it acility staff failed to provide and homelike environment is in the survey sample,					
(The facility staff failed comfortable, and hom Resident #9's bathrod	nelike environment in					
-	The findings include:						
- 1 c n (a d 1 s ir re s	depression, high blood nellitus, and anxiety. Minimum Data Set), assessment, with an Alate) of 2/7/19, coded 3 on the BIMS (Brief acore, indicating the rempairment for daily desident was coded as upervision for eating; ygiene, dressing, tran	d pressure, type 2 diabetes The most recent MDS a quarterly Medicare ARD (Assessment reference the resident as scoring a interview for mental status) esident has no cognitive escision making. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) IĐ PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	incontinent of bladd On 4/14/19 at 2:20 made of Resident # appeared to have be toilet and a ring of of floor around the new appeared to have a discoloration inside shower handle was wall above the tub a bottom of the tub an anything. On 4/16/19 at 9:02 a conducted in Reside (Other staff member Maintenance). Whe were any issues in the toilet needs re-caulk scrubbed. The hose need a light bulb and wall." When OSM # bathroom was home better and touched uabout the process formaintenance issues stated, "There is a lowhere issues are plated to hall and address the was asked to review Resident #9's bathroom on 4/16/19 at 9:27 a conducted in Reside (housekeeper). Whethere were any issues stated, "It needs some	er and bowel. p.m., an observation was 9's bathroom. The toilet een changed to a smaller size ld caulking remained on the v toilet. The bathtub bright green blue the tub bottom and sides. A observed hanging from the and the hose extended into the lad was not connected to	F 5	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/17/2019
i	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	When OSM #9 was responsible for clear she stated, "House looked like that last the bright green blu she stated, "It was to OSM #9 was asked the maintenance de know if the toilet had A review of the facil Services" with an el documented in part cleaning of all interimpatient rooms, part Hospitality Services cleanliness of all interimpations of inferior and alignment of the facilities are to be cleaned repairstoiletsar Maintenance Superimpations of each resident of e	ng and has cleaning issues." s asked what department is uning resident's bathrooms, keeping. The bathroom week." When asked about the discoloration inside the tub, from wear and tear." When I if toilet area was reported to epartment, she stated, "I don't seen reported." ity's policy "Hospitality fective date of 11/30/14, "Policy: Standards for routine for spaces will be followed, tientbathsProcedure: The Supervisor will:Ensure the erior areas as indicated above	F	84		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 584 F 607 SS=E	comfortable and hor housekeeping and ravailable to maintain comfortable interior On 4/16/19 at 3:15 pstaff member) #1 (E (Regional Director of #2 (Interim Director made aware of the finformation was prosurvey.	melike environment. To have maintenance services a sanitary, orderly, and" D.m., ASM (Administrative executive Director), AMS #3 of Clinical Services), and ASM of Clinical Services) were indings. No further vided by the end of the	F 58			
	§483.12(b) The facilimplement written possible. §483.12(b)(1) Prohibine glect, and exploits misappropriation of (§483.12(b)(2) Estable to investigate any sur	ity must develop and plicies and procedures that: pit and prevent abuse, ation of residents and resident property, lish policies and procedures				
	paragraph §483.95, This REQUIREMEN' by: Based on staff inten review, clinical recon record review, it was failed to implement p the protection of resi neglect for four of 41 sample; Residents # ten of twenty five em	T is not met as evidenced view, facility document d review, and employee determined that facility staff colicies and procedures for dents from abuse and residents in the survey 42, #72, #9, and #30; and for ployee records reviewed, ical nurse) #6, LPN #7, RN				

495236 B. WING	17/2019
ENVOY AT THE MEADOWS ENVOY AT THE MEADOWS GOOCHLAND, VA 23063	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607 Continued From page 30 (registered nurse) #1 and RN #7, OSM (other staff members) # 15, #16, #17, #3, #9, #10). 1. The facility staff failed to implement the policy and procedures to complete an investigation for a resident-to-resident altercation between Residents #42 and #72 on 10/16/18, and failed to evidence results of an investigation were report to the required state agency within 5 working days. 2. The facility staff failed to evidence that policy and procedures were followed to report an allegation of abuse eriofficials for Resident #39 allegation of abuse reported to the facility staff failed to evidence that policy and procedures were followed to submit a follow up report within five working days to the SA (State Agency) and other officials for Resident #30 allegation of abuse reported to the facility staff failed to evidence that policy and procedures were followed to submit a follow up report within five working days to the SA (State Agency) and other officials for Resident #30's 9/19/18 allegation of abuse and failed to evidence complete a thorough investigation was completed. 4. The facility staff failed to implement the abuse policies and procedures for screening new employees prior to hired since the last survey for ten of twenty five employees records reviewed LPN (licensed practical nurse) #8, LPN #7, RN #7, RN #7, CSM#15, CSM#16, CSM#17, CSM#3, CSM#19, SM#19, SM#1	5.28-19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495236	B. WING			04/	04/17/2019	
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	evidence results of an the required state age Resident #42 was adr 11/29/17 with the diag traumatic brain injury, pressure, alcohol abudepression and deme (Minimum Data Set) with an ARD (Assessr 3/4/19. The resident viseverely impaired in a decisions. The reside extensive care for batifor all other areas of a Resident #72 was adm 9/16/16 with the diagn chronic obstructive pur frontotemporal demen anxiety disorder, schiz pressure, benign intrappendign neoplasm of the hyperplasia. The most Data Set) was a quarte ARD (Assessment Refine The resident was code impaired in ability to make The resident was code care for bathing and su areas of activities of data areas of ac	r2 on 10/16/18, and failed to investigation were report to ency within 5 working days. mitted to the facility on moses of but not limited to hypothyroidism, high blood se, hepatitis C, epilepsy, ntia. The most recent MDS was a quarterly assessment ment Reference Date) of was coded as being bility to make daily life nt was coded as requiring ning and supervision only ctivities of daily living. mitted to the facility on oses of but not limited to Imonary disease, tia, adjustment disorder, cophrenia, high blood cranial hypertension, e prostate and prostatic trecent MDS (Minimum erly assessment with an ference Date) of 3/22/19, and as being severely ake daily life decisions. The day are quiring extensive upervision only for all other aily living. mitted to the facility on one of 3/22/19, and as being severely ake daily life decisions. The day of 3/22/19, and as requiring extensive upervision only for all other aily living. mitted to the facility on one of 3/22/19, and as being severely ake daily life decisions. The day of 3/22/19, and as requiring extensive upervision only for all other aily living. mitted to the facility on one of 3/22/19, and as being severely ake daily life decisions. The day of 3/22/19, and as requiring extensive upervision only for all other aily living.	F	607	3. Facility staff will be educated on Res Abuse Policy by Executive Director or Designee to ensure residents are free f abuse and expectation of reporting sus incidents with 2 hours. Executive Director or Designee to audiallegations of abuse weekly x8 weeks a needed to ensure policies are followed included 2 hour reporting, thorough investigation, and 5 day follow up. Human Resources Manager will be ed on obtaining background checks, swor statements, license verification, and reference checks on employees prior to employment by Executive Director or Designee. Human Resource Manager of Designee to review new hire files prior start date weekly x8 weeks. 4. The results of the Quality Monitoring reviewed at the monthly Quality Assur Performance Improvement (QAPI) meters of the provement of the review, analysis, and further recommendations.	rom pected it nd as to ucated n or to g to be ance		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 607	#72)'s front shirt por separated and put of supervision) with staimmediately." There was no evide of an investigation was no evide of an investigation of any ASM #1 (Administra Executive Director). On 4/15/19 at 3:00 pinvestigation for (Rebe located. He was investigation was evident as investigation was evident as a conducted with ASM Clinical Services). A reported to upper mallegation is suspect agency within 2 to 2 investigate and subrithe investigation and #3 stated, "We don't done." A review of the facility Abuse Notice to Employers and subrithe investigation and the investigation	cket. Residents immediately on 1:1 (one-to-one staff aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated aff. Investigation initiated, completed, and aff. Investigation initiated, completed, and aff. Investigation initiated, in a state aff. In abuse and affine a	F 60	7		

4 .	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		TE SURVEY MPLETED	
	495236 B. WING				- 04/17/2019		
	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
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F 607	shall take statemen suspect(s) and all p other employees in abuse. He/she sha evidence. Upon condetailed report shall suspect(s), who is a (have) been identified the investigation. R results of all investig Director or his or he and to other officials law, including to the 5 working days of the violation is verified a must be taken" On 4/16/19 at 1:30 p (ASM #1) was made further information w 2. The facility staff f	ts from the victim, the cossible witnesses including all the vicinity of the alleged I also secure all physical expletion of the investigation, a be prepared. *Any expletion exployee, once he/she has ed, will be suspended pending eview of Report: Report the exitions to the Executive expletions to the Executive in accordance with State State Survey Agency, within the incident, and if the alleged expropriate corrective action expletions. The Executive Director aware of the findings.	F 60	7			
	allegation of abuse vand failed to submit working days to the officials for Resident reported to the facilit Resident #9 was additional reported to the facilit Resident #9 was additional reported to the facilit Resident #9 was additional reported to the facilit Resident #9 was additional reported to the facility (Minimum Data Set), assessment, with an date) of 2/7/19, code 13 on the BIMS (Briescore, indicating the impairment for daily of and submit and the second reported to the second reported to the second reported to the second reported to the second reported reported to the second reported reported to the second reported	within the two-hour time frame a follow up report within five SA (State Agency) and other #9's allegation of abuse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495236	B. WING			04	/17/2019
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	P GODE	, <u>, , , , , , , , , , , , , , , , , , </u>	1112010
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
total care for bathing; of bladder and bowel. The facility submitted Reported Incident) to 3/11/19. The initial FI "Report date: 3/12/19 Resident reported that nursing assistants) we another male staff me transferring her. Inve applicable, date notific Responsible party 3/1 the facility staff failed abuse within the requivers of the second that there was reporting a follow up to addition, there was reported to the SA that complete and thoroug 3/11/19 incident involvers of Clinical Second the second control of the second c	istance for hygiene, nd toileting; and was coded and as always incontinent) an initial FRI (Facility the SA (State Agency) on RI documented in part, Incident date: 3/11/19. It two CNA's (Certified ere verbally rude to her and ember hurt her while stigation initiated If cation provided to: 1/16" It was noted that to report the allegation of ired two-hour time frame. If the facility's FRI, it was no evidence of the facility to the initial FRI to the SA. no evidence that the facility to the initial FRI to the SA. no evidence that the facility to the grident #9. In mately 1:30 p.m. ASM thember) #3 (Regional rvices), was asked for the for the 3/11/19 FRI and #3 stated, "The previous ng) is no longer here and a not here too." No follow up	F 6	507			

MANE OF PHOVIDEN OR SUPPLIER EIN/OY AT THE MEADOWS STIDMARY STATEMENT OF IDENTIFIED STATE ADDRESS, GITY, STATE, ZIP CODE STIDMARY STATEMENT OF IDENTIFIED STATE REGULATORY OR LSC IDENTIFYING INFORMATION PRETX PROVIDERS PLAN OF CORRECTION		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
ENVOY AT THE MEADOWS ENVOY AT THE MEADOWS SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILET BE PRECIDED BY FULL RESULATION OF LIST IDENTIFYING INFORMATION) FRETTY TAG Continued From page 35 template for FRIIs. I send a fax to the Ombudaman and the administrator is responsible for reporting the FRI. I provide a brief description of the incident when the initial report if done. I health professionals, such as the Board of Nursing and the OLC (Office of Licensure and Certification), and the leav officer if needed. I keep the fax confirmation for each fax sent. Then I vivil conduct the investigation. I conduct interviews with the parties involved and have the staff wire a statement. Then I review resident charts or other documents as required. I document all the information gained from the investigation and put it in a FRII book. A summary of the findings are mailed to the respective bodies with the resolution and finding included. A follow up report is faxed to the OLC within five days. When ASM #I was asked if the facility has developed and implemented a written policy and procedure to ensure reporting of suspected crimes with the mandated timeframes, he stated. "Yes. We have a rime prevention policy. We have lighting install around the outside of the building. We have a law officer come in to speak with the staff on this topic." A review of the facility's policy. "Resident Abuse" with an effective date of 9/21/17 documented in part, " "Procedure for Reporting Abuse Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse The Journal and a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation in to later than 2 hours after the allegation in to later than 2 hours after the allegation in some abuse to the Administrator			495236	B. WING _		04/	17/2019
FREIN TAG RESULATORY OR LISC IDENTIFYING INFORMATION) F 607 Continued From page 35 template for FRIs. I send a fax to the Ombudsman and the administrator is responsible for reporting the FRI. I provide a brief description of the incident when the initial report if done. I then alert the responsible party, the physician, adult protective services, the department of health professionals, such as the Board of Nursing and the OLC (Office of Licensure and Certification), and the law officer if needed. I keep the fax confirmation for each fax sent. Then I will conduct the investigation. I conduct interviews with the parties involved and have the staff write a statement. Then I review resident charts or other documents as required. I document all the information gained from the invostigation and put lif in a FRI book. A summary of the findings are mailed to the respective bodies with the resolution and findings included. A follow up report is faxed to the OLC within five days. When ASM #1 was asked if the facility has developed and implemented a written policy and procedure to ensure reporting of suspected crimes with the mandated timeframes, he stated. "Yes. We have a crime prevention policy. We have lighting install around the outside of the building. We have a law officer come in to speak with the staff on this topic." A review of the facility's policy "Resident' Abuse" with an effective date of 92/1/17 documented in part, *" Procedure for Reporting Abuse Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation in solved abuse to the Administrator		•			2715 DOGTOWN ROAD	<u> </u>	
template for FRI's. I send a fax to the Ombudsman and the administrator is responsible for reporting the FRI. I provide a brief description of the incident when the initial report if done. I then alert the responsible party, the physician, adult protective services, the department of health professionals, such as the Board of Nursing and the OLC (Office of Licensure and Certification), and the law officer if needed. I keep the fax confirmation for each fax sent. Then I will conduct the investigation. I conduct interviews with the parties involved and have the staff write a statement. Then I review resident charts or other documents as required. I document all the information gained from the investigation and put it in a FRI book. A summary of the findings are mailed to the respective bodies with the resolution and findings included. A follow up report is faxed to the OLC within five days. When ASM #1 was asked if the facility has developed and implemented a written policy and procedure to ensure reporting of suspected crimes with the mandated imeriames, he stated. "Yes. We have a crime prevention policy. We have lighting install around the outside of the building. We have a law officer come in to speak with the staff on this topic." A review of the facility's policy "Resident Abuse" with an effective date of 9/21/17 documented in part, "Procedure for Reporting AbuseAny employee, who wincesses or has knowledge of an act of abuse or an allegation of abuseto a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation involve abuseto the Administrator	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
law. In the absence of the Executive Director, the		template for FRI's. Ombudsman and the for reporting the FR of the incident where then alert the responsability of the incident where then alert the responsability of the incident where then alert the responsability of the finding and the OL Certification), and the keep the fax confirm I will conduct the invinterviews with the part of the findings are more than the incident of the findings are more than the individual of the findings are more than the resolution and pure of the findings are more than the resolution and pure of the findings are more than the resolution and prepart is faxed to When ASM #1 was developed and impless of the facility of the facility of the staff on this with the staff on this with an effective data part, "Procedure for the facility of abuse or an a resident, is obligated immediately, but no allegation involve abused to other officials."	I send a fax to the le administrator is responsible I. I provide a brief description of the initial report if done. I resible party, the physician, vices, the department of s, such as the Board of C (Office of Licensure and le law officer if needed. I reation for each fax sent. Then vestigation. I conduct le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and have the le late involved and le respective bodies and findings included. A follow le late of the facility has lemented a written policy and le reporting of suspected le dated timeframes, he stated. Interporting of suspected le late of the late and late in the speak le of 9/21/17 documented in le of 9/21/17 documented in le of 9/21/17 documented in le of 9/21/17 documented in le of spection of abuse Any le sses or has knowledge of an le gation of abuse to a le to report such information later than 2 hours after the le the events that cause the le use to the Administrator in accordance with State	F 60			

PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495236 B. WING 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 36 F 607 Director of Clinical Services is the designated abuse coordinatorOnce an allegation of abuse is reported, the Executive Director ... is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations ... In all cases, the Executive Director ...will ensure notification to the resident's legal guardian, family, member, responsible party, or significant other of the alleged, suspected or observed abuse ...and the resident's attending physician ... Investigation: The Abuse Coordinator ...shall investigate all reports or allegations of abuse ... Preliminary Investigation: ... An incident report shall be filed by the individual in charge who received the report ... This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Abuse Coordinator ...Investigation: ...Upon completion of the investigation, a detailed report shall be prepared ...Review of the Report: Report the results of all investigations to the Executive Director ... and to other officials in accordance with state law. including to the State Survey Agency, within five working days of the incident ...' On 4/16/19 at 3:15 p.m., ASM #1 (Executive Director), AMS #3 (Regional Director of Clinical Services), and ASM #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to evidence that policy and procedures were followed to submit a follow

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	_	495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	1172013
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F 607	Agency) and other of	working days to the SA (State officials for Resident #30's fabuse and failed to evidence	F 60	07		
	6/16/17 with the diag spina bifida (1), high (2), depression, and MDS (Minimum Dat assessment, with ar date) of 3/1/19, code 15 on the BIMS (Bris score, indicating no decision-making. The requiring setup and extensive assistance total assistance for the	dmitted to the facility on gnoses of but not limited to a blood pressure, paraplegia anxiety. The most recent a Set), an annual Medicare a ARD (Assessment reference ed the resident as scoring a ef interview for mental status) cognitive impairment for daily ne resident was coded as supervision for eating; e for hygiene and dressing; ransfers, toileting, and tys incontinent of bladder and				
	faxed to the OLC (O Certification) on 9/19 reporting of an allegation. The FRI docum 9/19/18. Incident Data Involved: Name of (F Type": an X was man "Allegation of abuse/incident, including long Resident felt she was (certified nursing assolicense # suspended Under the heading: "investigation": the Floonducted/Report for	Resident #30)." "Incident ked on the box next to mistreatment". "Describe cation, and action taken: s 'bullied' by the CNA istant) name of CNA, CNA pending investigation."				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04.	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD GOOCHLAND, VA 23063	<u> U4/</u>	11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Upon further review submitted to the Stathere was no evider follow up for the 9/1 agency). In addition the facility reported a complete and thor Resident #30's 9/19 On 4/15/19 at appro (administrative staff Director of Clinical Stacility's investigation follow up report, ASI DON (director of nurlot of other things are could be produced. On 4/16/19 at 11:39 conducted with AMS Member) #1. AMS #reporting a FRI. ASN template for FRI's. I Ombudsman and the for reporting the FRI of the incident when then alert the responsadult protective service health professionals, Nursing and the OLC Certification), and the keep the fax confirm I will conduct the inventerviews with the particles.	Agency])". Next to this heading litten. of the initial FRI record the Agency, it was noted that use of the facility reporting a 9/18 FRI, to the the SA (state it, there was no evidence that to the SA that they performed ough investigation of the /18 above allegation. ximately 1:30 p.m. ASM member) #3 (Regional fervices), was asked for the infor the 9/19/18 FRI and will #3 stated, "The previous ring) is no longer here and a re not here too." No follow up a.m., an interview was (Administrative Staff it was asked the process for will #1 stated, "I use a guidance send a fax to the eadministrator is responsible. I provide a brief description the initial report if done. I sible party, the physician, ces, the department of such as the Board of confice of Licensure and relaw officer if needed. I action for each fax sent. Then restigation. I conduct arties involved and have the int. Then I review resident	F6	607			

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	' '	NG		TE SURVEY MPLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 607	document all the infinvestigation and purof the findings are nowith the resolution are up report is faxed to When ASM #1 was developed and imples original with the man "Yes. We have a crimes with the man have lighting install abuilding. We have a with the staff on this	ormation gained from the at it in a FRI book. A summary nailed to the respective bodies and findings included. A follow the OLC within five days. asked if the facility has emented a written policy and reporting of suspected adated timeframes, he stated. Impervention policy. We around the outside of the a law officer come in to speak topic."	F 6	07		
	Director), AMS #3 (F Services), and ASM Clinical Services) we	o.m., ASM #1 (Executive Regional Director of Clinical #2 (Interim Director of ere made aware of the information was provided by				
	birth defect of the br happens if the spina close completely dur pregnancy. This can spinal cord. This inf the following website https://medlineplus.c 4. The facility staff f policies and procedu employees prior to h ten of twenty five em LPN (licensed practi (registered nurse) #1					
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
	employee records of newly hired emp was conducted and LPN (licensed prace 4/1/19. Review of revealed the crimin completed on 6/7/was obtained on 9/LPN # 6 was hired #6's employee recorded the criminal was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference verification was dat two reference checks in CSM # 15/19. Review of the criminal background background check completed on 10/30 record failed to evic OSM #17 was hired #16's employee recorded to evic OSM #17 was hired #17's employee recorded to evic OSM #17 was hired #17's employee file. OSM # 3 (social se 10/31/18. Review of 10/31/18. Review of 10/31/18. Review of 10/31/18. Review of 10/31/18. Review of 10/31/18.	19 a review of twenty-five randomly selected from a list ployees since the last survey d revealed the following: etical nurse) #7 was hired on LPN #7's employee record hal background check was 18, and the license verification (18/18. on 8/23/18. Review of LPN pord revealed a background 19. LPN #6's license look up ted 4/14/19, and only one of ications could be located in the se) #7 was hired on date of the employee file revealed cound check was dated #7's license verification was was 8/31/18. Review of RN pord revealed there were no	F6	507		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING	_		04/	17/2019
Ì	PROVIDER OR SUPPLIER AT THE MEADOWS			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1715 DOGTOWN ROAD GOOCHLAND, VA 23063	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	date 3/14/19. Revirecord revealed no reference checks in OSM # 10 (environ 3/15/19, review of Crevealed there were record. On 4/16/19 at approinterview was condidirector of human reprocess for screenii OSM #4 stated, "Apinterview to gauge the second interview, and sure good fit. Offer start the process, of current, in good stare check through Virgin (office of inspector of the results to come the company mails in barrier crimes. Send from previous employee results of the backg statement (sworn stago into employee filestatement, criminal checks and license #4 was informed of OSM #4 was provided was asked to provided /clarification. OSM # see what she could	ental services) was hired on ew of OSM #9's employee sworn statement, and no in the file. mental services) hire date was DSM #10's employee record en oreference checks in the eximately 10:40 a.m., an acted with OSM #4 (regional esources) regarding the facilitying and hiring new employees. Splicant first schedule an hem. Then if good schedule and meet administer, to make the job discuss pay. Then neck license make sure inding, do criminal background has State police, do OIG general), drug screen. Wait for back. If there is something, it to make sure there are no if off two reference checks byer. During this time they is stay home pending the round check then obtain attement). Should be able to be and find the sworn background check, reference checks." At this time, OSM the above identified concerns. See the employee files and e any additional information 4 stated she would look to	F 6	;07			

NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCIES) (EACH DETICIENCY MIST BE PRECEISE BY PULL PRECEIVE (MIST BE PRECEISE BY PULL BE PRECEIVE (MIST BE PRECEISE BY PULL BE PRECEIVE BY AND PROVIDERS PLAN OF CORRECTION COMPRETING CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 607	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	TIPLE CONSTRUCTION PING		(X3) DATE SURVEY COMPLETED	
ENVOY AT THE MEADOWS (A) ID PREFIX (EACH DEFICIENCY WILLS THE PRECEDED BY FULL REQUIRED TO FORMATION) FOR TIME OF THE MEADOWS (EACH DEFICIENCY WILS' BE PRECEDED BY FULL REQUIRED TO FORMATION) FOR TIME OF THE MEADOWS FOR THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR TIME OF THE MEADOWS FOR T			495236	B. WING		l na	!/17/201Q
FREDUATORY OR LSC IDENTIFYING INFORMATION) F 607 Continued From page 42 #4 (Regional director of clinical services) asked to speak with this surveyor. ASM #4 stated did QAPI (quality assurance and performance improvement) on 2/22/19 by completing an audit of nineteen employee files for: application, references, and background checks CPR (cardiopulmonary resuscitation), OIG (office of inspector general). ASM #4 stated did education on facility policy on 2/22/19 with department staff. When asked what was done for the issues identified in the nineteen employee files, ASM #4 stated, "For the ones identified, supposed to get OIG and reference checks, go back and correct it but did not document it in the action plan." On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding the above concerns, in regards to LPN #7's criminal background check, license verification and missing reference checks, OSM #4 stated, "She (LPN #7) is agency, she (LPN #7) came 4/1/19. Criminal background was done when hired with the agency. They verified her license but did not provide reference checks. We should have rechecked her license, this is agency, we treat it differently and we should not."					2715 DOGTOWN ROAD		#1172019
#4 (Regional director of clinical services) asked to speak with this surveyor. ASM #4 stated did QAPI (quality assurance and performance improvement) on 2/22/19 by completing an audit of nineteen employee files for: application, references, and background checks CPR (cardiopulmonary resuscitation), OIG (office of inspector general). ASM #4 stated did education on facility policy on 2/22/19 with department staff. When asked what was done for the issues identified in the nineteen employee files, ASM #4 stated, "For the ones identified, supposed to get OIG and reference checks, go back and correct it but did not document it in the action plan." On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding the above concerns, in regards to LPN #7's criminal background check, license verification and missing reference checks, OSM #4 stated, "She (LPN #7) is agency, she (LPN #7) came 4/1/19. Criminal background was done when hired with the agency. They verified her license but did not provide reference checks. We should have rechecked her license, this is agency, we treat it differently and we should not."	PREFIX	(EACH DEFICIENC)	'MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	
license verification and missing reference check, OSM #4 stated, "The criminal records check and license check were not completed at the time of hire. I did not see it, so redid it on 4/14/19." Regarding RN #7's criminal background check, and license verification, OSM #4 stated, "The sworn statement has two different dates (2/28/18 and 10/15/17) can't explain that. License verification was done on a different date altogether, if rehire or transfer we are provided, that information, we also do it again. I do not have anything to back that up." OSM #4 stated in regards RN #1's reference checks at the time of		#4 (Regional directors speak with this survey QAPI (quality assurimprovement) on 2/of nineteen employer references, and back (cardiopulmonary reinspector general), on facility policy on When asked what videntified in the nine stated, "For the one OIG and reference but did not document on 4/17/19 at approup interview regardiregards to LPN #7's license verification a OSM #4 stated, "Sh (LPN #7) came 4/1/done when hired with her license but did now when hired with her license verification a OSM #4 stated, "The license verification a OSM #4 stated, "The license check were in hire. I did not see it, Regarding RN #7's cand license verification was done altogether, if rehire of that information, we have anything to back	or of clinical services) asked to reyor. ASM #4 stated did ance and performance 22/19 by completing an audit per files for: application, exground checks CPR associtation), OIG (office of ASM #4 stated did education 2/22/19 with department staff. The state of the issues at the end of the issues are provided, also do it again. I do not sk that up." OSM #4 stated in	F 6	507		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04.	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
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F 607	still work here as ne OSM #15's hire data reviewing the employ background, check obtained on 4/14/19 the hire date with us check and sworn state to her transfer at the there are no referent in regards to OSM #4 state have reference check observed looking the record. OSM #4 the statement and no reto the missing sworn checks for OSM #9, sworn statement and Regarding OSM #10 and 3/15/19, after the had completed the OTherefore, this cannot be facility policy with 11/30/14 and revisio "Abuse, Neglect, Exdocumented in part, applying for employr screened for a history criminal Background Employment history Criminal Background Criminal Background contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property. This includes the contains the same property and	checks and she (RN #1) does beded (PRN)." OSM #4 stated a was 5/2/18, and when byee record it was noted the was missing and it was a cost of transferred and a sis 2/14/19. The background attement were completed prior a coriginal time of hire, but ace checks." 17's missing reference atted, "Accurate we do not cks." OSM #4 brought was rough OSM #3's employee an stated, "There is no sworn afterence checks." In regards a statement and reference OSM #4 stated, "There is no do no reference checks." Osm missing reference checks." Osm missing reference checks." Osm #9 were hired on 3/14 and education of staff. Ot be past non-compliance). The an effective date of a date of 11/28/17, titled, ploitation & Misappropriation" 1. Screening: Persons ment with the center will be any of abuse, neglect, perpropriation of resident des but is not limited to:	F6	507		

STATEMENT OF DEFICIENCIES (X1) PROVIDENT AND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ſ	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, Z 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Sworn Disclosure S Documentation of s actions form (sic.) I and other registries Information from fo The facility policy w 11/30/14 and revisic "Background Check following, "Policy: It to conduct background checks under the heading "the following is doct may be give a cond pending the success background check is completed received, unless star mechanism to begin work until the check is completed received, unless star mechanism to begin pf background check specific requirement. The facility policy wi 1/10/2018, and effect "Employment Application and provemployment offers a successful completic credentialing and reference references listed price references listed prices."	Statement prior to hire status of any disciplinary icensing or registration boards rmer employers." ith an effective date of on date of 9/1/2017 titled, ks" documented in part the is the policy of The Company und checks to include criminal s," On page five of seven Background Check Process" umented in part, "Candidates itional offer of employment sful completion of the unless otherwise prohibited by mstance is a job candidate to candidate's background and a positive report is ate requirements allows a memployment prior to receipt k (please refer to your state ts)." th a revision date of ctive date of 11/30/14 titled, ation Procedure" documented "Policy: It is the policy that all d in an open position with the plete and sign an employment ride reference. All	F6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04/	17/2019
ļ	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From pay	ge 45 nust be retained with the	F 607	7		
	employment applica	ition. Applications for hired must be retained in the				
F 609 ŚS=D	No further information Reporting of Alleged CFR(s): 483.12(c)(1	l Violations	F 609			
į		nse to allegations of abuse, , or mistreatment, the facility				
	involving abuse, neg mistreatment, includ source and misapprare reported immedi hours after the allegathat cause the allegaserious bodily injury, the events that cause abuse and do not rethe administrator of officials (including to adult protective serv for jurisdiction in long accordance with Staprocedures.	ing injuries of unknown opriation of resident property, lately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ices where state law provides g-term care facilities) in te law through established				
	designated represen accordance with Sta Survey Agency, withi incident, and if the al appropriate correctiv	t the results of all administrator or his or her tative and to other officials in te law, including to the State n 5 working days of the leged violation is verified e action must be taken. I is not met as evidenced				·

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04	/17/2019
	PROVIDER OR SUPPLIER			27	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD OOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	record review, and farwas determined the fran allegation of abuse (State Agency) and or required timeframe ar of all investigations wincident for two of 41 sample; Resident #9 and time frame and failed within five working da and other officials for abuse reported to the allegation was not repuntil 3/12/19. 2. The facility staff faireport within five work Agency) and other officials for abuse immediately saff faireport within five work Agency) and other officials include: 1. The facility staff faireport within five work Agency) and other officials for abuse immediately and time frame and failed within five working day and other officials for a legation was not repuntil 3/12/19. Resident #9 was admit 12/5/18 with the diagnitic and other diagnitic and the di	n, staff interview, clinical cility document review, it acility staff failed to ensure e was reported to the SA ther officials within the nd failed to report the results lithin 5 working days of the residents in the survey and Resident #30. Illed to report an allegation of nd or within the two-hour to submit a follow up report ys to the SA (State Agency) Resident #9's allegation of facility staff on 3/11/19. The ported to the State Agency led to submit a follow up ing days to the SA (State icials for Resident #30's abuse. Illed to report an allegation of d or within the two-hour to submit a follow up report ys to the SA (State Agency) Resident #9's allegation of facility staff on 3/11/19. The orted to the State Agency) Resident #9's allegation of facility staff on 3/11/19. The orted to the State Agency	F		1. Executive Director will conduct a folloup investigation on the allegation of about for resident #9 occurring on 3/11/19 and submit findings to OLC by 5/14/2019. Executive Director will conduct a follow investigation on the allegation of abuse resident #30 occurring on 9/19/18 and submit findings by 5/14/2019. 2. Executive Director or Designee will interview residents to ensure that they a free from abuse. Follow ups will be done based on findings. 3. Executive Director and Director of Nursing have been re educated on guide for abuse reporting and investigation by Regional Director of Clinical Services. Facility staff will be educated on Reside Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspincidents with 2 hours. Executive Director or Designee to audit allegations of abuse weekly x8 weeks and as needed to ensure policies are followed to included 2 hour reporting, thorough investigation, and 5 follow up. 4. The results of the Quality Monitoring reviewed at the monthly Quality Assurant Performance Improvement (QAPI) meet for review, analysis, and further recommendations.	v-up for are e elines y the nt om ected tor e day	5.78.19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AT THE MEADOWS		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(X5) COMPLETION DATE	
	mellitus, and anxiety (Minimum Data Set) assessment, with an date) of 2/7/19, code 13 on the BIMS (Bri score, indicating the impairment for daily resident required see ating; extensive as dressing, transfers, total care for bathing of bladder and bowe. The facility submitte Reported Incident) to 3/11/19. The initial I "Report date: 3/12/1 Resident reported the nursing assistants) wanother male staff m transferring her. Invapplicable, date notif Responsible party 3/the facility staff failed abuse within the required Upon further review noted that there was reported to the SA the complete and thorous 3/11/19 incident invo On 4/15/19 at approximation (administrative staff in Director of Clinical Sefacility's investigation	y. The most recent MDS y, a quarterly Medicare of ARD (Assessment reference ed the resident as scoring a ef interview for mental status) of resident has no cognitive decision making. The tup and supervision for sistance for hygiene, and toileting; and was coded g; and as always incontinent) el. d an initial FRI (Facility to the SA (State Agency) on FRI documented in part, el. l at two CNA's (Certified were verbally rude to her and member hurt her while estigation initiated If fication provided to: 11/16" It was noted that to report the allegation of wired two-hour time frame. of the facility's FRI, it was no evidence of the facility to the initial FRI to the SA. Is no evidence that the facility at they performed a gh investigation of the	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019
]	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71772013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 609	DON (director of nu	ge 48 rsing) is no longer here and a re not here too." No follow up	F 60	09		
	conducted with AMS Member) #1. AMS reporting a FRI. AM template for FRI's. Ombudsman and the for reporting the FR of the incident when then alert the responsability and the OLO Certification), and the keep the fax confirm I will conduct the invinterviews with the pataff write a stateme charts or other docudocument all the information and puriof the findings are may with the resolution and puriof the findings are may be forcedure to ensure crimes with the mane procedure to ensure crimes with the mane with the staff on this with the staff on this	e administrator is responsible I. I provide a brief description the initial report if done. I usible party, the physician, rices, the department of a such as the Board of C (Office of Licensure and e law officer if needed. I ustion for each fax sent. Then estigation. I conduct arties involved and have the nt. Then I review resident ments as required. I ormation gained from the tit in a FRI book. A summary ailed to the respective bodies and findings included. A follow the OLC within five days. Easked if the facility has emented a written policy and reporting of suspected dated timeframes, he stated. The prevention policy. We around the outside of the law officer come in to speak topic."				
,	with an effective date	y's policy "Resident Abuse" of 9/21/17 documented in or Reporting AbuseAny				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		F	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	•	495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		,1112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	act of abuse or an a resident, is obligated immediately, but no allegation is made, is allegation involve at and to other officials law. In the absence Director of Clinical Sabuse coordinator is reported, the Exercisponsible for ensure completed timely an officials in accordance regulations In all completed timely an officials in accordance guardian, family, me significant other of the observed abuse and physician Investigate all abuse Preliminary report shall be filled to who received the repified as soon as possimost accurate inform submitted to the Abu Investigation: Up investigation, a detai Review of the Repoinvestigations to the other officials in according to the State working days of the interior of the state working days of the interior at 15 p.	esses or has knowledge of an allegation of abuseto a do report such information later than 2 hours after the fifthe events that cause the buseto the Administrator in accordance with State of the Executive Director, the Services is the designatedOnce an allegation of abuse butive Directoris aring that reporting is dispropriately to appropriate one with Federal and State ases, the Executive Director tion to the resident's legal mber, responsible party, or the alleged, suspected or alleged, suspected or alleged, suspected or alleged, suspected or alleged, suspected or alleged, suspected or alleged. In charge bothThis report shall be sible in order to provide the mation in a timely fashion, and se Coordinator on completion of the led report shall be prepared both. Report the results of all executive Directorand to ordance with state law, a Survey Agency, within five ancident"	F 60	0.9		
		egional Director of Clinical #2 (Interim Director of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04	/17/2019
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				2715 DOGTO	ORESS, CITY, STATE, ZIP CODE OWN ROAD ND, VA 23063	1 04	11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X EA	PROVIDER'S PLAN OF CORRECTI ICH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	findings. No further information of the survey. 2. The facility staff report within five wo Agency) and other of 9/19/18 allegation of Resident #30 was a 6/16/17 with the diagspina bifida (1), high (2), depression, and MDS (Minimum Datassessment, with ardate) of 3/1/19, code 15 on the BIMS (Briescore, indicating no decision-making. The requiring setup and extensive assistance total assistance for the bathing; and as always bowel. A review of the Facilifaxed to the OLC (Of Certification) on 9/19 reporting of an allegation.	failed to submit a follow up rking days to the SA (State officials for Resident #30's f abuse. dmitted to the facility on gnoses of but not limited to blood pressure, paraplegia anxiety. The most recent a Set), an annual Medicare of ARD (Assessment reference of the resident as scoring a ef interview for mental status) cognitive impairment for daily ne resident was coded as supervision for eating; of for hygiene and dressing; ransfers, toileting, and the system of the syste	F	09	BLIOTENOTY		
-	9/19/18. Incident Dat Involved: Name of (F Type": an X was mar "Allegation of abuse/	Resident #30)." "Incident ked on the box next to mistreatment". "Describe cation, and action taken:					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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ENVOY	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP O 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE		
	(certified nursing as license # suspender Under the heading: investigation": the Fooducted/Report for Department of Heal Certification [State A 9/26/18 was had write Upon further review was noted that there facility reporting a for the the SA (state agno evidence that the that they performed investigation of the fallegation. On 4/15/19 at appro (administrative staff Director of Clinical Sfacility's investigation follow up report, ASA DON (director of nur lot of other things are could be produced. On 4/16/19 at 11:39 conducted with AMS Member) #1. AMS # reporting a FRI. ASM template for FRI's. I Ombudsman and the for reporting the FRI. of the incident when then alert the respon adult protective servihealth professionals,	sistant) name of CNA, CNA d pending investigation." "Facility internal FRI documented, "Will be prward to VDH/OLC (Virginia th Office of Licensure and Agency])". Next to this heading litten. of the facility's FRI record, it was no evidence of the allow up for the 9/19/18 FRI, to ency). In addition, there was a facility reported to the SA a complete and thorough Resident #30's 9/19/18 above eximately 1:30 p.m., ASM member) #3 (Regional ervices), was asked for the for the 9/19/18 FRI and M #3 stated, "The previous sing) is no longer here and a error here too." No follow up a.m., an interview was (Administrative Staff a was asked the process for 1 #1 stated, "I use a guidance send a fax to the error administrator is responsible. I provide a brief description the initial report if done. I sible party, the physician, ces, the department of	F 6	09					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	DE		
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	keep the fax confirm I will conduct the invinterviews with the pataff write a statement of the findings are movestigation and pure of the findings are moved and implementally and implementation of the findings are moved in the resolution and preport is faxed to When ASM #1 was a developed and implementation of the finding are moved in the man in the first and the	ne law officer if needed. I nation for each fax sent. Then restigation. I conduct parties involved and have the ent. Then I review resident iments as required. I primation gained from the tit in a FRI book. A summary nailed to the respective bodies and findings included. A follow the OLC within five days. Easked if the facility has emented a written policy and reporting of suspected dated timeframes, he stated. The prevention policy. We around the outside of the law officer come in to speak	F 6	09			
	Director), AMS #3 (F Services), and ASM Clinical Services) we findings. No further in the end of the survey (1) Spina Bifida: is a birth defect of the bra happens if the spinal close completely during pregnancy. This can spinal cord. This info the following website. https://medlineplus.gov (2) Paraplegia: Paral	neural tube defect - a type of ain, spine, or spinal cord. It column of the fetus doesn't ng the first month of damage the nerves and ormation was obtained from					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04.	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=E	obtained from the for https://medlineplus.i. (2) Paraplegia: Parafunction in part of your obtained from the for https://medlineplus.i. Investigate/Prevent/CFR(s): 483.12(c)(2) §483.12(c) In response neglect, exploitation must: §483.12(c)(2) Have violations are thorous with same thorous for investigation is in professional pro	pillowing website: gov/paralysis.html alysis is the loss of muscle our body. This information was pillowing website: gov/paralysis.html (Correct Alleged Violation P)-(4) Inse to allegations of abuse, or mistreatment, the facility evidence that all alleged ghly investigated. Int further potential abuse, or mistreatment while the pagress. It the results of all administrator or his or her administrator or his or her attative and to other officials in the law, including to the State in 5 working days of the action must be taken. This not met as evidenced view, facility document do review, and employee determined that facility staff do report to the required State for abuse and neglect for four essurvey sample; Residents	F 610			
	·					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495236	B. WING			04/	/17/2019
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD COOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	an investigation was r days to the required s	led to evidence an ducted, and the follow up of eported within 5 working tate agency, for a tercation that occurred on	F	610	F 610	,	5-76-19
·	five working days to the other officials for Resident	facility staff on 3/11/19, and nvestigation for the			1.Executive Director will conduct a fol up investigation of the resident to residentercation between resident #42 and # occurring on 10/16/18 and submit find the OLC by 5/14/2019.	lent 72 ings to	
	report within five worki				Executive Director will conduct a follo investigation on the allegation of abuse resident #9 occurring on 3/11/19 and st findings to the OLC by 5/14/2019. Executive Director will conduct a follo investigation on the allegation of abuse resident #30 occurring on 9/19/18 and submit findings to the OLC by 5/14/20	e for abmit w-up e for	
	an investigation was redays to the required st	ucted, and the follow up of eported within 5 working ate agency, for a ercation that occurred on			2.Executive Director or Designee will interview residents who reside in the factor ensure that they are free from abuse Follow ups will be done based on findi	e.	
	not limited to, traumation hypothyroidism, high babuse, hepatitis C, epil	noses that included but are brain injury, lood pressure, alcohol epsy, depression and ecent MDS (Minimum Data esessment with an ARD					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY IPLETED
		495236	B. WING_			
	PROVIDER OR SUPPLIER	1994		STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1/17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 610	resident was coded as ability to make daily lit was coded as requiring and supervision only factivities of daily living. Resident #72 was adm 9/16/16 with the diagon not limited to, chronic disease, frontotemport disorder, anxiety disordisorder, anxie	s being severely impaired in re decisions. The resident g extensive care for bathing or all other areas of l. Initted to the facility on oses that included but are obstructive pulmonary al dementia, adjustment der, schizophrenia, high intracranial hypertension, e prostate and prostatic t recent MDS (Minimum erly assessment with an increase Date) of 3/22/19. In the date of the decisions. In the date of the decisions of the date of the decisions of the decision only for all other decisions.	F6	3.Executive Director and Nursing have been re edu for abuse reporting and in Regional Director of Clim 4/17/2019. Facility staff w Resident Abuse Policy by or Designee to ensure resi abuse and expectation of incidents with 2 hours. E or Designee to audit alleg, weekly x8 weeks and as no policies are followed to increporting, thorough invest follow up. 4.The results of the Quality reviewed at the monthly Quality reviewed at the monthly Quality review, analysis, and for review, analysis, and for recommendations.	cated on guidelines avestigation by the ical Services as of ill be educated on Executive Director dents are free from reporting suspected xecutive Director ations of abuse eeded to ensure cluded 2 hour tigation, and 5 day ty Monitoring to be Quality Assurance at (QAPI) meetings	
	stamped by the State A incident that occurred of Residents #42 and #72 #42) started hitting (Re and (Resident #42) too #72)'s front shirt pocke separated and put on 1 supervision) with staff, immediately." There was no evidence this investigation within days.	documented, "(Resident sident #72) in the head k \$10 from (Resident t. Residents immediately 11 (one-to-one staff Investigation initiated				

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	PLE CONSTRUCTION (X3		X3) DATE SURVEY COMPLETED	
		495236	B. WING_		04	/17/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	investigation of any ASM #1 (Administra Executive Director). On 4/15/19 at 3:00 pinvestigation for (Rebe located. He was investigation was evaluated to the required on 4/16/19 at 8:45 at #3 (the Regional Director of the stated, "Abuse if management; if an at it is reported to the shours, and have 5 da follow up." Regard follow up for this FR any evidence it was A review of the facility Abuse Notice to Employees the Abuse Notice to Employees of abuse Coordinator and/or Eshall take statements suspect(s) and all poother employees in the abuse. He/she shall evidence. Upon condetailed report shall suspect(s), who is an (have) been identified the investigation. Regresults of all investigation or her bery and the suspector of his or her	FRI's was requested from tive Staff Member - the D.m., ASM #1 stated the FRI sident #42 and #72) could not not able to evidence that the rer initiated, completed, and uired State Agency. D.m., in an interview with ASM sector of Clinical Services), are reported to upper abuse allegation is suspected, state agency within 2 to 24 ays to investigate and submit ding the investigation and I, she stated, "We don't have done." Director of Belongings" Abuse Coordinator or all investigate all reports orInvestigation: *The Abuse Director of Clinical Services as from the victim, the possible witnesses including all the vicinity of the alleged also secure all physical appletion of the investigation, a poe prepared. *Any in employee, once he/she has done to the Executive designated representative	F 61	10			
	and to other officials	in accordance with State					

PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WING 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 57 F 610 law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken...." On 4/16/19 at 1:30 p.m., the Executive Director (ASM #1) was made aware of the findings. No further information was provided. 2. The failed to submit a follow up report within five working days to the SA (State Agency) and other officials for Resident #9's allegation of abuse reported to the facility staff on 3/11/19, and failed to evidence an investigation for the resident's allegation of abuse. Resident #9 was admitted to the facility on 12/5/18 with the diagnoses of but not limited to depression, high blood pressure, type 2 diabetes mellitus, and anxiety. The most recent MDS (Minimum Data Set), a quarterly Medicare assessment, with an ARD (Assessment reference date) of 2/7/19, coded the resident as scoring a 13 on the BIMS (Brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making. The resident required setup and supervision for eating; extensive assistance for hygiene, dressing, transfers, and toileting; and was coded total care for bathing; and as always incontinent) of bladder and bowel. The facility submitted an initial FRI (Facility Reported Incident) to the SA (State Agency) on 3/11/19. The initial FRI documented in part, "Report date: 3/12/19. Incident date: 3/11/19. Resident reported that two CNA's (Certified nursing assistants) were verbally rude to her and another male staff member hurt her while

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 610	applicable, date not Responsible party 3 the facility staff faile abuse within the recurrence Upon further review noted that there was reporting a follow up in addition, there was reported to the SA to complete and thorous 3/11/19 incident involved in the staff Director of Clinical Stacility's investigation follow up report, ASDON (director of nullot of other things are could be produced. On 4/16/19 at 11:39 conducted with AMS Member) #1. AMS reporting a FRI. AM template for FRI's. Ombudsman and the for reporting the FRI of the incident when then alert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the incident when the salert the responsable to the factor of the salert the responsable to the factor of the salert the responsable to the factor of the salert the responsable to the salert the responsable	vestigation initiated If ification provided to: i/11/16" It was noted that d to report the allegation of quired two-hour time frame. of the facility's FRI, it was is no evidence of the facility to to the initial FRI to the SA. as no evidence that the facility that they performed a ugh investigation of the polving Resident #9. eximately 1:30 p.m. ASM member) #3 (Regional Services), was asked for the for the 3/11/19 FRI and SM #3 stated, "The previous rsing) is no longer here and a re not here too." No follow up a.m., an interview was s (Administrative Staff #1 was asked the process for S #1 stated, "I use a guidance	F 6	10		

LANDELAN OF CORRECTION INTERCATION NUMBER.		ľ	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	staff write a statement charts or other docudocument all the infinivestigation and pure of the findings are nowith the resolution as up report is faxed to When ASM #1 was developed and imply procedure to ensure crimes with the man "Yes. We have a crimes with the man "Yes. We have a crimes with the staff on this building. We have a with the staff on this with an effective dat part, "Procedure femployee, who with act of abuse or an a resident, is obligated immediately, but no allegation involve ab and to other officials law. In the absence Director of Clinical Sabuse coordinator is reported, the Executes ponsible for ensure completed timely an officials in accordance regulationsIn all callegations in the coordinator and in the staff of the	ent. Then I review resident iments as required. I ormation gained from the at it in a FRI book. A summary nailed to the respective bodies and findings included. A follow the OLC within five days, asked if the facility has emented a written policy and reporting of suspected adated timeframes, he stated, ime prevention policy. We around the outside of the a law officer come in to speak topic." Ty's policy "Resident Abuse" of 9/21/17 documented in or Reporting AbuseAny resses or has knowledge of an allegation of abuseto a to report such information later than 2 hours after the fifthe events that cause the useto the Administrator in accordance with State of the Executive Director, the ervices is the designatedOnce an allegation of abuse outive Directoris	F 6	510		

	OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1112013	
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	abusePreliminary report shall be filed who received the refiled as soon as posmost accurate informations. Investigation:Up investigation; a detaReview of the Repinvestigations to the other officials in accincluding to the Statiworking days of the On 4/16/19 at 3:15 p Director), AMS #3 (F Services), and ASM Clinical Services) we findings. No further information the survey. 3. The facility staff for report within five working allegation of evidence an investig allegation of abuse. Resident #30 was ac 6/16/17 with the diag spina bifida (1), high (2), depression, and MDS (Minimum Data assessment, with an	Il reports or allegations of Investigation:An incident by the individual in charge portThis report shall be sible in order to provide the mation in a timely fashion, and use Coordinator on completion of the illed report shall be prepared fort: Report the results of all Executive Directorand to ordance with state law, as Survey Agency, within five incident" D.m., ASM #1 (Executive Regional Director of Clinical #2 (Interim Director of ere made aware of the ere made aware of the ere made aware of the salled to submit a follow up king days to the SA (State fficials for Resident #30's abuse on and failed to ation for the resident's entired to the facility on moses of but not limited to blood pressure, paraplegia anxiety. The most recent anxiety, an annual Medicare ARD (Assessment reference	F 6	610			
		d the resident as scoring a f interview for mental status)					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
·	score, indicating no decision-making. Trequiring setup and extensive assistance for bathing; and as always bowel. A review of the Faci faxed to the OLC (Cortification) on 9/11 reporting of an alleg #30. The FRI docur 9/19/18. Incident Da Involved: Name of (Involved: Name of (In	cognitive impairment for daily he resident was coded as supervision for eating; e for hygiene and dressing; transfers, toileting, and ays incontinent of bladder and lity Reported Incident (FRI) office of Licensure and 19/18, revealed the initial ation of abuse for Resident mented in part, "Report Date te: 9/19/18. Resident Resident #30)." "Incident riced on the box next to finistreatment". "Describe cation, and action taken: s'bullied' by the CNA sistant) name of CNA, CNA pending investigation." Facility internal RI documented, "Will be rward to VDH/OLC (Virginia of Office of Licensure and gency])". Next to this heading ten. of the facility's FRI record, it was no evidence of the low up for the 9/19/18 FRI, to of the Inaddition, there was no ility reported to the SA that	F 6			
	On 4/15/19 at approx (administrative staff r	imately 1:30 p.m. ASM nember) #3 (Regional				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ļ		495236	B. WING	i		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			27	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD BOOCHLAND, VA 23063		
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	Director of Clinical Stacility's investigation follow up report, ASDON (director of nullot of other things are could be produced. On 4/16/19 at 11:39 conducted with AMSMember) #1. AMSTERPORTING a FRI. ASMETERPORTING a FRI. ASMETERPORTING the incident when then alert the resportable of the incident when then alert the responsable of the fax confirm I will conduct the investigation), and the keep the fax confirm I will conduct the investigation and put of the findings are meter with the resolution are up report is faxed to when ASM#1 was a developed and imple procedure to ensure crimes with the mand "Yes. We have a crimave lighting install a	Services), was asked for the n for the 9/19/18 FRI and SM #3 stated, "The previous rsing) is no longer here and a e not here too." No follow up a.m., an interview was a (Administrative Staff #1 was asked the process for M #1 stated, "I use a guidance send a fax to the e administrator is responsible. I provide a brief description the initial report if done. I usible party, the physician, ices, the department of such as the Board of C (Office of Licensure and e law officer if needed. I ation for each fax sent. Then estigation. I conduct arties involved and have the nt. Then I review resident ments as required. I urmation gained from the it in a FRI book. A summary ailed to the respective bodies and findings included. A follow the OLC within five days. I sked if the facility has mented a written policy and reporting of suspected lated timeframes, he stated. The prevention policy. We round the outside of the law officer come in to speak	F	310			

PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WING 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 610 Continued From page 63 F 610 On 4/16/19 at 3:15 p.m., ASM #1 (Executive Director), AMS #3 (Regional Director of Clinical Services), and ASM #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. (1) Spina Bifida: is a neural tube defect - a type of birth defect of the brain, spine, or spinal cord. It happens if the spinal column of the fetus doesn't close completely during the first month of pregnancy. This can damage the nerves and spinal cord. This information was obtained from the following website: https://medlineplus.gov/spinabifida.html (2) Paraplegia: Paralysis is the loss of muscle function in part of your body. This information was obtained from the following website: https://medlineplus.gov/paralysis.html F 622 Transfer and Discharge Requirements F 622 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) SS≃E §483.15(c) Transfer and discharge-§483.15(c)(1) Facility requirements-(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility: (C) The safety of individuals in the facility is endangered due to the clinical or behavioral

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATI	E SURVEY
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	PROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 97	71772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
; ; ; ;	otherwise be endange (E) The resident has fa appropriate notice, to punder Medicare or Medicare, resident refuses to pay resident who becomes admission to a facility, resident only allowable or (F) The facility ceases (ii) The facility may not resident while the appe § 431.230 of this chapte exercises his or her rigid discharge notice from the 431.220(a)(3) of this chapte exercises his or her rigid discharge or transfer woor safety of the resident facility. The facility must that failure to transfer or S483.15(c)(2) Document when the facility transfer esident under any of the paragraphs (c)(1)(i)(A section, the facility must or discharge is document medical record and approximation or provider.	iduals in the facility would red; ailed, after reasonable and pay for (or to have paid dicaid) a stay at the facility. If the resident does not paperwork for third party ird party, including denies the claim and the office for his or her stay. For a eligible for Medicaid after the facility may charge a charges under Medicaid; to operate. It transfer or discharge the real is pending, pursuant to per, when a resident of the facility pursuant to ser, when a resident of the facility pursuant to ser, unless the failure to puld endanger the health of or other individuals in the st document the danger or discharge would pose. Itation. The facility pursuant to set document the danger of discharge would pose. Itation. The serior of this is ensure that the transfer of the resident's repriate information is	F 622	1.Resident #49 transferred to the hospital 3/24/19 and returned the same day from Resident #69 transferred to the hospital 3/24/19 and returned 3/28/19 Resident #61 transferred to the hospital 1/27/19 and returned 1/28/19. Resident # 53 transferred to the hospital 1/28/18 and returned 12/26/18. 2.Director of Nursing or Designee will conduct a Quality Review of residents discharged over the last thirty days to determine what information was proviethe receiving facility/hospital. Follow ubased on findings. 3.Director of Nursing or Designee to educe the care plan goals, bed hold policy physician documentation. Director of Nursing or Designee will review inform provided during resident transfers to receiving facility/hospital for 8 weeks at 4. The results of the quality monitoring the reported to the quality assurance committee team monthly for review, and and further recommendations	ded to to to y and and as will	5.28.19

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	(i) of this section. (B) In the case of pasection, the specific be met, facility atterneeds, and the service facility to meet the resident (2)(i) of this section (A) The resident's passed on (B) A physician when ecessary under pathis section. (iii) Information proving the facility of the contact information (C) Advance Directive (D) All special instruongoing care, as appendix of the resident's consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff interreview, and clinical required information failed to ensure physicial record for four the consistent with facility of the resident's consistent with safe and effective this REQUIREMEN by: Based on staff interreview, and clinical required information failed to ensure physicinical record for four the consistent of the consistent of the consistent of the consistent with safe and effective this REQUIREMEN by: Based on staff interreview, and clinical required information failed to ensure physicinical record for four the consistent of the consistent of the consistent of the consistent of the consistent with safe and effective the consistent with s	e transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot inpts to meet the resident ice available at the receiving iced(s). In required by paragraph (c) must be made by- hysician when transfer or ary under paragraph (c) (1) ition; and In transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ided to the receiving provider mum of the following: icion of the practitioner care of the resident. cantative information including ive information ctions or precautions for coropriate. care plan goals; ary information, including a s discharge summary, is discharge summary, is discharge summary, is applicable, and ation, as applicable, to ensure itransition of care. T is not met as evidenced view, facility document	F 622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	,	495236	B. WING		·	04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		-	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		,	17723 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL ASC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 622	#53. 1. The facility staff	failed to evidence that any of	Fε	522			
	the required documentation was provided to the hospital when Resident #49 was transferred to the hospital on 3/24/19.						
	the comprehensive required document	failed to provide evidence that care plan goals and physician ation, were sent to the nen Resident #69 was nospital on 3/24/19.					
	of the required doc	failed to evidence what, if any umentation was provided to Resident #61 was transferred /27/19.					
	Resident # 53's cor	failed to evidence that nprehensive care plan goals resident to the hospital for the 8/2018.					
	The findings include	e:					
	the required docum	failed to evidence that any of the lentation was provided to the dent #49 was transferred to 1/19.		į			
	11/1/18 with the dia limited to, dysphagis blood pressure, oste chronic kidney disea anxiety disorder, an pulmonary disease. (Minimum Data Set)	admitted to the facility on gnoses including, but not a, macular degeneration, high eoarthritis, depression, ase, spondylosis, aphasia, ad chronic obstructive The most recent MDS) was an annual assessment sement Reference Date) of					

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING	i	04	/17/2019	
1	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE	
F 622	3/7/19. The resider moderately impaired decisions.	ge 67 It was coded as being It in ability to make daily life It is a record revealed a nurse's	F 6	522			
	note dated 3/24/19 tresident in respirato (vital signs) 177/89 (respirations), 97.0 (sat (oxygen saturatitherapy. Notified NF sounds diminished (Resident using abdorapid. N.O. (new orathe hospital for eval	that documented, "Noted ry distress. Obtained VS (blood pressure), 30 (temperature), 72 (pulse), O2 on) 90% (out of 100%) via O2 (Nurse Practitioner). Lung with) slight wheezing noted. Deminal muscle. Respiration der) to send resident out to (evaluation). Granddaughter (emergency services) called.					
	reveal any evidence resident information including but not limi information, resident information, special	e clinical record failed to of what, if any, required was provided to the hospital, ited to physician contact representative contact instructions for ongoing care, and comprehensive care plan					
	#1 (Registered Nurs- process for sending room / hospital, RN f demographics sheet the bed hold, call the care plan and transfe facility keeps a copy stated, "We keep the When asked about e documentation is ser	.m., in an interview with RN e), when asked about the a resident to the emergency 1 stated, " send a copy of the med (medication) sheet, family, send a copy of the er form." When asked if the of the transfer form, RN #1 e yellow copy in the chart." vidence of what nt to the hospital, RN #1 eacket with a checklist on the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71772013	
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F 622	outside, which has a it. We pull off the coordinate of the coordinate of the coordinate of the coordinate of the hospital should be it.	ge 68 a copy of the checklist form on opy and keep it in the chart." a.m., in an interview with ASM staff Member - the Regional Services), ASM #3 stated, klist. Information that is sent d be documented in a nurse's	F 62	22			
	Notification & Right "Information provide must include but is r information of the pr care of the resident, information including *Advanced Directive or precautions for or *Comprehensive car necessary informatio resident's discharge	pplicable to ensure safe and					
	(ASM #1) was made further information w 2. The facility staff fathe comprehensive or required documental receiving facility whe transferred to the hose Resident #69 was ac 3/28/19 with the diagobstructive and reflux	ailed to provide evidence that are plan goals and physician ion were sent to the n Resident #69 was					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;)	E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING _		04	/17/2019	
]	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
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F 622	retention of urine. (Minimum Data Set assessment, with a date) of 4/4/19, cod on the BIMS (Brief iscore, indicating the cognitive impairmer. A review of the clinic note that was dated documented in part than 60 milliliters out to change Foley cat catheter) Attempte (indwelling urinary on Notified MD (medicastated to send to Expossible urine retent (responsible person policy was explained condition change and Resident was tran ambulance) to (name Further review of the verbal physician's or that documented in evaluation." The review documentation of which is the conducted with LPN documents are sent transferred to the hothe face sheet, the latest assessment is assessment.	The most recent MDS), a five day Medicare n ARD (Assessment reference ed the resident as scoring a 9 nterview for mental status) e resident has moderate at for daily decision making. cal record revealed a nurse's 3/24/19 at 6:00 p.m., which "Observed resident with less tiput in four hours. Attempted heter (indwelling urinary ed to reinsert Foley catheter atheter) had no urine return. al doctor) of change. MD a (Emergency Room) for tion and distention. RP) was notified and bed hold d. Resident was notified of ad bed hold policy explained sported via (name of e of hospital)" e clinical record revealed a der that was dated 3/24/19, part, "May send to ER for lew failed to evidence any nat was provided to the r Resident #69's 3/24/19	F 62	2			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	policy, a list of the conformation, and any LPN #2 was asked sent to the hospital. "I put it in my notes, and the transfer info." On 4/16/19 at 3:15 I Member) #1 (Execut (Regional Director of #2 (Interim Director made aware of the finformation was prosurvey. (1) Obstructive and uropathy is structura normal urine flow, so dysfunction (obstruction formation was obtain the sent of the required document of the required document of the hospital when Refer to the hospital on 1/2 Resident # 61 was a 01/26/2019 with diagnot limited to chest p diabetes mellitus (2). Resident # 61's mosset), a 5-Day assess	are plan, physicians contact y special instructions." When about how the information is evidenced, LPN #2 stated, a copy of the bed hold policy, and a copy of the bed hold policy, and a copy of the bed hold policy, and a copy of the chart." PM, ASM (Administrative Staff tive Director), AMS #3 f Clinical Services), and ASM of Clinical Services) were indings. No further vided by the end of the continuous leading to renal tive nephropathy. The canned from the website: anuals.com/professional/geniobstructive-uropathy/obstructive-ailed to evidence what, if any mentation was provided to esident #61 was transferred ex7/19. Idmitted to the facility on anoses that included but were tain, atrial fibrillation (1) and the recent MDS (minimum data ment with an ARD	F 6	22			
	Resident # 3 as scor	ce date) of 03/26/19, coded ing a 9 (nine) on the staff tal status (BIMS) of a score					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
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	of 0 - 15, 9 (nine) - 1 cognition intact for r The nurse's "Progrefor Resident # 61 do (temperature) 101.9 respond. Saturation (two liters) via (by) rwarm and moist. As changes to self, time not clear, garbled at than yesterday. (Nan.o. (new order) to s Med (medical) ctr (Ctransfer. 11:50 a.m. Squad) ems (emerghere to transfer." The facility's nurse's Data Collection) date pm (3:30 p.m.)" for F"15:40 (3:40 p.m.) Rambulance transport Number)." Review of the clinical failed to evidence do 61's comprehensive provided to the receit transfer to the hospit On 04/15/19 at approximate ASM # 3, region were provide the dat # 61 was transferred hospital. A request visition of the control of the clinical and ASM # 3, region were provide the dat # 61 was transferred hospital. A request visition of the control of the clinical and ASM # 3, region were provide the dat # 61 was transferred hospital.	being moderately impaired of making daily decisions. Ses Notes," dated 01/27/2019 ocumented, "11:30 a.m., Temple, alert to name, slow to 02 (oxygen) 91% @ (at) 2L o/c (nasal cannula). Skin is SM (altered mental status) and surroundings. Speech times, Grip strength weaker ame of Physician) notified with end to (Name of Hospital) center)911 called for (Name of Emergency ency medical technician) "Admission/Readmission and 01/28/2019 at "Time 1530 Resident # 61 documented, esident admitted to unit via the Readmitted to (Room I record for Resident # 61 ocumentation that Resident # care plan goals were ving facility at the time of	F 6:	22		
	comprehensive care	plan goals were provided to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	Continued From pa the receiving facility	(hospital).	F 622				
·	director of clinical so the request for docu 61's comprehensive provided to the rece	a.m., ASM #3, regional ervices stated in regards to imentation that Resident # care plan goals were siving facility, "If we provided t is in the nurse's notes."					
	conducted with LPN #2. When asked ab documents are sent transferred to the hosend the facesheet, relevant labs [labora policy, a list of the cainformation, and any LPN #2 was asked a evidenced, she state	AM, an interview was (Licensed Practical Nurse) (Licensed Practical Nurse) (Display the process for what with the resident who is (Display to the last progress notes, any (Licensed Practical Nurse) (Licensed Practical Nurse) (Display to the process notes, any (Licensed Practical Nurse) (Lic					
	(administrative staff director, and ASM #2	oximately 3:43 p.m., ASM member) #1, the executive 2, interim director of clinical e aware of the above findings.		·			
	References: (1) A problem with th heartbeat. This infor the website:	en was provided prior to exit. e speed or rhythm of the mation was obtained from gov/medlineplus/atrialfibrillati		-			
	(2) A chronic disease regulate the amount	in which the body cannot of sugar in the blood. This	i				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPP LER/CLIA

AND PLAN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING_		0,	4/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	DE	4/1//2019
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	information was obta https://www.nlm.nih. 001214.htm. 5. The facility staff of Resident # 53's common were sent with the Resident # 53's mosson was 12/26/18 with discount with hypoxia (2), per and chronic obstruct Resident # 53's mosset), a significant chawith an ARD (assess 01/02/18, coded Resident # 53's mossor of 0 - 15, 15 in moderate cognitive in making. A review of Resident revealed the admissing Resident # 53 was secare from 12/18/18 to The resident clinical in the second control of the resident clinical in the second control of the sec	ained from the website: gov/medlineplus/ency/article/ ailed to evidence that sprehensive care plan goals lesident to the hospital for the /2018. t recent facility admission agnoses that included but shronic respiratory failure (1) spheral vascular disease (3), sive pulmonary disease (4). t recent MDS (minimum data ange in status assessment ment reference date) of ident # 53 as scoring a 15 on mental status (BIMS) of a dicating the resident has inpairment for daily decision # 53's clinical record on record documented ent to [hospital] for acute of 12/26/18 related to a fall, record did not specify if plan goals were sent along	F 62	22		
d d t t	conducted with LPN (#2. When asked abo documents are sent v ransferred to the hos he face sheet, the las relevant labs [laborate	a.m., an interview was Licensed Practical Nurse) ut the process for what with the resident who is pital, LPN #2 stated, "I send st progress notes, any ory tests], the bed hold e plan, physicians contact				

INMEOF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES THE MADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063 PRICE TO CONTINUE A SUMMARY STATEMENT OF DEFICIENCIES THE MADDRESS AND FOOMBETTON AND FOOMBETTON FROM THE MEADOWS F 622 Continued From page 74 information, and any special instructions." When LPN 82 was acked about how the information sent to the hospital is evidenced, LPN 82 stated, "I put it in my notes, a copy of the bet hold policy, and the transfer information in the chart." On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, interior information the chart." On 04/16/18 on the facility of the findings, When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Potter and Perry." No further information was provided. References: 1. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nlm.gov/mediineplus/respiratory/a ilure.html 2. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp oxia. 3. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
ENVOY AT THE MEADOWS (24) ID PRIETX THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF MUST BE PRECEDED BY FULL FEBRUARY OF OBJECT OF			495236	B. WING			0.0	4/17/2019
PREFIX TAG REGULATORY OR LSC (DENTIFY) MINFORMATION) F 622 Continued From page 74 information, and any special instructions." When LPN #2 was asked about how the information sent to the hospital is evidenced, LPN #2 stated, "I put it in my notes, a copy of the bed hold policy, and the transfer information in the chart." On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 3, regional director of clinical services, and ASM # 3, regional director of clinical services, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Potter and Perry." No further information was provided. References: 1. A condition in which not enough exygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratory/a ilure.html 2. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp oxia. 3. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem					2715 DO	GTOWN ROAD		
information, and any special instructions." When LPN #2 was asked about how the information sent to the hospital is evidenced, LPN #2 stated, "I put it in my notes, a copy of the bed hold policy, and the transfer information in the chart." On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, interim director of clinical services, and ASM #3, regional director of clinical services, were made aware of the findings. When asked what standard the facility follows regarding their nursing care ASM # 3 stated, "We follow the facility's policies and Potter and Perry." No further information was provided. References: 1. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa ilure.html 2. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp oxia. 3. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPL	OULD BE	
vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing		information, and any LPN #2 was asked sent to the hospital "I put it in my notes, and the transfer info On 04/16/18 at appr (administrative staff director and ASM # services, and ASM # services, were made When asked what si regarding their nursi follow the facility's possible. A condition in white passes from your lurinformation was obtain https://www.nlm.nih.gilure.html 2. Deficiency of oxygethe body. This inform website: https://www.merriamoxia. 3. The vascular syst blood vessels. It included in the carry arteries can become called atherosclerosis vessels and block blood blook	y special instructions." When about how the information is evidenced, LPN #2 stated, a copy of the bed hold policy, ormation in the chart." Toximately 3:45 p.m., ASM member) # 1, the executive 2, interim director of clinical # 3, regional director of clinical # aware of the findings. tandard the facility follows ng care ASM # 3 stated, "We olicies and Potter and Perry." On was provided. This timed from the website: gov/medlineplus/respiratoryfa gen reaching the tissues of nation was obtained from the e-webster.com/dictionary/hyp em is the body's network of ides the arteries, veins and blood to and from the heart. thick and stiff, a problem is Blood clots can clog and flow to the heart or brain.	F 6	22			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 0-1	1172013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	bleeding inside the obtained from the whttps://www.nlm.nih ases.html. 4. Disease that mal can lead to shortnes was obtained from the https://www.nlm.nih. Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transfersedent, the facility transfersedent, the facility transfersedent, the reasons for the reasons for the reasons for the reasons for the reasons for the reasons discharge in the reasons discharge	body.) This information was rebsite: .gov/medlineplus/vasculardise kes it difficult to breath that is of breath. This information he website: .gov/medlineplus/copd.html. s Before Transfer/Discharge)-(6)(8) before transfer. sfers or discharges a must- t and the resident's the transfer or discharge and nove in writing and in a fer they understand. The copy of the notice to a copy of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in his section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the	F 62	22		
}	before transfer or dis- (A) The safety of indi	viduals in the facility would			i	

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019
ļ	PROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	· · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	this section; (B) The health of individual be endangered, under this section; (C) The resident's heal allow a more immediate under paragraph (c)(1). (D) An immediate transcrequired by the resident under paragraph (c)(1). (E) A resident has not adays. §483.15(c)(5) Contents notice specified in paramust include the follow (i) The reason for transcrii) The effective date of (iii) The location to which transferred or discharge (iv) A statement of the receives such requests to obtain an appeal form completing the form and hearing request; (v) The name, address telephone number of the Long-Term Care Ombuc (vi) For nursing facility mand developmental disabilities, the mailing allelphone number of the he protection and advocable in the protection and advocable in	paragraph (c)(1)(i)(C) of iduals in the facility would paragraph (c)(1)(i)(D) of lith improves sufficiently to be transfer or discharge, v(i)(B) of this section; after or discharge is nt's urgent medical needs, v(i)(A) of this section; or resided in the facility for 30 of the notice. The written ingraph (c)(3) of this section ing: after or discharge; of transfer or discharge; of the resident is ed; resident's appeal rights, dress (mailing and email), of the entity which is and information on how in and assistance in id submitting the appeal (mailing and email) and the Office of the State disman; esidents with intellectual bilities or related and email address and agency responsible for cacy of individuals with es established under Part	F 623	1.Resident #49 transferred to the hospid 3/24/19 and returned the same day from Written notification has been sent to the ombudsman and the resident represent as of 4/25/2019. Resident #61 transferred to the hospita 1/27/19 and returned 1/28/19. Written notification will be sent to resident representative and Ombudsman on 5/9 2.Social Services Director or Designee or review resident transfers to hospital with past 60 days to ensure resident representative and Ombudsman were provided with written notification of a hospital transfer. Follow-ups will be do based on findings. 3.Executive Director or Designee to educe Director of Social Work on providing resident representative and Ombudsman written notification on hospital transfer executive Director or Designee will review written notification to resident representative and Ombudsman for 8 wand as needed to ensure required notification is provided. 4.The results of the Quality Monitoring reviewed at the monthly Quality Assura Performance Improvement (QAPI) meetor review, analysis, and further recommendations.	m ER. he tative la on l/2019. will thin ne leate in s. he weeks to be ince	5.28.19

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (VAL) REQUIRED FOR LEGISLATION OF DESICIENCIES (VAL) REQUIRED FOR LEGISLATION OF DESICIES (VAL) REQUIRED FOR LEGISLATION OF DESICIES

	OF DEFICIENCIES OF CORRECTION	T(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		ATE SURVEY OMPLETED
		495236	B. WING				4/17/2019
1	PROVIDER OR SUPPLIER AT THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 5 DOGTOWN ROAD OCHLAND, VA 23063		17112013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	and Bill of Rights Accodified at 42 U.S.C (vii) For nursing faci disorder or related cemail address and tagency responsible advocacy of individuestablished under the for Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Indivision Mentally III Individual Individual III Indivision Mentally III Individual	ct of 2000 (Pub. L. 106-402, c. 15001 et seq.); and disabilities, the mailing and elephone number of the for the protection and uals with a mental disorder ne Protection and Advocacy duals Act. Ges to the notice. The notice changes prior to ror discharge, the facility ipients of the notice as soon the updated information The in advance of facility closure of closure, the individual who is the facility must provide from the impending closure and the impending closure and the impending closure and the impending closure and the impending closure and the impending closure and the impending closure and the impending closure and the impending closure and in adequate dents, as required at § The is not met as evidenced wiew, clinical record review the review, it was determined alled evidence written ided to the Resident or the Ombudsman of a the ombudsman of a the combudsman of	F6	523			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		717723010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 623	Ombudsman were protification of a hos resident was sent to 2. The facility staff 61 or Resident # 61	provided with written poital transfer when the poital transfer when the poital transfer when 3/24/19. failed to provide Resident # representative written peresident was transferred to	F6	23		
	Resident #49's resident management of the combuds o	ailed to evidence that lent representative and the			·	
	11/1/18 with the diag dysphagia, macular pressure, osteoarthr kidney disease, spor disorder, and chronic disease. The most a Set) was an annual a (Assessment Refere	dmitted to the facility on moses of but not limited to degeneration, high blood itis, depression, chronic adylosis, aphasia, anxiety cobstructive pulmonary recent MDS (Minimum Data assessment with an ARD noe Date) of 3/7/19. The as being moderately impaired by life decisions.				
	note dated 3/24/19 the resident in respirator (vital signs) 177/89 (forespirations), 97.0 (al record revealed a nurse's nat documented, "Noted y distress. Obtained VS plood pressure), 30 remperature), 72 (pulse), O2 (n) 90% (out of 100%) via O2 (Nurse Practitioner). Lung with) slight wheezing noted. minal muscle. Respiration er) to send resident out to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
1	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1172013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 623	Continued From pathe hospital for eval (name) aware. 911 Bed hold policy give Further review of the reveal any evidence hospital transfer was Representative and On 4/15/19 at 3:55 p#1 (Registered Nurs notifying the family it transfer, RN #1 state family, we don't do a asked about notifyin stated, "Nurses do ron 4/15/19 at 4:01 p#3 (Other Staff Mem Services), when ask Ombudsman, OSM Ombudsman for even hospital." When ask notification, OSM #3 month, I email a noti	ge 79 (evaluation). Granddaughter (emergency services) called. on." e clinical record failed to that written notification of this is provided to the Resident the Ombudsman. o.m., in an interview with RN ie), when asked about in writing of the hospital ed, "Nurses just call the is written notification." When ig the Ombudsman, RN #1 iot notify Ombudsman." o.m., in an interview with OSM iber - Director of Social ed about notifying the #3 stated, "I notify the iry discharge including ied how she provides the stated, "Every 2 weeks to a ioe." OSM #3 was asked to	F 62	DEFIGIENCY)		DATE	
	#49 was provided. Olist sent on 4/8/19, w 3/22/19 to 4/8/19 (rechospital on 3/24/19), #49. OSM #3 stated were admissions and 4/8/19. I don't see he I assume because shospital." OSM #3 wwas notified of Resid 3/24/19, OSM #3 stawas not made aware	th notification for Resident DSM #3 looked and found the hich included the dates of sident was sent to the did not include Resident, "The list I sent that date I discharges from 3/22 to er (Resident #49) on the list, he did not get admitted to the has asked if the Ombudsman ent #49's hospital transfer on ted, "No, the Ombudsman of that transfer." When g written notification to the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING			l na	/17/2019
	PROVIDER OR SUPPLIER			271	REET ADDRESS, CITY, STATE, ZIP CODE 5 DOGTOWN ROAD OCHLAND, VA 23063		1112019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623		nge 80 ted, "I don't do the written amily." She was not sure who	F 6	623			
	with ASM #3 (Admin Regional Director of written notification to "(ASM #2 - the Interpretations) fills them book. The letter shor discharge. If it is	AM, in a follow up interview nistrative Staff Member - the f Clinical Services) about o the family, ASM #3 stated, rim Director of Clinical out, makes a copy for the ould be done for any transfer on't in the book it wasn't done."					
	Discharge Notification documented, "Notice resident and resident transfer or dischargemove in writing (in a understand.). The Othe notice to a represstate Long-Term Careasons for the transfersident's medical re NoticeNotice must practicable before transfersion to the Ombo	ity policy, "Transfer / on & Right to Appeal" e Before TransferNotify the nt representative(s) of the e and the reasons for the language and manner they Center must send a copy of esentative of the Office of the are Ombudsman. Record the sfer or discharge in the ecordTiming of the t be made as soon as ransfer or discharge. Note: udsman in these situations racticable, such as a list of hly basis"					
	(ASM #1) was made further information w 2. The facility staff f 61 or the Resident #	o.m., the Executive Director e aware of the findings. No vas provided. ailed to provide Resident # 61's representative written e resident was transferred to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		n ₄	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	_ 04	1112013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
	the hospital on 01/2 Resident # 61 was a 01/26/2019 with diamot limited to chest diabetes mellitus (2) Resident # 61's mosset), a 5-Day assess (assessment references assessment for merof 0 - 15, 9 (nine) - b cognition for making 61 was coded as recofone staff member The nurse's "Progrefor Resident # 61 do (temperature) 101.9 respond. Saturation (two liters) via (by) nwarm and moist. As changes to self, time not clear, garbled at than yesterday. (Na n.o. (new order) to so Med (medical) ctr (C transfer. 11:50 a.m. Squad) ems (emergence to transfer." The facility's nurse's Data Collection) date pm (3:3:30 p.m.)" for "15:40 (3:40 p.m.) Refore the control of the control of the collection of the collection) date pm (3:3:30 p.m.)" for "15:40 (3:40 p.m.) Refore the collection of th	7/19. admitted to the facility on gnoses that included but were pain, atrial fibrillation (1) and the facility of the facility	F 62	23			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	I` 'aa		DATE SURVEY COMPLETED	
		495236	B. WING			04/	17/2019	
}	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD E	BE ATE	(X5) COMPLETION DATE	
	Review of the clinical failed to evidence of notification was properlimental failed to evidence of notification was properlimental failed. The hosp of transfer to the hosp of transfer to the hosp (administrative staff and ASM # 3, region were provide the dall # 61 was transferred hospital. A request provide documentat the transfers to Responsible party. On 04/16/19 at 7:54 director of clinical seresponsible party. On 04/16/19 at 7:54 director of clinical serequest for documentation it is in the transfers to Responsible party. On 04/06/19 at approper (administrative staff director, and ASM # 2 services, were made to the website of the website: https://www.nlm.nih.gon.html.	al record for Resident # 61 ocumentation that written vided to Resident # 61 or consible party in regard to the ital on 01/27/19. Toximately 5:15 p.m., ASM member) # 1, administrator hal director of clinical services, te of 01/27/19, when Resident diffrom the facility to the was made at that time to ion of written notification of ident# 61 and Resident # 61's a.m., ASM # 3, regional ervices stated in regard to the intation of written notification esident# 61 and Resident # ty, "If we provided the	F 6	23				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	1/17/2019	
l	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		#177Z013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 623	information was obta https://www.nlm.nih. 001214.htm.	ained from the website: gov/medlineplus/ency/article/	F 62				
	CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transf the resident goes on nursing facility must the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facility bed-hold periods, wh paragraph (e)(1) of th resident to return; an (iv) The information s of this section. §483.15(d)(2) Bed-ho the time of transfer of hospitalization or ther facility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on resident interpresentations specifies the duration	bed-hold policy and return- e before transfer. Before a fers a resident to a hospital or therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if e resident is permitted to esidence in the nursing coayment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d epecified in paragraph (e)(1)	F 62	25			

				(3) DATE SURVEY COMPLETED		
		495236	B. WING_		04	1/17/2019
	ROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF() TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
	to provide a bed hold resident's representat hospital for one of 41 sample, Residents #6 The facility staff failed hold policy with Resident #61's resport The findings include: Resident #61's resport The findings include: Resident #61 was add 01/26/2019 with diagn not limited to chest padiabetes mellitus (2). Resident #61's most reset), a 5-Day assessment reference Resident #3 as scorin assessment for mental of 0 - 15, 9 (nine) - being cognition for making defended as required for the nurse's "Progress for Resident #61 docu (temperature) 101.9, alterspond. Saturation 02 (two liters) via (by) n/c warm and moist. ASM changes to self, time and clear, garbled at time time time time time time time tim	ined that facility staff failed policy to the resident or the tive upon a transfer to the residents in the survey of the send a copy of the bed ent #61 at the time of and or provide a copy to esible party on 01/27/19. mitted to the facility on oses that included but were in, atrial fibrillation (1) and ecent MDS (minimum data ent with an ARD adate) of 03/26/19, coded g a 9 (nine) on the staff atatus (BIMS) of a scoreing moderately impaired of eaily decisions. Resident # ring extensive assistance or activities of daily living. Notes," dated 01/27/2019 mented, "11:30 a.m., Tempert to name, slow to a (oxygen) 91% @ (at) 2L (nasal cannula). Skin is (altered mental status) and surroundings. Speech ines, Grip strength weaker	F		o the hospital on A copy of the provided to sponsible party ignee will residents y days to was sent with hospital and responsible ndings. ignee to educate resident and y of facility's transfer. ee will review he bed hold sident and or 8 weeks and as tification is Ionitoring to be lity Assurance (API) meetings	5.28.19
t		of Physician) notified with				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495236	B. WING			04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			271	EET ADDRESS, CITY, STATE, ZIP CODE 5 DOGTOWN ROAD OCHLAND, VA 23063		,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 625	Med (medical) ctr (0 transfer. 11:50 a.m Squad) ems (emerg here to transfer." The facility's nurse's Data Collection) dat pm (3:3:30 p.m.)" fo "15:40 (3:40 p.m.) Fambulance transpor Number)." Review of the clinica failed to evidence do policy was provided	ge 85 Center)911 called for . (Name of Emergency gency medical technician) s "Admission/Readmission led 01/28/2019 at "Time 1530 or Resident # 61 documented, Resident admitted to unit via led to the transfer regard to the transfer	Fe	525				
	(administrative staff and ASM # 3, region was provide the date # 61 was transferred hospital. A request provide documentation sent with to Residen provided to Residen the time of transfer. On 04/16/19 at 7:54 director of clinical serequest for document was sent with Resident provided to Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident we provided the document was sent with Resident was sent was sent with Resident was sent was sent was sent with Resident was sent was se	oximately 5:15 p.m., ASM member) # 1, administrator all director of clinical services, of 01/27/19, when Resident I from the facility to the was made at that time, to fon the bed hold policy was t # 61 to the hospital and/or t # 61's responsible party at a.m., ASM # 3, regional rivices stated in regard to the station the bed hold policy ent # 61 to the hospital and/or t # 61's responsible party, "If tumentation it is in the nurse's						
		a.m., an interview was (Licensed Practical Nurse)						

TAND PLAN OF CORRECTION I IDENTIFICATION NUMBER, I		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		495236	B. WING		04	1/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	#2. When asked ab documents are sent transferred to the EI hospital, LPN #2 state the last progress not hold policy, a list of tocontact information, When LPN #2 was a information is evider in my notes, a copy the transfer information. On 04/06/19 at apprecadministrative staff director, and ASM #2 services, were made No further information. References: (1) A problem with the heartbeat. This inforthe website:	oout the process for what with the resident who is R (emergency room) or ted, "We send the facesheet, tes, any relevant labs, the bed the care plan, physicians and any special instructions." asked about how the need, LPN #2 stated, "I put it of the bed hold policy, and	F 6	25		
F 656 SS=E	regulate the amount of information was obtain https://www.nlm.nih.go01214.htm. Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The factorial formation in factorial formation in factorial formation in factorial formation in factorial formation in factorial factorial formation in factorial	in which the body cannot of sugar in the blood. This ined from the website: jov/medlineplus/ency/article/Comprehensive Care Plan ensive Care Plans cility must develop and nensive person-centered	F 650	6		
	care plan for each res	sident, consistent with the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S COMPLI	
		495236	B. WING		04/1	7/2019
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656			F 656	F 656 Care plan development		5-28-19
	§483.10(c)(3), that indobjectives and timefra medical, nursing, and needs that are identificances assessment. The complete describe the following (i) The services that a comminate or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wounder §483.10, including treatment under §483.3 provided due to the resurder §483.10, including treatment under §483.3 (iii) Any specialized sere abilitative services provide as a result of the recommendations. If a findings of the PASAR rationale in the residential (iv) In consultation with resident's representating (A) The resident's goard desired outcomes. (B) The resident's prefituting discharge. Facil whether the resident's community was assess local contact agencies entities, for this purpos (C) Discharge plans in plan, as appropriate, in requirements set forth section. This REQUIREMENT by:	ames to meet a resident's mental and psychosocial ed in the comprehensive aprehensive aprehensive care plan must reto be furnished to attain int's highest practicable psychosocial well-being as et, §483.25 or §483.40; and would otherwise be required esto or §483.40 but are not sident's exercise of rights ing the right to refuse 10(c)(6). Ervices or specialized the nursing facility will PASARR a facility disagrees with the R, it must indicate its int's medical record. In the resident and the ve(s)-lis for admission and deference and potential for ities must document desire to return to the sed and any referrals to and/or other appropriate se. Ithe comprehensive care in accordance with the		1.1) Resident #13 has her bed in lovas indicated in her plan of care. 2) Resident # 52 is receiving her meas prescribed by her physician as in in her plan of care. 3) Resident # 70 is receiving treatmer services as prescribed by her physicial indicated in her plan of care. 4) Resident # 41 continues to receive therapy as ordered by the physicial indicated in her plan of care. 5) Resident # 31 no longer has an Ambien and the comprehensive cath has been updated. 6) Resident # 73 implementation for as indicated on care plan is approprize resident needs. 2. Residents who reside in the facility comprehensive care plan developed according to the RAI manual. The implementation of interventions for residents care will be based on phys orders and interventions to assist reto meet their highest psychosocial we Follow up will be based on findings.	edications indicated nent ician as order for ire plan call bell iate for y have a ician sidents ell being.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04/17/2019
	ROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
ļ	was determined the faimplement the compre 41 residents in the sui #13, #52, #70, #41, #3 1. The facility staff faile bed in the low position the bed per the compre 2. The facility staff faile medications to Reside order and the compre 3. The facility staff faile #70's comprehensive administering a physic 4. The facility staff faile care plan for Resident MD (medical doctor) o 5. The facility staff faile comprehensive care plansomnia. 6. The facility staff faile 73's comprehensive care plansomnia. 7. The facility staff faile 73's comprehensive care plansomnia. 1. Resident #13 was at 10/08/18 with a recent with diagnoses that incomprehensive care with diagnoses that incomprehensive care that incomprehensive care plansomnia.	clinical record review, it decility staff failed to shensive care plan for six of rivey sample, Residents 31 and #73. ed to have Resident #13's in while the resident was in rehensive care plan. ed to administer int #52 per the physician mensive care plan. ed to implement Resident care plan by not care plan for exident oxygen per rivers. ed to implement the oxygen #41 to provide oxygen per rivers. ed to develop a lan for Residents # 31's lan for Residents # 31's land for Residents # 31's land did to the facility on readmission on 3/23/19, sluded but were not limited by dementia, and diabetes. (minimum data set)	F 65	3. The licensed nursing staff / MDS coordinator will update residents care when needed with interventions to add changes in care. The licensed nurse wire educated by the DON or designee on updating the care plan and following interventions as outlined. Physician or will be reviewed by the DON or design daily, five times a week for eight week ensure that care plan is updated in a timanner. Quality review observations we completed weekly for eight weeks by the DON or designee to ensure intervention being implemented as written in the placare. 4. The results of the quality monitoring be reported to the quality assurance committee for review, analysis and furtive recommendations, tervention are implemented as written.	ress ll be ders ee s to mely vill be le is are an of

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063		041112013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
	assessment referer resident as scoring interview for mental resident was severe cognitive decisions. requiring extensive dependent upon one all of her activities of coded as requiring extensive documented in part, for falls r/t (related to transfers, decondition incontinence, poor communication/	a "5" on the BIMS (brief status) score, indicating the ely impaired to make daily Resident #13 was coded as assistance to being totally or more staff members for f daily living. The resident was extensive assistance of two or for transfers and moving in care plan dated, 2/24/19, "Focus: the resident is at risk or nonambulatory/Hoyer lift for oning, gait/balance problems, prehension, impaired hearing ntions" documented in part, " Indee of Resident #13 on during the initial screening of #13 was observed in her bed, as bed was at the waist level of	F6	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71772013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
	the low position if you asked the purpose of stated, "It's how to purpose of and meet the reside. An interview was concurse) #2, on 4/15/1 about the purpose of "It's how to take car When asked if the or RN #2 stated, "Absoimplement further mneeds." When asked to keep the bed in lois in the bed, where resident is in the bed position." The facility policy, "Edocumented in part, needs are addresse interventions oriente maintaining the high mental and psychos. The facility policy, "Omanagement" documented to be at centered intervention implemented to mini injury." Administrative staff rexecutive director, A clinical services and	ou leave the room." When of the care plan, CNA #2 properly care for the resident ent's needs. Inducted with RN (registered 9 at 2:53 p.m. When asked of the care plan, RN #2 stated, e of them (the residents). Fare plan should be followed, plutely, unless you need to reasures according to their difference of the care plan documents, by position when the resident should the bed be when the difference of the care plan documents and the low seest Practice - Care Plans" "Process: The resident's difference of through patient centered difference of the above of the	F 6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495236	B. WING			04/17/201	a
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	0.0117201	<u> </u>
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5 BE COMPLI ATE DAT	ETION
2. The facility staff i medications to Resorder and the comporter	failed to administer ident #52 per the physician orehensive care plan. Idmitted to the facility on ises that included but were not er, COPD [chronic obstructive - general term for chronic, disease that is usually a shysema and chronic (1)], high ciety, chronic pain and IDS (minimum data set) terly assessment, with an ice date of 3/13/19, coded the a "1" on the BIMS (brief status) score, indicating the impaired to make daily The resident was coded as sorganized thinking that esident #52 was coded as allucinations and delusions. In Section N - ident was coded as receiving	F 6	556			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495236	B. WING				04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		,	2715 DO	ADDRESS, CITY, STATE, ZIP C GTOWN ROAD ILAND, VA 23063	OODE	1	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X CF	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
	documented in part anti-anxiety medica disorder." The "Inte "Administer ANT-Al ordered by physicial effectiveness Q-SH The physician ordered documented, "Meth MG (milligram) Tab three times daily at p.m.), 2200 (10:00) *Methadone is used people who are exparound the clock for be treated with other Review of the Janual administration recomphysician order. On the nurse initialed the initials, indicating it is documentation on the Review of the nurse nursing documentation. The February 2019 physician order. The not having been administration and 2/21/19 at 10:00 the MAR failed to evithe medication was Review of the nurse.	it, "Focus: The resident uses attions r/t (related to) Anxiety reventions" documented in part, NXIETY medications as in. Monitor for side effects and IIFT (every shift)." If dated, 12/31/18, adone* HCL (hydrochloride) 5 let; 3 tabs (tablets) by mouth 0600 (6:00 a.m.) 1400 (2:00 p.m.) for pain." If to relieve severe pain in ected to need pain medication of a long time and who cannot or medications (2). Ary 2019 MAR (medication and circled their wasn't given. There was no ne reverse side of the MAR. Is notes failed to evidence ion on 1/14/19. MAR documented the above of MAR documented the above of Methadone was circled as inistered on 2/9/19 at 10:00 p.m., 2/18/19 at 6:00 a.m., p. p.m. The reverse side of idence documentation of why not administered. Is notes for the above dates evidence the reason why the	F	556				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495236	B. WING			04/1	7/2019
ļ	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE		172019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E E APPROPRI	3F	(X5) COMPLETION DATE
	The March 2019 Maphysician order. The not having been adra.m. and 2:00 p.m., 3/13/19 at 2:00 p.m., documented on the The physician order "Methadone HCL (hytabs (20 mg) PO (byday) for pain." The March 2019 Maphysician order. The administration of the 3/17/19 and 3/18/19 Review of the nurse! failed to evidence domedication was not a "Methadone HCL 20 mouth) TID (three times and the medication was con 3/28/19, the 6:00 as not administred. documented, "3/26/19 Medication - Methadoin from pharmacy."	AR documented the above e Methadone was circles as ministered on 3/8/19 at 6:00 3/12/19 at 2:00 p.m. and There was nothing reverse side of the MAR. dated, 3/14/19 documented, ydrochloride) 5 mg; give 4 mouth) TID (three times a AR documented the above MAR failed to document the Methadone on 3/16/19, at 2:00 p.m. s notes for the above dates cumentation of why the administered. dated, 3/26/19, documented, mg tab (tablet) PO (by nes a day)." R documented the above 2:00 p.m. and 10:00 p.m., sircled as not administered. a.m. dose was documented The reverse of the MAR 9 - 1400 (2:00 p.m.), one - meds (medications) not	F 6				
· []		notes for the above dates cumentation of why the given as ordered.					
-	The physician order d	lated, 2/14/19, documented.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING	à	04	/17/2019	
-	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CO: 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		, , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE	
	"Reduce am (morni treat anxiety) (3), to (continue) pm (ever mg."	ng) dose of Ativan (used to 0.5 mg (milligrams), containg) dose of Ativan @ (at) 1 2019 (medication d) documented the above The Ativan scheduled for had the nurse's initials with a There was nothing reverse of the MAR. The ted the Ativan 1 mg to be 0 p.m. to have the nurse's 4/19, 2/15/19, 2/19/19, and e side of the MAR 1/19 at 5:00 p.m., eping." There were no other e side of the MAR. Is notes for the above dates evidence documentation of was not administered. Inducted with CNA (certified 2 on 4/15/19 at 2:51 p.m. pose of the care plan, CNA or properly care for the	F	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY	
		495236	B. WING		0/	1/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	An interview was on nurse) #1 on 4/15/1 about the process sordered medication administration, RN a circle around their on the back of the I giving it. If it's not a lif they can't get it to notify the doctor an something else in the facility has an e #1 stated that there room that contains narcotics." When as nurse's initials indice that nurse did not grasked if a nurse show medication is not grashed if a nurse's medication is not grashed if an an nurse's medication is not grashed if the physician "Absolutely and a new When asked if the redication and the medications as order plan, RN #1 stated, Administrative staff executive director, A clinical services and of clinical services and of clinical services we concern on 4/15/19 No further information.	onducted with RN (registered 9 at 4:07 p.m. When asked staff follows if a physician is not available for #1 stated, "I first circle it (draw r initials) on the front and write MAR what the reason for not vailable, I'd call the pharmacy. me in a timely manner, I'd do see if they want to give ne meantime." When asked if mergency medication box, RN was a box in the medication antibiotics, diuretics and some sked what a circle around the ate, RN #1 stated it means to the medication. When bould document why a wen, RN #1 stated, "Yes, they to the the reverse side of the note." When asked if a wen, refused or not available, in be notified, RN #1 stated, on the notified, RN #1 stated, on the should be documented." The note of the note is that following the care when the care are plan states to give the ered, is that following the care. "No, that's not."	F 65	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING			04/	17/2019
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	11/2010
ENVOY	AT THE MEADOWS		GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG			ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	Continued From pa Chapman, page 12- (2) This information	~	F6	56			
	following website: https://medlineplus. tml	gov/druginfo/meds/a682134.h					
·	following website: https://medlineplus.thml.	gov/druginfo/meds/a682053.h					
	#70's comprehensiv	ailed to implement Resident e care plan by not sician ordered treatment.					
	8/14/2018. Diagnose limited to: spina bific	dmitted to the facility on sees included but were not la (1), pressure ulcer of the four (2) (3), muscle weakness left leg.					
	quarterly assessmer reference date) of 4/ having a score of 15 interview for mental	OS (minimum data set), a nt, with an ARD (assessment 13/19 coded the resident as out of 15 on the BIMS (brief status) indicating the resident t to make daily decisions.					
	The resident was co assistance for most In Section M - Skin (ded as requiring limited of her activities of daily living. Conditions, the resident was a unstageable pressure injury				•	
	2019, documented, 'with Dakin's Solution alginate then cover vand as needed." In a						
		9: Ischium Wounds- Cleanse , cover with foam dressing eded."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
<u> </u>		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	1112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 pa	ge 97	F 656	6		
	documented, "The late to sacrum and left is surgical related to be	e care plan dated 3/14/19, resident has a pressure injury schium, abd (abdominal) istory of ulcers and lack of ns: treatments as ordered."				
	March 2019 docum Sacrum-cleanse wit with silver alginate t every day and as no	th Dakin's Solution (5), cover then cover with foam dressing seded." the treatment was not ministered on: March 1st, 5th,				
	March 2019 docume Wounds- Cleanse w with foam dressing treatment was not d	administration record) dated ented, "2/12/19: Ischium vith Dakin's Solution, cover every day and as needed." the ocumented as being arch 1st, 5th, 22nd, 23rd, and				
	interview was condu Resident #70 was a administered daily.	oximately 9:40 a.m., an locted with Resident #70. sked if her wound care is Resident #70 replied, "Mostly. my dressings most days but s days."	·			
	interview was condu staff member) #2, th Services, after revier and comprehensive asked if the physicia was administered or 22nd, 23rd, and 26th	ximately 9:47 a.m., an cted with ASM (administrative e Interim Director of Clinical wing Resident #70's MAR care plan. ASM #2 was n ordered wound treatment the days of March 1st, 5th, a. ASM #2 replied, "If the off the treatment I can't say it				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(Xa	3) DATE SURVEY COMPLETED	•
		495236	B. WING			04/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	E, ZIP CODE	04/1/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAĢ	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
	was done." ASM #2 care plan was being "No." On 4/17/19 at approte the Executive Direct member) #2, the Int Services and ASM #Clinical Services we findings. The facility policy titl Plan" dated 7/31/17, resident's needs are centered intervention or maintaining the himental and psychos No further information. Spina bifida is a nubirth defect of the brown happens if the spinal close completely durpregnancy. This can spinal cord. Screening can check for spinal discovered only after symptoms of spinal between the person. Most people normal intelligence. Since they may have learn bowel problems, or hilling in the website:	was asked if Resident #70's pollowed. ASM #2 replied, oximately 10:30 a.m., ASM #1, tor, ASM (administrative staff erim Director of Clinical 43, the Regional Director of re made aware of the ed, "Best Practice - Care addressed through patient as oriented toward attaining ghest practicable physical, ocial well-being." on was provided prior to exit. eural tube defect - a type of ain, spine, or spinal cord. It column of the fetus doesn't	F6	56			
	meta?v%3Aproject=r	medlineplus&v%3Asources=		<u> </u>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495236	B. WING _		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71172013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	medlineplus-bundle 65789432.7550202 555684133	ge 99 &query=spina+bifida&_ga=2.1 80.1555684133-764922449.1 re also called bedsores, or	F 656			
	pressure sores. The and soft tissue pressuch as a chair or b pressure reduces bl of blood supply can area to become dan information was obta	y can form when your skin s against a harder surface, ed, for a prolonged time. This ood supply to that area. Lack cause the skin tissue in this				
	is described below (in NPUAP stage is use appearance of an arpractice of changing known as reverse stages. Stage 4 (pressure full-thickness skin ardirectly palpable fasc cartilage, or bone in eschar may be visible edges), undermining occur. Depth varies a slough or eschar obsloss, this is an unstagunstageable pressure full-thickness skin an extent of tissue dama be confirmed because eschar. If slough or eschar it slough or eschar it below. Obtained from the we	The NPUAP staging system cable 1 and figure 2) [5]. The d to describe the initial ea of skin damage. The the stage as healing occurs, aging, is not recommended injury) is characterized by dissue loss with exposed or sia, muscle, tendon, ligament, the ulcer. Slough and/or e (picture 1). Epibole (rolled, and/or tunneling often by anatomical location. If secures the extent of tissue geable pressure injury, the injury is characterized by dissue loss in which the age within the ulcer cannot e it is obscured by slough or schar is removed, a stage 3 njury will be revealed. (See) This information was bsite: .com/contents/clinical-stagin				

STATEMENT OF DEFICIENCIES (X1) PE AND PLAN OF CORRECTION (Di		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495236	B. WING		n/	1/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		·	STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 656			F6	556		
	d-soft-tissue-injury? Ostaging&source=s 4&usage_type=defa 04	t-of-pressure-induced-skin-andsearch=pressure%20ulcer%2 earch_result&selectedTitle=1~ault&display_rank=1#H761282			<u>.</u> .	-
	is widely used in a value and has been advoc management of bur broad-spectrum ant	imicrobial activity with efficacy	,			
	other antibiotic-resis information was obt https://www.uptodat	nt Enterococcus (VRE), and			·	
	=dakins%20solution =default&anchor=H	§ionRank=1&usage_type 10128208&source=machineL le=2~33&display_rank=1#H1				
	4. The facility staff facare plan for Reside MD (medical doctor)	ailed to implement the oxygen nt #41 to provide oxygen per orders.				
	limited to stroke, res pressure, gastrostor The most recent MD quarterly review asso (Assessment Refere documented that Re	dmitted to the facility iagnoses including, but not piratory failure, high blood ny status (1) and dementia. S (Minimum Data Set), a essment with an ARD nce Date) of 2/28/19, sident #41 had moderate t for daily decision-making.				
İ	and 12:15 p.m., Res	.m., on 4/15/19 at 8:55 a.m., ident #41's oxygen flowrate entrator was observed set at				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495236	B. WING	i	•	04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	TITEO 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	2 ½ liters per minute A review of the clinic (medication adminis April 2019, which do Oxygen 3L/Min (3 lit cannula"	e during each observation. cal record revealed a MAR stration record) that was dated ocumented in part, "12/29/18: ers per minute) via nasal e clinical record revealed a lated April 2019, that	Fé	356			
	ruther review of the comprehensive care documented in part, respiratory status/dit chronic respiratory from comprehensive care	e clinical record revealed a plan dated 2/21/19, that "The resident has altered ficulty breathing related to ailure with hypoxia (5)." The plan "Interventions" "Provide oxygen per MD					
	conducted with LPN #2. When LPN #2 w for administering oxy flowrate, LPN #2 sta Take the oxygen to t correct level." When nurse would determi correct level? LPN # cylinder on the conceput the black ball on the line but at the cerasked the process for implementing oxygen "The nurse checks it creates the care plan	p.m., an interview was (Licensed Practical Nurse) vas asked about the process vgen at the prescribed ted, "You look at the order. he room and set it at the 1 LPN #2 was asked, how the ne if the flowrate is set at the 2 stated, I look at the entrator at eye level. I would the line, not above or below her." When LPN #2 was or care planning and therapy, LPN #2 stated, (physician's orders) and It would be placed on the nistration record), that is					

A95236 B. WING O4/17/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			495236	B. WING		04	/17/2019
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI		(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
how you follow the order." A review of the facility's policy "Oxygen Therapy" with a revision date of 8/28/17, documented in part, "Oxygen therapy is the administration of a FiO2 (Fraction of Inspired Oxygen) greater than 21% by means of various administration devicesProcedurePhysician's order or oxygen therapy shall include: Administration modalityliter flowcontinuous or PRN Review physician's orderStart O2 flowrate at the prescribed liter flow or appropriate flow for administrative device." A review of the "Invacare Perfecto2 Oxygen Concentrator User Manual" documented in part, "1. Turn the flowrate knob A to the setting prescribed by your physicianTo properly read the flowmeter B, locato the prescribed flowrate line on the flowmeter. Next turn the flow knob until the ball C rises to the line. Now, center the ball on the I/min (liter per minute) line prescribed." According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." On 4/16/19 at 3:15 p.m., ASM (Administrative Staff Member) #1 (Executive Director), AMS #3 (Regional Director of Clinical Services), and ASM	H A C F F E E E E E E E E E E E E E E E E E	A review of the faciliwith a revision date part, "Oxygen theraper of the part, "Oxygen theraper of the part, "Oxygen theraper of the procedurePhysicallyliter flow. ProcedurePhysicallyliter flow. Review physician's of the prescribed liter fadministrative device. A review of the "Invactor of the "Invactor of the prescribed by your phe flowmeter B, location on the flowmeter by the flowmeter B, location on the flowmeter B, location on the limin (liter oxygen should be the dangerous side effects oxygen toxicity (Thouse thould routinely checker of the procedure of the dangerous and procedure of the danger	ity's policy "Oxygen Therapy" of 8/28/17, documented in py is the administration of a spired Oxygen) greater than arious administration devices ician's order for oxygen at Administration accontinuous or PRN order Start O2 flowrate at low or appropriate flow for e." Accare Perfecto2 Oxygen Manual" documented in part, whob A to the setting or order the prescribed flowrate r. Next turn the flow knob to the line. Now, center the r per minute) line prescribed." In mentals of Nursing, 6th erry, 2005, page 1122, reated as a drug. It has cets, such as atelectasis or mson, 2002). As with any concentration of oxygen sly monitored. The nurse cet the physician's orders to s receiving the prescribed in. The six rights of ration also pertain to oxygenm., ASM (Administrative executive Director), AMS #3	F 6	56		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	-	(X3) DATE SURVEY COMPLETED	
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	#2 (Interim Director made aware of the information was prosurvey. (1) Gastrostomy state ICD-10-CM code the diagnosis for reimbinformation was rethttps://www.icd10da-Z99/Z77-Z99/Z93-,5. The facility staff comprehensive carrinsomnia. Resident # 31 was a 03/15/18 and a read diagnoses that incluinsomnia (2), respirobstructive pulmonal hypertension (5). Resident # 31's moset), a quarterly ass (assessment reference Resident # 31 as a cinterview for mental - 15, 15 - being cognitive.	r of Clinical Services) were findings. No further by fundings. No further by fundings. No further by fundings. No further by fundings. No further by fundings is a billable/specific funding f	F6	S56	JENCY)		
	The physician's orde Resident # 31 docur coated) 5MG (millign tab (tablet) by mouth sleep. 03/16/19."	ers dated "April 2019" for mented, "Zolpidem F/C (film ram) Tablet (Ambien). 1 (one) at bedtime as needed for on administration record) or Resident # 31 documented,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	"Zolpidem F/C (film (Ambien). 1 tab by r for sleep. 03/16/19. 03/16/19. 03/16/19 through 03 31 received Zolpide opportunities. Furth "March 2019" failed non-pharmacologica attempted prior to the The MAR (medicatic dated April 2019 for "Zolpidem F/C (film (Ambien). 1 tab by n for sleep. 03/16/19." 04/01/19 through 04 31 received Zolpider opportunities. Furth "April 2019" failed to non-pharmacologica attempted prior to the The comprehensive dated 03/11/2019 do documentation for in Zolpidem. On 04/16/19 at 12:43 conducted with RN (temporary traveling for the temporary traveling for the	coated) 5MG Tablet mouth at bedtime as needed 'Review of the MAR dated 8/31/19 revealed Resident # m ten out of sixteen her review of the MAR dated to evidence documentation of al approaches being he administration of Zolpidem. On administration record) Resident # 31 documented, coated) 5MG Tablet houth at bedtime as needed Review of the MAR dated //11/19 revealed Resident # m seven of eleven her review of the MAR dated evidence documentation of approaches being he administration of Zolpidem. care plan for Resident # 31 cumented failed to evidence somnia and the use of B p.m., an interview was	F 68	56		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
	(administrative staff director, and ASM # services, were mad No further information. References: (1) Comes as a table extended-release (le CR) to take by moust sublingual tablet (Edunder the tongue and which is sprayed into the tablets, sublingual tayou will take the menthan one time a day. If you are taking the (Intermezzo), you wineeded, not more thif you wake up and his leep. Zolpidem will with a meal or immethe directions on you and ask your doctor part you do not under as directed. You will sleepy soon after you remain sleepy for so medication. Plan to go zolpidem tablets, ext sublingual tablets (Edundaready in bed and call the tablets (In already in bed and call the tablets of hours after taking of hours after taking the call the tablets and the tablets of the tablets o	member) #1, the executive 2, interim director of clinical e aware of the above findings. On was provided prior to exit. et (Ambien) and an ong-acting) tablet (Ambien th. Zolpidem also comes as a dluar, Intermezzo) to place and an oral spray (Zolpimist), of the mouth over the tongue. It tablets, extended-release ablets (Edluar), or oral spray, dication as needed, not more immediately before bedtime. Sublingual tablets If take the medication as an one time during the night neve difficulty returning to work faster if it is not taken diately after a meal. Follow ar prescription label carefully, or pharmacist to explain any erstand. Use zolpidem exactly probably become very a take zolpidem and will me time after you take the go to bed right after you take ended-release tablets, dluar), and oral spray and to hours. Take zolpidem termezzo) only when you are an remain in bed for at least take zolpidem if you will be seep for the required number the medication. If you get up	F 6	56		
	of hours after taking too soon after taking					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	<u> </u>	1772013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
	experience drowsir memory, alertness, information was ob- https://medlineplus.tml. (2) A common sleep may have trouble fa or both. As a result, have poor-quality sl refreshed when you was obtained from the https://www.nlm.nihml. (3) When not enouglungs into your bloo obtained from the whitps://www.nlm.nihilure.html. (4) Disease that macan lead to shortnes was obtained from the thttps://www.nlm.nih. (5) High blood pressobtained from the whitps://www.nlm.nih.essure.html.	disorder. If you have it, you alling asleep, staying asleep, you may get too little sleep or eep. You may not feel wake up. This information the website: .gov/medlineplus/insomnia.ht who alline plus/respiratoryfa kes it difficult to breath that so of breath. This information he website: .gov/medlineplus/respiratoryfa kes it difficult to breath that so of breath. This information he website: .gov/medlineplus/copd.html.	F 6				
	Resident # 73 was a 08/06/12 with a re-a diagnoses that include	Idmitted to the facility on dimission of 04/27/15 with ded but were not limited to allure (2), atrial fibrillation (3)					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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İ	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
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	and diabetes mellitumes and diabetes mellitumes asset), a quarterly asset), a quarterly asset), a quarterly asset (assessment reference Resident # 73 as so interview for mental - 15, 3 (three) - beincognition for making 73 was coded as refor all activities of da "Functional Limitation Resident # 73 as "Nof her upper extreminand). On 04/14/19 at 2:30 Resident # 73 reveated of his bed. Ob revealed it was lying bed. When asked if Resident # 73 stated to a white cord under the opposite side of the observation revealed to reach for the call but the comprehensive dated 02/07/2019 do (Resident # 73) is ab has clear speech, visuadequate without devassistance with ADLs status. He is ambulated walker [sic] with as each is bed when he is of and a quarter) handra	st recent MDS (minimum data essment with an ARD nce date) of 03/22/19, coded oring an 3 (three) on the brief status (BIMS) of a score of 0 g severely impaired of daily decisions. Resident # quiring supervision with setupally living. Section G0400 in In Range of Motion" coded o impairment" on both sides ties (shoulder, elbow, wrist, p.m., an observation of led he was sitting on the servation of the call bell on the floor underneath his he could locate his call bell on the privacy curtain toward the room. Further I Resident # 73 was unable bell under his bed. care plan for Resident # 73 cumented, "Focus. le to make his needs known, sion and hearing are vices. He does need a due to impaired cognitive tory and uses a wheeled at on it. He sits on a chair by at of bed. He has 2 ½ (two alls on each side of the bed es them to help transfer and	F 6	56		

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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ENVOY	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 0-	#11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPROPERTY)	DBE	(X5) COMPLETION DATE
	O2/07/2019." Under documented, "Encoto call for assistance on 04/16/19 at 2:55 conducted with LPN 4. When asked to care plan, LPN # 4 sof the resident and to living." When asked on the care plan to be and it is not followed plan was being implement. When asked a being observed on the care plan document be encouraged to us stated, "The care plan document be encouraged within reach." On 04/06/19 at approximation of further information. The care made within reach." On 04/06/19 at approximation of further information. The care made within reach. The care mad	r "Interventions" it burage the resident to use bell e. Date Initiated: 02/07/2019." is p.m., an interview was I (licensed practical nurse) # describe the purpose of the stated, "Monitor the progress to maintain a healthy level of diff something is documented be followed or implemented to could you say that the care emented, LPN # 4 stated, about Resident # 73's call belt he floor under his bed and the ing the Resident # 73 should se his call bell, LPN # 4 an is not being followed. He to use the call bell if it is not example of the above findings. In was provided prior to exit.	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495236	B. WNG_			04/17/2019
	ROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	•	
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F 657 SS=D	(3) A problem with the heartbeat. This inform the website: https://www.nlm.nih.gon.html. Care Plan Timing an CFR(s): 483.21(b)(2) \$483.21(b)(2) A combediate between the comprehensive at (ii) Prepared by an iniculdes but is not lin (A) The attending physical (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the interpretation of the practicable for the resident's care plan. (F) Other appropriate disciplines as determined in the vertical proposed in the practice of the resident's care plan. (F) Other appropriate disciplines as determined in the vertical proposed in the practical propo	ebsite: gov/ency/article/000158.htm. ne speed or rhythm of the rmation was obtained from gov/medlineplus/atrialfibrillati d Revision (i)-(iii) nensive Care Plans prehensive care plan must 7 days after completion of assessment. Aterdisciplinary team, that nited to ysician. e with responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident bresentative is determined a development of the e staff or professionals in ined by the resident's needs he resident. ised by the interdisciplinary ssment, including both the	F6	57 F 657 Care plan timing and revisi 1. The care plan for resident # 31 I updated to reflect the intervention resident education to use brakes o device. 2. Residents who have experienced within the past thirty days will be by the interdisciplinary team to en interventions are in place and app Care plans will be updated or revinceded. 3. The licensed nurse will be re eduthe DON or designee on updating plan timely and following interven outlined. Physician orders will be by the DON or designee daily, five weekly for eight weeks to ensure the plan is updated in a timely manner review observations will be compleweekly for eight weeks by the DO designee to ensure interventions a implemented as written in the plan	has been of on rollator a fall reviewed isure that ropriate, sed as cated by the care tions as reviewed times nat care c. Quality leted N or	5.28.19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			l na	/17/2019
ļ	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		715 DOGTOWN ROAD		71712010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	by: Based on staff intervirand facility document that the facility staff facomprehensive care puthe survey sample, Reference and the survey sample and the survey sample and the survey	ew, clinical record review, review, it was determined illed to review/revise a clan for on of 41 residents in esident # 31. to review/revise Residents care plan for following a mitted to the facility on ission of 03/16/19 with d but were not limited to ry failure, (3), chronic disease (4), and ecent MDS (minimum data sment with an ARD edate) of 02/13/19, coded ing a 15 on the brief atus (BIMS) of a score of 0 vely intact for making daily 31 was coded as being vities of daily living. ituation, Background, and Notify) Communication 1 dated 04/09/19; es observed; Appearance: d oriented) v/s (vital signs) its) 0 (zero) c/o (complaint otify: Primary Care	F	357	4. The results of the quality review da be reported to the quality assurance committee monthly for review, analys further recommendations.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS		<u> </u>	2	BTREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 _04	71772019
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	4/9/19 Time: 2pm (2 Family/Health Care Family Member). Da (3:00 p.m.)." The facility's "Fall R Report" for Residen documented, "Residen documented, "Residen documented, "Residen cocurrences" it docu transferring to and fir rollator break use." The comprehensive dated 03/11/2019 do documentation of Re and interventions rel On 04/16/19 at 12:43 conducted with RN (temporary traveling I Resident # 31's fall of comprehensive care 03/11/2019, RN # 6 a not updated with the stated, "It should be asked to describe the resident's care plan f stated, "It is review II meeting weekly and every morning. If the interventions are put documentation that th updated."	2:00 p.m.). Name of Agent Notified: (Name of ate: 4/9/19 Time: 1500pm coot Cause Investigative t # 31 dated 04/09/19 dent slipped trying to sit in er)." Under ation for minimizing future amented, "Education on rom rollator. Education on care plan for Resident # 31 becumented failed to evidence esident # 31's fall on 04/09/19 ated to the fall. 3 p.m., an interview was registered nurse) # 6 MDS, coordinator, regarding on 4/9/19. After reviewing the plan for Resident # 31 dated agreed that the care plan was new intervention. LPN # 6 on the care plan." When e procedure for updating a following a fall, RN # 6 DT (interdisciplinary team) during the morning meeting, are is any new fall, and new in place, there would be the care plan that it was	F	657			
	(administrative staff r	eximately 3:43 p.m., ASM nember) #1, the executive , director of clinical services,	,				Î

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED
		495236	B. WING			4/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 0	4/1//2019
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T I	were made aware of No further information. References: (2) A common sleep may have trouble far or both. As a result, have poor-quality slarefreshed when you was obtained from the https://www.nlm.nihml. (3) When not enoughlungs into your blood obtained from the whittps://www.nlm.nih.ilure.html. (4) Disease that make can lead to shortnes was obtained from the https://www.nlm.nih. (5) High blood press obtained from the weather the sure.html. (4) A chronic disease regulate the amount information was obtained from the weather.//www.nlm.nih.essure.html.	of the above findings. on was provided prior to exit. o disorder. If you have it, you alling asleep, staying asleep, you may get too little sleep or eep. You may not feel wake up. This information he website: .gov/medlineplus/insomnia.ht th oxygen passes from your d. This information was ebsite: gov/medlineplus/respiratoryfa kes it difficult to breath that is of breath. This information he website: gov/medlineplus/copd.html. ure. This information was	F6			
	Quality of Care CFR(s): 483.25		F 68	4		

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	ROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		71712010
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	§ 483.25 Quality of car Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe practice, the comprehe care plan, and the residents receive accordance with profe practice, the comprehe care plan, and the resident intervies and clinical record revifacility staff failed to enthe survey sample, receives in accordance standards of practice acare plan for Resident. The facility staff failed per the physician orde. The findings include: Resident #52 was adm 9/17/18 with diagnoses limited to lung cancer, pulmonary disease - genonreversible lung disecombination of emphyshigh blood pressure, and depression. The most recent MDS assessment, a quarterlassessment reference resident as scoring a ""	and the comprehensive sent, the facility must ensure treatment and care in assional standards of ensive person-centered idents' choices. is not met as evidenced ew, facility document review it was determined the asure one of 41 residents in ceived the care and ewith professional and the comprehensive #52. to administer medications are for Resident #52. antitled to the facility on a sthat included but were not COPD [chronic obstructive eneral term for chronic, ease that is usually a sema and chronic. (1)], nxiety, chronic pain and (minimum data set) by assessment, with an date of 3/13/19, coded the 1" on the BIMS (brief atus) score, indicating the	F 6	1.Resident # 52 is received ordered by physician. To completed the MAR for Ativan. 2.Residents with physician anxiety medications will DON or designee to ensibeing administered as professional standard of medication administrated medication administrated to medicated weekly for end DON or designee to ensiavailable and medication administrate conducted weekly for end DON or designee to ensiavailable and medication administrate completed as well as do medication administrated accordance with physical standard of the qualical committee team month and further recomments.	The licensed nurse radministration of administration of administration of the same and medication is per physician order. It will be re educated wing physician orders in accordance with of practice for the same medications are per medications are on administration is per medication or the tion record in cian order. The same medications are on administration is per medications are on administration is per medication or the tion record in cian order. The same medications will lity assurance ally for review, analysis of the same and	5-28-19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AT THE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063					
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F 684	cognitive decisions. having periods of di comes and goes. R having periods of ha The resident was consistance of one stactivities of daily living Medications, the resident are seven days of an are seven days of an are seven.	The resident was coded as sorganized thinking that esident #52 was coded as allucinations and delusions. Doded as requiring limited taff member for most of her	F 68	4				
	"Reduce am (morni treat anxiety (2)], to (continue) pm (even mg." The February MAR administration recor	ng) dose of Ativan [used to 0.5 mg (milligram), cont ling) dose of Ativan @ (at) 1						
	scheduled for 2/15/1 nurse's initials with a was nothing docume the MAR. The MAR mg dose to be admi nurse's initials circle 2/19/19, and 2/24/19 MAR documented o "Pending arrival from 5:00 p.m., the reverse documented, "Sleep notes on the reverse the circled doses of a	9 at 9:00 a.m. had the a circle around them. There ented on the reverse side of also documented the Ativan 1 nistered at 5:00 p.m. with the d on 2/14/19, 2/15/19, 0. The reverse side of the n 2/14/19 at 5:00 p.m. In pharmacy." On 2/14/19 at 5e side of the MAR ing." There were no other eside of the MAR regarding Ativan listed above.						
	documented in part, anti-anxiety medicati disorder." The "Interv "Administer ANT-AN	care plan dated, 3/26/19, "Focus: The resident uses ons r/t (related to) Anxiety ventions" documented in part, XIETY medications as . Monitor for side effects and						

F 684 Continued From page 115 effectiveness Q-SHIFT (every shift)." Review of the nurse's notes for the above dates and times, failed to evidence documentation of why the medication was not administered and or notification to the physician. An interview was conducted with RN (registered nurse) #1 on 4/15/19 at 4:07 p.m. When asked about the process staff follows if a physician ordered medication is not available for administration, RN #1 stated, "I first circle it (draw a circle around their initials) on the front and write on the back of the MAR what the reason for not giving it. If it's not available, I'd call the pharmacy. If they can't get it to me in a timely manner, I'd notify the doctor and see if they want to give something else in the meantime." When asked if the facility has an emergency medication box, RN #1 stated that there was a box in the medication room that contains antibiotics, diuretics and some narcotics." The box of emergency mediations stored in the medication room was observed on 4/15/19 at 4:16 p.m. accompanied by RN (registered nurse) #2. The label on the box documented, "Lorazepam 0.5 mg (Ativan)" was available in the emergency box. In "Fundamentals of Nursing" 8th edition, 2005;	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (CACIT DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 115 effectiveness Q-SHIFT (every shift)." Review of the nurse's notes for the above dates and times, falled to evidence documentation of why the medication was not administered and or notification to the physician. An interview was conducted with RN (registered nurse) #1 on 4/15/19 at 4:07 p.m. When asked about the process staff follows if a physician ordered medication is not available for administration, RN #1 stated, "I first circle it (draw a circle around their initials) on the front and write on the back of the MAR what the reason for not giving it. If it's not available, ['d call the pharmacy, if thoy can't get it to me in a timely manner, I'd notify the doctor and see if they want to give something else in the meantime." When asked if the facility has an erirergency modication box, RN #1 stated that there was a box in the medication room that contains antibiotics, diuretics and some narcotics." The box of emergency mediations stored in the medication room that contains antibiotics, diuretics and some narcotics." The box of emergency mediations stored in the medication room was observed on 4/15/19 at 4:16 p.m. accompanied by RN (registered nurse) #2. The label on the box documented, "Lorazepam 0.5 mg (Ativan)" was available in the emergency box. In "Fundamentals of Nursing" 5th edition, 2005;			495236	B. WING			04/17/2019	
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Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."		effectiveness Q-SH Review of the nurse and times, failed to why the medication notification to the ph An interview was conurse) #1 on 4/15/1 about the process sordered medication administration, RN is a circle around their on the back of the N giving it. If it's not avif they can't get it to notify the doctor and something else in the facility has an er #1 stated that there room that contains a narcotics." The box of emergen medication room wa 4:16 p.m. accompar #2. The label on the "Lorazepam 0.5 mg emergency box. In "Fundamentals of Patricia A. Potter and Inc; Page 419. "The directing medical tre obligated to follow phelieve the orders ar	IFT (every shift)." Is notes for the above dates evidence documentation of was not administered and or hysician. Inducted with RN (registered at 4:07 p.m. When asked taff follows if a physician is not available for the stated, "I first circle it (draw initials) on the front and write faR what the reason for not vailable, I'd call the pharmacy. The me in a timely manner, I'd is see if they want to give the meantime." When asked if the meantime. When asked if the meantime in the medication antibiotics, diuretics and some cy mediations stored in the sobserved on 4/15/19 at the sobserv	F 6	84			

AND PLAN OF CORRECTION (X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063	1 01	7172013
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F 684	executive director, clinical services and of clinical services of concern on 4/15/19	ASM #2, the interim director of d ASM #3, the regional director were made aware of the above	F 6	684			
F 686 SS=E	Non-Medical Reade Chapman, page 12- (2) This information following website: https://medlineplus. tml.	was obtained from the gov/druginfo/meds/a682053.h Prevent/Heal Pressure Ulcer	F6	86			
	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the inc demonstrates that th (ii) A resident with pr necessary treatment with professional sta promote healing, pre new ulcers from dev This REQUIREMEN by: Based on staff inter- and clinical record re the facility staff failed treatment and service	rehensive assessment of a must ensure thates care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition ney were unavoidable; and ressure ulcers receives and services, consistent undards of practice, to event infection and prevent					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						3) DATE SURVEY COMPLETED		
		495236	B. WING_			04	1/17/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
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	Resident #30's left he March 2018 through 2018. In addition, the stage of the pressure January 2019. 2. The facility staff fail received the necessar promote the healing of The findings include: 1. The facility staff fail measurements and as completed to assess a Resident #30's left he March 2018 through J 2018. In addition, the stage of the pressure January 2019. Resident #30 was adm 6/16/17. Resident #30 were not limited to par disease and obesity. MDS (minimum data swith an ARD (assessm 3/1/19, coded the residint act. Section G code requiring extensive as staff with bed mobility dependent on two or m Section M coded the resident materials.	led to ensure weekly sesessments were and monitor the healing of sel pressure injury from July 2018, and in October e staff failed to assess the injury from March 2018 until ed to ensure Resident #70 by treatment and services to a pressure injury. Bed to ensure weekly sesesments were and monitor the healing of all pressure injury from uly 2018, and in October staff failed to assess the injury from March 2018 until entitled to the facility on the diagnoses included but allysis, peripheral vascular Resident #30's most recent selt), an annual assessment ment reference date) of dent as being cognitively and Resident #30 as sistance of two or more and as being totally more staff with transfers.	F6	86	1. Resident # 30 was seen by wound consultant physician on 4/23/2019 documentation of left heel pressur as resolved. A weekly skin assessmicensed nurse on 5/7/2019 does not any new skin integrity concerns. R 70 is being provided treatment and to promote wound healing as prese the physician. 2. Residents identified as having prinjury treatment orders have been for weekly measurements, assessme staging documentation in the media record. Follow up to be conducted findings. 3. The licensed nursing staff in the f will be re educated by DON/ design documenting weekly pressure injur measurements, staging and assessm monitor the healing process. Weekly pressure ulcer assessments will be coby a licensed nurse and given to the The interdisciplinary team will meet to review residents with noted pressinjury to ensure all documentation treatments are appropriate. 4. The results of the quality monitor be reported to the quality assurance committee for review, analysis and i recommendations.	with re injury ent by a identify esident # services ribed by essure reviewed ents, and eal based on facility ee on y eents to y ompleted DON. t weekly sure and	5.28.19	
		iuries and as have one						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) D/	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIF 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	, CODE	4/17/2019
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F 686	stage three pressur comprehensive care documented, "The r integrityAbdomina Administer treatmer effectiveness. Week #30's most recent B pressure sore (injury	e injury (1). Resident #30's e plan dated 6/28/18 esident has impaired skin I surgical site. Left Heel ets as ordered and monitor for sky skin Checks" Resident raden scale for predicting // risk dated 3/6/19	F6	586		
	Review of Resident a nurse's note dated resident was readmi fluid filled blister on tapply skin prep to thobtained. Resident #30 was di Further review of Refailed to reveal an asinjury on the left heel note documented Rethe facility. The 5/22 necrotic tissue with a brown drainage to the documented the mean approximately 12 cm (width) by 0.1 cm Further review of Refailed to reveal anoth heel until 7/23/18. A documented the presence of a wound physician codocumented the area cm by 5.5 cm by 1.2 cm hurse's note dated pressure injury on the	described as as as as as as as as as as as as as				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ENVOY	AT THE MEADOWS			27	715 DOGTOWN ROAD		
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F 686	Continued From pay	ge 119	Fe	888			
	1	ays after the previous					
		13/18) documented the					
	pressure injury on th	ne left heel measured 5.5 cm					
······································		n. A wound care physician		.			
		documented the pressure					
		el measured 4.9 cm by 4.5 cm					
	by 0.2 cm.	d 9/5/18 documented the					
		ne left heel measured 4.5 cm			·		
		. A nurse's note dated					1
		the pressure injury on the					1
	left heel measured 4	1.2 cm by 3.8 cm by 0.2 cm.					!
		1 9/17/18 documented the					· 1
		ne left heel measured 4.5 cm		Ì			
		. A nurse's note dated					
		I the pressure injury on the					
		3.9 cm by 3.5 cm by 0.1 cm.					
		1 11/5/18 (42 days after the n 9/24/18) documented the					
		le left heel measured 1.7 cm		l			
		. A nurse's note dated				i	
		d the pressure injury on the			·		ľ
		.2 cm by 2.9 cm by 0.1 cm.					
	A nurse's note dated	11/19/18 documented the					
		e left heel measured 1.8 cm					
	by 2.5 cm by 0.1 cm.					ļ	
		11/26/18 documented the					
		e left heel measured 2.2 cm	•	Ì			
	by 2.2 cm by 0.1 cm.	12/3/18 documented the				}	
		e left heel measured 1.9 cm					
		A nurse's note dated					
		d the pressure injury on the					
	left heel measured 1.	.5 cm by 2.2 cm by 0.1 cm.					
	A nurse's note dated	12/21/18 documented the		Ì			
		e left heel measured 1.9 cm					
	by 2.8 cm by 0.1 cm.						[
		12/28/18 documented the					
i	pressure injury on the	e left heel measured 2.1 cm			•		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	pressure injury on t 2.8 cm by 0.1 cm. A nurse's note date pressure injury on tl by 2.8 cm by 0.1 cm 1/21/19 documented left heel measured A nurse's note dated pressure injury on the 2 cm by 0.1 cm. documented the premeasured 1.4 cm by note dated 2/25/19 of the 2/4/19 measured pressure injury on the 2/4/19 measured pressure injury on the 2.8 cm by 0.1 cm. None of the above a stage of the pressure beginning on 3/4/19 following assessmenthe left heel: 3/4/19- stage 3- 2.5 3/18/19- stage 3- 0.3 4/9/19- stage 3- 0.3 4/9/19- stage 2 (1) - 4/15/19- "no open ar protect."	d 1/7/19 documented the he left heel measured 2 cm by d 1/14/19 documented the he left heel measured 1.7 cm n. A nurse's note dated d the pressure injury on the 1.6 cm by 2.5 cm by 0.1 cm. d 1/28/19 documented the ne left heel measured 1.5 cm A nurse's note dated 2/4/19 essure injury on the left heel by 1.2 cm by 0.1 cm. A nurse's (approximately 21 days after ment) documented the ne left heel measured 1.8 cm of the left heel	F	686			
	multiple changes in t	reatment orders were made lod and that the treatments					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
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F 686	were administered On 4/16/19 at appre (administrative staf- director of nursing of measurements of F- measurements about by ASM #2. On 4/17/19 at 9:55- conducted with RN wound care nurse, June 2018). RN #5- facility every Monda stated she measure completes wound care.	as ordered. eximately 2:00 p.m., ASM f member) #2 the interim was asked for all desident #30's wounds. The ve were all that was provided a.m., an interview was (registered nurse) #5 (the employed at the facility since stated she works at the lay and Wednesday. RN #5 wounds on Mondays and are on Mondays and	F 6	586			
	document pressure weekly form but now the pressure record there was a lack of #30's left heel in the made aware assess the nurses' notes un assessments were culcer record. RN #5 what the facility staff	injury assessments on a vidocuments assessments on a vidocuments assessments on a N #5 was made aware assessments for Resident clinical record. RN #5 was ments were only observed in till 3/4/19 when the documented on the pressure stated she did not know fidid with the previous forms.					
	conducted with ASM member) #2 (the dir ASM #2 was asked pressure injury asse ASM #2 stated the athe skin integrity, a cit looks like and meathe assessment sho	(administrative staff ector of clinical services). to describe the information a ssment should consist of. ssessment should contain lescription of the wound, what surements. When asked if uld consist of the staging of ASM #2 stated, "Yes but by a					

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	director), ASM #2 a director of clinical significants the above concern. The facility docume & Wound" documer completed by licens non-pressure/pressidentified wounds as healed. Re-evaluation weekly wound report. This important that the be identified, whether developed after adminfluenced its developed after adminfluenced its development of addideterioration of the precognized, assessed discussion under Precognized, assessed adequacy of the planulcers. When assessing the "Determine the ulce This information was	a.m., ASM #1 (the executive nd ASM #3 (the regional ervices) were made aware of the titled, "Best Practices- Skin ated, "Weekly skin evaluations and nurses. Completion of ure/wound tracking forms on a indicated weekly until e wound/skin treatment within ate and every 2 weeks pairments documented on t" The each existing pressure ulcer are present on admission or nission, and that factors that appears, the potential for itional ulcers or for the pressure ulcer(s) be ad and addressed (see evention regarding overall erventions). Any new ests a need to reevaluate the infor preventing pressure ulcer itself, it is important to: r's stage;" sobtained from the website:	F 68	,		
	03/NPUAP-F-tag-fine The Pressure Ulcer Guide by NPUAP sta pressure ulcer asses accurately document	Treatment Quick Reference Ites on page 8 concerning				77-148

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 686	= = 111111111111111111111111111111111	-	F 68	6		
	wound edges, sinus tunneling, exudate, presence/absence of epithelialization." Pastates, "Re-evaluate of care, and the indicates not show programetes (or as expect overall condition and information was obtained to the condition of the condition	and periwound condition, tracts, undermining, necrotic tissue, odor, of granulation tissue, and age 10 of this reference of the pressure ulcer, the plan vidual if the pressure ulcer ress toward healing within 2 and given the individual's disability to heal)" This ained from: National Pressure II and European Pressure II. Pressure Ulcer Prevention cal Practice Guideline.				
	No further information	on was presented prior to exit.				
	and underlying soft ti prominence or relate device. The injury ca open ulcer and may as a result of intense or pressure in combi tolerance of soft tissu may also be affected	localized damage to the skin issue usually over a bony of to a medical or other n present as intact skin or an be painful. The injury occurs and/or prolonged pressure nation with shear. The ue for pressure and shear by microclimate, nutrition, ities and condition of the soft				
	erythema, which may pigmented skin. Pres erythema or changes	in Alized area of non-blanchable v appear differently in darkly		•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		į.	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 04	THEOLO
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686	changes do not includiscoloration; these pressure injury.	ude purple or maroon may indicate deep tissue	F 6	86		·
	loss with exposed departial-thickness los dermis. The wound moist, and may also ruptured serum-filled visible and deeper to Granulation tissue, so present. These injurtured adverse microclimate the pelvis and shear should not be used to associated skin damincontinence associatintertriginous dermated.	s of skin with exposed bed is viable, pink or red, present as an intact or d blister. Adipose (fat) is not ssues are not visible. Slough and eschar are not ies commonly result from e and shear in the skin over in the heel. This stage o describe moisture age (MASD) including ated dermatitis (IAD), citis (ITD), medical adhesive IARSI), or traumatic wounds				
	Full-thickness loss of is visible in the ulcer epibole (rolled wound Slough and/or escha of tissue damage varareas of significant a wounds. Undermining Fascia, muscle, tend and/or bone are not cobscures the extent of Unstageable Pressur was obtained from the https://www.npuap.or	ury: Full-thickness skin loss f skin, in which adipose (fat) and granulation tissue and d edges) are often present. It may be visible. The depthries by anatomical location; diposity can develop deeping and tunneling may occur. It is an exposed. If slough or eschar of tissue loss this is an elinjury. This information is website: 19/resources/educational-and ouap-pressure-injury-stages/				
	The facility staff fai	led to ensure wound care Resident #70 as ordered by			,	ļ

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	the physician on Ma 26th 2019. Resident #70 was a	arch 1st, 5th, 22nd, 23rd, and	F 68	86		
	limited to: spina bific	es included but were not da (1), pressure ulcer of the four (2) (4), muscle weakness left leg.				
	quarterly assessme reference date) of 4 having a score of 15 interview for mental was cognitively intact The resident was coassistance for most In Section M - Skin 6	OS (minimum data set), a nt, with an ARD (assessment /3/19 coded the resident as of 15 on the BIMS (brief status) indicating the resident of to make daily decisions. Oded as requiring limited of her activities of daily living. Conditions, the resident was a unstageable pressure injury ssure ulcers (3).				
	Risk" documented, 1	or Predicting Pressure Sore 18 indicating Resident #70 evelopment of a pressure				
	2019, documented, 'with Dakin's Solution alginate then cover and as needed." In a documented, "2/12/1	with foam dressing every day addition, the POS 9: Ischium Wounds- Cleanse 1, cover with foam dressing				
	documented, "The re to sacrum and left is	care plan dated 3/14/19, esident has a pressure injury chium, abd (abdominal) story of ulcers and lack of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			7172010			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	mobility; Intervention The TAR (treatment March 2019 documed Sacrum-cleanse with silver alginate every day and as master being administer 23rd, and 26th 2019 The TAR (treatment March 2019 documed Wounds- Cleanse with foam dressing Was not document March 1st, 5th, 22nd Review of the "Pressacrum revealed in - 3/4/19 "Sacrum. Secretimeter]) length Wound Edges: firm - 3/13/19 "Sacrum. Secretimeter] length 0.5, width 1.5 with granulation tiss no redness." - 3/25/19 "Sacrum. Secretimes."	t administration record) dated tented, "2/12/19: th Dakin's Solution (4) cover then cover with foam dressing seeded." was not documented red on: March 1st, 5th, 22nd, 9. It administration record) dated ented, "2/12/19: Ischium with Dakin's Solution, cover every day and as needed." ed as being administered on: d, 23rd, and 26th 2019. Sure Ulcer Record" for the part the following: tage 4. Measurements (cm 0.5, width 1.5, depth 1.3. und with granulation tissue. with no redness." Stage 4. Measurements (cm): , depth 1.5. Wound Bed: pink ue. Wound Edges: firm with Stage 4. Measurements (cm): , depth 1.5. Wound Bed: pink ue. Wound Edges: firm with Stage 4. Measurements (cm); , depth 1.5. Wound Bed: pink ue. Wound Edges: firm with Stage 4. Measurements (cm), depth 1.5. Wound Bed: pink ue. Wound Edges: firm with	F 6	886			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495236	B. WING		n⊿	1/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT! X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	(cm) length 3, width red with granulation with no redness." - 3/13/19, document Stage 4. Measurem 2.3, depth 3.2. Wou tissue. Wound Edge - 3/18/19, document Stage 4. Measurem 2.8, depth 3.2. Woultissue. Wound Edge - 3/25/19, document Stage 4. Measurem 2.8, depth 3.2. Woultissue. Wound Edge - 3/25/19, document Stage 4. Measurem 2.8, depth 3.2. Woultissue. Wound Edge The wound care num 2:00 p.m., document 0.5 (cm- centimeters granulating tissue, not (cm) x 2.8 (cm) x 3.2 odor. L back fold 0.5 pink wound bed. R (cm) x0.5 (cm) x 0.10 thigh wound bed yellow (cm) Santyl being us small amount yellow odor. Continue POC Observation was mark wounds, on 4/15/19, (registered nurse) #5 resident was observed The resident's foot with the wound to Resider the wound to Resider the stage of t	3, depth 3.2. Wound Bed: tissue. Wound Edges: firm ted in part, "Left Ischium. ents (cm) length 2.8, width and Bed: red with granulation is: firm with no redness." red in part, "Left Ischium. ents (cm) length 2.5, width and Bed: red with granulation is: firm with no redness." red in part, "Left Ischium. ents (cm) length 2.5, width and Bed: red with granulation is: firm with no redness." red in part, "Left Ischium. ents (cm) length 2.5, width and Bed: red with granulation is: firm with no redness." reses note dated 3/18/19 at red, "Wound care- Sacrum is x 1.5 (cm) x 1.5 (cm) codor. L (left) Ischium 2.5 (cm) granulating tissue no (cm) x 0.1 (cm), right back fold improved 0.2 (cm) pink wound bed. L post ow 4.5 (cm) x3 (cm) x 0.2 red. Abdomen 2.8x1.3x2.3 slough in base of wound, no (plan of care).	F6			
	wound bed was pink wound edges were ro	with granulation tissue. The olled. The wound to Resident	•			

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	1/17/2019	
ļ	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	E	7772019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 686	#70's left ischium w 2.5cm, length 2.7 cr bed was red with gr edges were rolled. I the wounds were. R stage four. She cam wounds, so far we h them but have gotte On 04/17/19 at appr interview was condu Resident #70 was a administered daily. The nurses change sometimes they mis On 4/17/19 at appro interview was condu staff member) #2, th Services, after review and comprehensive asked if the physicia was administered on 22nd, 23rd, and 26th nurse did not signed was done. Normally would initial the MAR could not do it then th date on the MAR and why the treatment co March 2019 nurse's r not document why we administered on the c 22nd, 23rd, and 26th	as measured as follows: width m, depth 2.4 cm. The wound anulation tissue. The wound RN #5 was asked what stages N #5 replied, "They are both he here with both of the lave not been able to heal n better." oximately 9:40 a.m., an loted with Resident #70. sked if her wound care is Resident #70 replied, "Mostly. my dressings most days but s days." ximately 9:47 a.m., an loted with ASM (administrative ele Director of Clinical wing Resident #70's MAR care plan. ASM #2 was nordered wound treatment of the days of March 1st, 5th, and ASM #2 replied, "If the loff the treatment I can't say it after doing wound care, you he nurse would circle that if enter a nurse's note stating uld not be administered."	F 6				
	& Wound" documented	ed, "Weekly skin evaluations d nurses. Completion of					

NAME OF PHROVIDER OR SUPPLIER EIWOY AT THE MEADOWS SUMMAPY SWITCHMENT OF DEPOIE VOICE (EXCH DEPOIE OR SUPPLIER) EBULATORY OR US DENTIFYING INFORMATION; F 686 Continued From page 129 non-pressure/pressure/wound tracking forms on identified wounds as Indicated weekly until healed. Ne-evaluate wound/skin treatment within two weekly wound report* To Af17/19 at approximately 4:30 p.m., ASM (administrative staff member) #2, the Director of Clinical Services and ASM #3, the Regional Director of Clinical Services were medo aware of the findings. No further information was provided prior to exit. 1. Spina bilida is a neural tube defect - a type of birth defect of the brain, spine, or spinal cord. It happens if the spinal cord. Screening tests during the sist month of pregnancy. This can damage the nerves and spinal cord. Screening tests during pregnancy can check for spina bifida. Sometimes it is discovered only after the baby is born. The symptoms of spina bifida. Sometimes it is discovered only after the baby is born. The symptoms of spina bifida are of normal intelligence. Some people need assistive devices such as braces, crutches, or wheelchairs. They may have learning difficulties, urinary and bowel problems, or hydrocephalus, a buildup of fluid in the brain. This information was obtained from the website: https://wsearch.nlm.nih.gov/wivsimo/ogi-bir/query-meta/7%5A/projoct-medifice/birs/projoct-me	STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
EINOY AT THE MEADOWS PROVIDER OR SUPPLIER			495236	B. WING	à		04/	/17/2010
PREFIX IAG CACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY ON ISC IDENTIFYING INFORMATION) PREFIX TAG CACS-REFERENCED TO THE APPROPRIATE COMMUNITORY	i				2715 DOGTOWN ROAD	ZIP CODE	04/	17/2019
non-pressure/pressure/wound tracking forms on identified wounds as indicated weekly until healed. Re-evaluate woundskin treatment within two weeks of start date and every 2 weeks threatiter. Skin impairments documented on weekly wound report" On 4/17/19 at approximately 4:30 p.m., ASM (administrative staff member) #2, the Director of Clinical Services and ASM #3, the Regional Director of Clinical Services were made aware of the findings. No further information was provided prior to exit. 1. Spina bifida is a neural tube defect - a type of birth defect of the brain, spine, or spinal cord. It happens if the spinal column of the fetus doesn't close completely during the first month of pregnancy. This can damage the nerves and spinal cord. Screening tests during pregnancy can check for spina bifida. Sometimes it is discovered only after the baby is born. The symptoms of spina bifida vary from person to person. Most people with spina bifida are of normal intelligence. Some people need assistive devices such as braces, crutches, or wheelchairs. They may have learning difficulties, urinary and bowel problems, or hydrocephalus, a buildup of fluid in the brain. This information was obtained from the website: https://wsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject-medlineplus&v%3Asourcos=medlineplus&vig0Asourcos=medl	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD E	BE IATE	COMPLETION
pressure sores. They can form when your skin		non-pressure/press identified wounds a healed. Re-evaluat two weeks of start of thereafter. Skin implemental wound report of the staff Clinical Services and Director of Clinica	sure/wound tracking forms on a indicated weekly until the wound/skin treatment within date and every 2 weeks pairments documented on rt" Eximately 4:30 p.m., ASM member) #2, the Director of d ASM #3, the Regional Gervices were made aware of the was provided prior to exit. Indicate and every 2 weeks pairments documented on rt" Eximately 4:30 p.m., ASM member) #2, the Director of d ASM #3, the Regional Gervices were made aware of the was provided prior to exit. Indicate a type of the review of the services were made aware of the first month of the fetus doesn't ring the first month of the damage the nerves and the review of the baby is born. The political sometimes it is the baby is born. The political vary from person to the with spina bifida are of the Some people need assistive the ces, crutches, or wheelchairs. The political prior was obtained to the province of the pro	F	586			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2019 FORM APPROVED

STATEMENT OF DEFICIENCES AND RAN OF CONFICTION AND RAN OF CONFICTION MAKE OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23683 GOOCHLAND, VA 23683 GOOCHLAND, VA 23683 F 686 Continued From page 130	CENTE	HS FOR MEDICARE	& MEDICAID SERVICES	· · · · · ·		C	MB NC	. 0938-0391
ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DEPICENCIES CACOCHLAND, WA 23083 PHERIX TAS SUMMARY STATEMENT OF DEPICENCIES CACH LOND, WA 23083 PROCEDURALLY, WA 23083 PROCE						LE CONSTRUCTION		
ENVOY AT THE MEADOWS SURPLAY STATES OF DEPTICE STORES STREET ADDRESS, CITY, STATE, ZP CODE 2721 DOGTOWN ROAD GOOCHLAND, VA 23083			495236	B. WING	i		04	/17/2019
Description Description	NAMEOF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
DATE OF THE PROPERTY	ENVOY	AT THE MEADOWS	•		2	2715 DOGTOWN ROAD		
FRETIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 686 Continued From page 130 and soft tissue press against a hardor surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area, Lack of blood supply can cause the skin tissue in this area to become damaged or dio. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00147.htm 3. NPUAP staging - The NPUAP staging system is described below (table 1 and figure 2) [5]. The NPUAP stage is used to describe the initial appearance of an area of skin damage. The practice of changing the stage as healing occurs, known as reverse stagling, is not recommended [8]. Stage 4 (pressure injury) is characterized by full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible (picture 1). Epibolo (rolld edges), undermining, and/or tunneling often occur. Depth varies by anatomical location, if slough or eschar obscures the extent of tissue loss, this is an unstageable pressure injury. Unstageable pressure injury is characterized by full-thickness skin and tissue lose in which the oxtent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar is removed, a stage 3 or stage 4 pressure injury is characterized. See 'Debridement' below.) This information was obtained from the website: https://www.uptodate.com/contents/clinical-stagin g-and-management-of-pressure-sicure/second-confirmed-because in its obscured-skin-an d-soft-itssue-injury/Search-pressure-induced-skin-an d-soft-itssue-injury/Search-pressure-induced-skin-an d-soft-itssue-injury/Search-pressure-induced-skin-an d-soft-itssue-injury/search-pressure-induced-skin-an d-soft-itssue-injury/search-pressure-induced-skin-an d-soft-itssue-injury/search-pressure-induced-skin-an d-soft-itssue-injury/search-pressure-induced-skin-an d-soft-itssue-injury search-pressure-induced-skin-an d					(GOOCHLAND, VA 23063		
and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00147.htm 3. NPUAP staging - The NPUAP staging system is described below (table 1 and figure 2) [5]. The NPUAP stage is used to describe the initial appearance of an area of skin damage. The practice of changing the stage as healing occurs, known as reverse staging, is not recommended [8].Stage 4 (pressure injury) is characterized by full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcor. Slough and/or eschar may be visible (picture 1). Epibole (rolled edges), undermining, and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an unstageable pressure injury. Unstagoable pressure injury is characterized by full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. (Soe 'Debridement' below.) This information was obtained from the website: https://www.uptodate.com/contents/clinical-stagin g-and-management-of-pressure-induced-skin-an d-soft-tissue-injury?search=pressure/s20ulcer%2 Ostaging&source=soarch_pressure/s20ulcer%2 Ostaging&source=soarch_pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-skin-an d-soft-tissue-injury-gearch=pressure-induced-s	PRÉFIX	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
		and soft tissue pressuch as a chair or become dare to become dare information was obten https://medlineplus.coo147.htm 3. NPUAP stagingis described below (NPUAP stage is use appearance of an are practice of changing known as reverse stages, or bone in eschar may be visible edges), undermining occur. Depth varies slough or eschar obsoloss, this is an unstaunstageable pressurfull-thickness skin are extent of tissue dambe confirmed because eschar. If slough or eschar ibelow obtained from the weather the stage of the weather the stage of the weather the stage of the weather the stage of the weather the stage of the weather the stage of the weather the stage of the weather the stage of the weather the weather the stage of the weather the stage of the weather the stage of the weather the weather the weather the weather the stage of the weather the wea	s against a harder surface, red, for a prolonged time. This lood supply to that area. Lack cause the skin tissue in this naged or die. This ained from the website: gov/ency/patientinstructions/0 The NPUAP staging system table 1 and figure 2) [5]. The red to describe the initial rea of skin damage. The red the stage as healing occurs, aging, is not recommended re injury) is characterized by red tissue loss with exposed or cia, muscle, tendon, ligament, the ulcer. Slough and/or te (picture 1). Epibole (rolled panatomical location. If secures the extent of tissue geable pressure injury. The injury is characterized by red tissue loss in which the age within the ulcer cannot reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed, a stage 3 njury will be revealed. (See a) This information was reschar is removed.	F	886			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	1/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS	·	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689	4. Dakin's solution (is widely used in a vand has been advocmanagement of bur broad-spectrum ant in the clinical setting Vancomycin-resista other antibiotic-resis information was obt https://www.uptodat-and-dressings-for-ledakins%20solution=default&anchor=Hrearning&selectedTit 0128208 Free of Accident Ha	0.025% sodium hypochlorite) variety of difficult wound types cated by some for the n wounds. It has imicrobial activity with efficacy of MRSA, nt Enterococcus (VRE), and stant bacteria. This ained from the website: e.com/contents/topical-agents ocal-burn-wound-care?search §ionRank=1&usage_type 10128208&source=machinel. le=2~33&display_rank=1#H1 zards/Supervision/Devices	F 68				
	as free of accident h §483.25(d)(2)Each r supervision and assi accidents. This REQUIREMEN by: Based on observation document review, it was taff failed to implement of 41 residents in the 13. The facility staff failed in the low position who	s.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING_			04	/17/2019
ENVOY A		ATEMENT OF DEFICIENCIES	ID	2715 DG	TADDRESS, CITY, STATE, ZIP CODE OGTOWN ROAD CHLAND, VA 23063 PROVIDER'S PLAN OF CORRECTION		(×5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 689	Continued From page The findings include:	e 132	F 68	39 6	89 Free of Accident and Hazards		5.28.19
	10/08/18 with a recent with diagnoses that in to: high blood pressure. The most recent MDS assessment, a quarter assessment reference resident as scoring a interview for mental stresident was severely cognitive decisions. Requiring extensive as dependent upon one all of her activities of coed as requiring extensive as dependent upon one all of her activities of coed as requiring extensive as dependent upon one all of her activities of coed as requiring extensive staff members for the bed. Observation was made 4/14/19 at 1:09 p.m. dependents. Resident #7 She was asleep. The this surveyor, approximate the waist level of this 39 inches. The comprehensive condocumented in part, "For the comprehensive condocumented in part,"	rly assessment, with an e date of 2/8/19, coded the "5" on the BIMS (brief tatus) score, indicating the impaired to make daily tesident #13 was coded as esistance to being totally or more staff members for daily living. The resident was ensive assistance of two or or transfers and moving in uring the initial screening of 13 was observed in her bed.		tl aa 22 id re ce b 3 in oo T te te in fe ce in	The bed for resident # 13 is maintaine lowest position when nursing state to be a sindicated on care plan. Fall risk evaluation tool will be used the sidents with high risk injuelated to fall. The residents identificing risk care plans will be reviewed need to fall. The residents identificing risk care plans will be reviewed need interventions. Follow up to a sed on findings. Nursing staff will be re educated emplementing fall interventions as identificated interventions as identificated interdisciplinary team will meet to discuss residents with falls to ensure the team wonduct rounds five times weekly entervention for resident are in place or eight weeks. The results of quality review data eported to the quality assurance coeam monthly for review, analysis a urther recommendations.	ed to cry ed as by the sident be on lentified signee. tweekly re s of the fill sure fall e, weekly will be mmittee	
	transfers, deconditioni incontinence, poor	ng, gait/balance problems, ehension, impaired hearing					

STATEM AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		04	1/17/2019	
	OF PROVIDER OR SUPPLIER Y AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	717/2019	
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	DBE	(X5) COMPLETION DATE	
F 68	acuity." The "Interve" "Bed in low position An interview was conursing assistant) # When asked how the devices or instruction CNA #2 stated, "You nurse's tell you." When asked their bed approximately waist room providing care Ma'am." When asked the resident's bed is should that be done, have to make sure if we leave a resident we leave a resident in the resident is a fall rist documented on the conterventions be in plead and the conterventions be in plead with RN #2. The facility policy, "C Management" documented to be at recentered intervention implemented to miniminjury." Administrative staff mexecutive director, Asclinical services and Ascentered and services and Ascentered interventions are contered interventions in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the contervention in the content in the c	entions" documented in part, " Inducted with CNA (certified 2, on 4/15/19 at 2:51 p.m. ee CNAs find which safety ins are required for a resident, it look in the care plan or the nen asked if a resident is a fall dibe elevated to high when no one is in the care plan documents, to be in the low position, Inducted with RN (registered if it is in the low position when in bed." Inducted with RN (registered if it is and has interventions beare plan, should those ace, RN #2 stated, ove observation was shared in part, "3. Residents isk for falls will have patient is developed and mize the risk of falling and/or nember (ASM) #1, the SM #2, the interim director of ASM #3, the regional director are made aware of the above	F 68	39			
	<u></u>						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		495236	B. WING _		04	/17/2019
	ROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689 F 695 SS=E	Continued From page No further information Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and The facility must ensu needs respiratory care care and tracheal such care, consistent with p practice, the comprehe care plan, the resident and 483.65 of this sub This REQUIREMENT by: Based on observation interview, facility docur record review, it was d staff failed to provide r services consistent wite practice, and the comp care plan for six of 41 sample, Residents #60 #53.	was provided prior to exit. fromy Care and Suctioning y care, including d tracheal suctioning. re that a resident who e, including tracheostomy ioning, is provided such rofessional standards of ensive person-centered s' goals and preferences, part. is not met as evidenced , resident interview, staff ment review and clinical etermined that the facility espiratory care and h professional standards of prehensive person-centered residents in the survey 0, #41, #69, #27, #20 and	F 6	DEFICIENCY)	nurse ve uire the the room receive quipment is or oxygen ministered roperly te bedside.	5.28.19
	order for Resident #60 spirometer. 1.b. The facility staff faincentive spirometer manitary manner. 2. The facility staff faile #41's oxygen according	iled to store Resident #60's outhpiece in a clean and d to administer Resident g to the physician's orders. d to ensure that Resident		Resident # 53 oxygen nasal cannot not in use is stored in sanitary materials. Residents in the facility with products for oxygen administration oxygen device: rooms have been sanitary storage of equipment where as of by the licensed nursing Resident's room rounds have been conducted by licensed nursing storage found to be in use without orders as of 5/6/2019.	nner. hysician and assessed for nen not in staff. n	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495236	B. WING_			04/	/17/2019
İ	ROVIDER OR SUPPLIER T THE MEADOWS			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
1	#27's, oxygen tubing orders. 5. The facility staff fail CPAP (1) (continuous mask in a sanitary mamask was observed upobservations. 6. The facility staff fail nasal cannula oxygen manner. The nasal cathat is placed in the refrom the oxygen system the resident's bed. The findings include: 1.a. The facility staff fail order for Resident #60 spirometer (1). Resident #60 was adm 2/22/19. Resident #60 were not limited to chrolisease (2), heart failude #60's most recent MD day Medicare assessment reference the resident as being a coded the resident as assistance of one staff dressing, toilet use and Review of the physicial	boxygen. illed to change Resident according to the physician's led to store Resident #70's positive airway pressure) anner. Resident #70's CPAP incovered during multiple led to store Resident #53's device in a sanitary nnula, a two-pronged tube lose for delivering oxygen em, was left uncovered on led to obtain a physician's led to obtain a physician's led to obtain a physician's led to obstructive pulmonary are and pain. Resident S (minimum data set), a 30 ment with an ARD led date) of 3/22/19, coded cognitively intact. Section G requiring extensive f with bed mobility, d personal hygiene.	F	695	3. Licensed nurses will be re educated to DON/designee on providing respirator care and services consistent with professional standard of practice to incadministering treatment with physician order as well as in a sanitary manner to prevent infection. Quality monitoring be completed by the DON or designee to ensure that oxygen administration and devices are handled and stored in a san manner in accordance with the physicial order. This will be completed weekly feeight weeks. 4. The results of the quality monitoring be reported to the quality assurance committee team monthly for review, an and further recommendations.	lude es will o itary in or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	495236	B. WING		04	1/17/2019	
NAME OF PROVIDER OR SUI	ws		STREET ADDRESS, CITY, STATE, ZI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	P CODE	# 1772019	
PREFIX (EACH DEF	IRY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
spirometer. Find plan dated 3/has potential status/difficult to document sincentive spiro. On 4/14/19 at and 4/15/19 at observed lying was sitting on 4/15/19 at 8:5 with Resident spirometer. Fit to use the inceit when he fee. On 4/15/19 at conducted with asked how nuresident has a stated the nurs and procedure have a physicincentive spiro asked why, Rhould be a nursalways calls the knows how often be used. On 4/16/19 at 8 staff member) ASM #2 (interir were made aways the conducted with a staff member) ASM #2 (interir were made aways calls the staff member) ASM #2 (interir were member) ASM #2 (interir were member)	al an order for an incentive Resident #60's comprehensive care 13/19 documented, "The resident for altered respiratory y breathing" The care plan failed specific information regarding an		95			

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING			l na	/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD GOOCHLAND, VA 23063	104	717/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 695	Continued From page 137		 F6	95				
		on was presented prior to exit.						
	help you keep your when you have a lui pneumonia. Using teaches you how to Deep breathing kee and healthy while yo problems, like pneumonial how to use an Incer Many people feel we and taking big breath device called an incertive spirometer instructed by your nuan active role in your lungs healthy." This from the website:	lungs healthy after surgery or ng illness, such as the incentive spirometer take slow deep breaths. ps your lungs well-inflated nu heal and helps prevent lung monia.						
	disease) makes it hat two main types are cemphysema. The malong-term exposure to damage the lungs. To smoke. Air pollution, also cause it." This if from the website: https://vsearch.nlm.nmeta?v%3Aproject=redlineplus-bundle&	obstructive pulmonary rd for you to breathe. The hronic bronchitis and ain cause of COPD is o substances that irritate and his is usually cigarette chemical fumes, or dust can information was obtained ih.gov/vivisimo/cgi-bin/query-nedlineplus&v%3Asources=query=copd&_ga=2.106270589628-1667741437.15501						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS	·		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 695	1.b. The facility staf	f failed to store Resident #60's r (1) mouthpiece in a clean	F6	95		
	2/22/19. Resident # were not limited to disease (2), heart for #60's most recent N day Medicare asses (assessment refere the resident as being coded the resident assistance of one states of the physical Review of the physical Resident #60, signer failed to reveal an orange spirometer. Resident plan dated 3/13/19 of has potential for alternative spirometer. On 4/14/19 at 2:43 pand 4/15/19 at 8:59 and 4/15/19 at 8:59 observed lying in bespirometer was observed lying in bespirometer.	nce date) of 3/22/19, coded g cognitively intact. Section G as requiring extensive raff with bed mobility, and personal hygiene. Dian's order sheet for d by the physician on 4/15/19 order for an incentive of #60's comprehensive care documented, "The resident red respiratory thing" The care plan failed to information regarding an a.m., Resident #60 was d. An uncovered incentive erved on a table in the erved				

	IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)			(3) DATE SURVEY COMPLETED			
		495236	B. WING			O/	l/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			2	TREET ADDRESS, CITY, STATE, ZIP CODE 1715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 695	was asked how an stored. RN #1 stat should be stored at bag with the date a When asked why, I and to keep dust of get used by anothe keep dates on ever On 4/16/19 at 8:51 staff member) #1 (t ASM #2 (interim dir made aware of the	I (registered nurse) #1. RN #1 incentive spirometer should be sed an incentive spirometer the bedside in a respiratory and the resident's name on it. RN #1 stated, "Contamination of it and make sure it doesn't er resident and we have to rything." a.m., ASM (administrative the executive director) and rector of clinical services) were above concern.	F 6	95			
	incentive spirometer. No further information (1) "An incentive sphelp you keep your when you have a lupneumonia. Using teaches you how to Deep breathing keep and healthy while you problems, like pneu How to use an Incel Many people feel would and taking big breat device called an incentive spirometer instructed by your nean active role in you	on was presented prior to exit. irometer is a device used to lungs healthy after surgery or ng illness, such as the incentive spirometer take slow deep breaths. ps your lungs well-inflated ou heal and helps prevent lung monia.					

	OF CORRECTION	IDENTIFICATION NUMBER:	1		ONSTRUCTIO				TE SURVEY MPLETED
		495236	B. WING					U4	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		J	2715	ET ADDRESS, DOGTOWN I CHLAND, \		P CODE	1 04,	71772019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CC	DER'S PLAN OF O PRECTIVE ACTI FERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 695		ge 140 gov/ency/patientinstructions/0	F 6	895					
	disease) makes it h two main types are emphysema. The m long-term exposure damage the lungs. I smoke. Air pollution also cause it." This from the website: https://vsearch.nlm.i meta?v%3Aproject= medlineplus-bundled	obstructive pulmonary and for you to breathe. The chronic bronchitis and lain cause of COPD is to substances that irritate and This is usually cigarette, chemical fumes, or dust can information was obtained with gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources=&query=copd&_ga=2.1062705589628-1667741437.15501							
	#41's oxygen accord Resident #41 was ac 12/8/17 with the diag stroke, respiratory fa gastrostomy status (dementia. The most Set), a quarterly revic (Assessment Refere documented that Re- cognitive impairment On 4/14/19 at 2:00 p and 12:15 p.m., Resi	diled to administer Resident ling to the physician's orders. Idmitted to the facility on phoses of but not limited to illure, high blood pressure, 1), respiratory failure, and recent MDS (Minimum Data ew assessment with an ARD note Date) of 2/28/19, sident #41 had moderate for daily decision-making.							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		495236	B. WING	ì	0	4/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, Z 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		#11/20[9
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	2 ½ liters per minut A review of the clini (medication adminis April 2019, which do Oxygen 3L/Min (3 li cannula" Further review of the physician's order, de documented in part via nasal cannula Further review of the comprehensive care documented in part, respiratory status/di chronic respiratory f comprehensive care "Interventions" "Pro doctor) orders." On 4/16/19 at 12:24 conducted with LPN #2. When LPN #2 v for administering oxy flowrate, LPN #2 stat Take the oxygen to t correct level. "When nurse would determit correct level, LPN #2 on the concentrator of black ball on the line but at the center." W process for care plar oxygen, LPN #2 state (physician's orders) a would be placed on t	e, during each observation. cal record revealed a MAR stration record) that was dated ocumented in part, "12/29/18: ters per minute) via nasal e clinical record revealed a ated April 2019, that , "12/29/18: Oxygen 3L/Min e clinical record revealed a plan dated 2/21/19, that "The resident has altered fficulty breathing related to ailure with hypoxia (5)." The plan documented in part, vide oxygen per MD (medical p.m., an interview was (Licensed Practical Nurse) was asked about the process yen at the prescribed ted, "You look at the order. The room and set it at the n LPN #2 was asked, how the ne if the flowrate is set at the extated, "I look at the cylinder at eye level. I would put the not above or below the line l/hen LPN #2 was asked the nning and implementing ed, "The nurse checks it and creates the care plan. It	F6	395		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL(E CONSTRUCTION	(X3) DAT	re survey MPLETED
		495236	B. WING	·		(X3) DAT CON O4,	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 04	1172019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	order." A review of the facil with a revision date in part, "Oxygen the a FiO2 (Fraction of 21% by means of vProcedurePhys therapy shall include modalityliter flow. Review physician's the prescribed liter fadministrative device. A review of the "Inva Concentrator User N"1. Turn the flowrate prescribed by your partner flowmeter B, loc line on the flowmeter until the ball C rises ball on the I/min (lite.) According to Fundar edition, Potter and P"Oxygen should be to dangerous side effect oxygen toxicity (Thordrug, the dosage or should be continuous should routinely check verify that the client if oxygen concentration medication administration."	ity's policy "Oxygen Therapy" of 8/28/17, that documented erapy is the administration of Inspired Oxygen) greater than arious administration devices sician's order for oxygen e: Administrationcontinuous or PRN orderStart O2 flowrate at flow or appropriate flow for e." acare Perfecto2 Oxygen Manual" documented in part, knob A to the setting physicianTo properly read ate the prescribed flowrate r. Next turn the flow knob to the line. Now, center the r per minute) line prescribed." mentals of Nursing, 6th ferry, 2005, page 1122, reated as a drug. It has ets, such as atelectasis or mson, 2002). As with any concentration of oxygen sly monitored. The nurse ek the physician's orders to s receiving the prescribed in. The six rights of ration also pertain to oxygen	F	695			
	Member) #1 (Execut	M, ASM (Administrative Staff ive Director), AMS #3 Clinical Services), and ASM					

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ') MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063		717/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICS)	D BE	(X5) COMPLETION DATE
	#2 (Interim Director made aware of the information was prosurvey. (1) Gastrostomy state ICD-10-CM code the diagnosis for reimber information was returned information was returned information was returned information was returned in a surgically stomach through the Medical Guide: Dict the Non Medical Remains of the Non Medical Remains of the outside. It treats digestive systems. If from the website: https://medlineplus.cg/ (4) PEG: Percutaned (PEG) is the preferron utritional support in gastrointestinal system utrition. This inform website: https://www.ncbi.nlm	of Clinical Services) were findings. No further wided by the end of the stus: is a billable/specific at can be used to indicate a ursement purposes. This rieved from the website: ata.com/ICD10CM/Codes/Z00/Z93.1 stomy tube (G-tube) is a tube y created opening into the e abdominal wall per Barron's ionary of Medical Terms for ader, Mikel A. Rothenberg, Chapman, page 243. Imp is surgery to create an man area inside the body to certain diseases of the This information was retrieved	F	395			
	tissues of the body. obtained from the we	ncy of oxygen reaching the This information was ebsite: -webster.com/dictionary/hyp					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				TE SURVEY MPLETED
		495236	B. WING			04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			2	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD GOOCHLAND, VA 23063		1172013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFIGIENCY)	BE	(X5) COMPLETION DATE
	oxia. 3. The facility staff factor of the BIMS (Brief in score, indicating the cognitive impairment on 4/14/19 at 1:15 probserved in his room oxygen by nasal can concentrator. Observed at a flow rate oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator oxygen concentrator delivered at a flow rate oxygen concentrator delivered at a flow	ailed to ensure that Resident ved receiving oxygen therapy der for oxygen. dmitted to the facility on gnoses of but not limited to ix uropathy (2), benign a (BPH) (3) with lower urinary ite kidney failure, and the most recent MDS, a five day Medicare ARD (Assessment reference of the resident as scoring a 9 nterview for mental status). Resident has moderate the for daily decision making. I.m., Resident #69 was a lying in bed receiving nula connected to an oxygen vation of the oxygen doxygen was being the of 2 liters per minute. I.m., and at 12:15 p.m., beserved in his room lying in a by nasal cannula connected trator. Observation of the revealed oxygen was being the of 1½ liters per minute.	F6	95	DEPIGIENCY		
	2/28/19, which docur at 3 liters per minute	al record revealed a e order that was dated nented in part, "O2 (oxygen) PRN (as needed) to keep on in the blood) above 92%."				·	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		495236	B. WING			4/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	7/11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	On 4/16/19 at 12:24 physician's order for therapy was request nurse) #3. On 4/16/19 at 12:45 stated, "Resident #6 oxygen." When revent physician orders with order for oxygen with order due to he (Representation of the POS (physician's or April 2019, which rean oxygen order. A review of the clinical (medication administed April 2019, that doct sats q (every) shift. Solvent every of the comprehensive care that documentation of the comprehensive care that documented in part of the comprehensive care that documented in part of the comprehensive care that documented in part of the comprehensive care that documented in part of the comprehensive care that documented in part of the comprehensive care that documented in part of the comprehensive care cannula) as ordered. On 4/16/19 at 12:24	i p.m., a copy of the r Resident #69's oxygen ted from RN (registered from RN (registe	F6	95		

A. BUILDING	DATE SURVEY COMPLETED	
495236 B. WING 04	17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 695 Continued From page 146 #2. When LPN #2 was asked about the process for obtaining physician orders when a resident is transferred to the hospital and returns to the facility, LPN #2 stated, "The orders are discontinued when a resident is sent to the hospital or emergency room. The resident will be admitted with a new set of orders. The physician orders (for Resident #69) for oxygen that was written on 2/28/19 are not valid. The physician orders that was signed by the physician on 3/29/19, do not have an order for oxygen. The oxygen was asked what standards of practice the facility follows, LPN #2 was asked what standards of practice the facility follows, LPN #2 stated, "The policy and procedures and Potter and Perry." A review of the facility's policy "Oxygen Therapy" with a revision date of 8/28/17, that documented in part, "ProcedurePhysician's order for oxygen therapy shall include: Administration modalityliter flowcontinuous or PRNPRN orders must include specific guidelines as to when the resident is to use oxygenReview physician's order" According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be centinuously monitored. The nurse should be continuously monitored. The nurse should be continuously monitored. The nurse should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDED SUPPLIED OF THE PROVIDED OF THE PROVIDED OF THE PROVIDED OF THE PROVIDED OF THE PROVIDED OF THE PROVIDED OF THE PROVIDED OF T

NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INF F 695 Continued From page 147 On 4/16/19 at 3:15 PM, ASM (Admin Member) #1 (Executive Director), A (Regional Director of Clinical Service #2 (Interim Director of Clinical Service made aware of the findings. No furth information was provided by the encountry. (1) Obstructive and reflux uropathy: uropathy is structural or functional hormal urine flow, sometimes leading.	2 36 B.	s. WING			
ENVOY AT THE MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INF F 695 Continued From page 147 On 4/16/19 at 3:15 PM, ASM (Admin Member) #1 (Executive Director), A (Regional Director of Clinical Service #2 (Interim Director of Clinical Service made aware of the findings. No furthinformation was provided by the encountry. (1) Obstructive and reflux uropathy: uropathy is structural or functional heads.				0/1/17	7/2019
FRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INF F 695 Continued From page 147 On 4/16/19 at 3:15 PM, ASM (Admin Member) #1 (Executive Director), A (Regional Director of Clinical Service #2 (Interim Director of Clinical Service made aware of the findings. No furtinformation was provided by the encountry. (1) Obstructive and reflux uropathy: uropathy is structural or functional here.			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	<u> </u>	72019
On 4/16/19 at 3:15 PM, ASM (Admi Member) #1 (Executive Director), A (Regional Director of Clinical Servic #2 (Interim Director of Clinical Servic made aware of the findings. No fundinformation was provided by the encountry. (1) Obstructive and reflux uropathy: uropathy is structural or functional h	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETION DATE
dysfunction (obstructive nephropath information was obtained from the was https://www.merckmanuals.com/protourinary-disorders/obstructive-uropaty ve-uropathy (2) Benign prostatic hyperplasia: is a men in which the prostate gland is enot cancerous. This information was from the website: https://www.niddk.nih.gov/health-infogic-diseases/prostate-problems/proment-benign-prostatic-hyperplasia (3) Hypoxia: Deficiency of oxygen retissues of the body. This information obtained from the website: https://www.merriam-webster.com/di	MS #3 es), and ASM ces) were ther d of the Cobstructive indrance of ig to renal y). The vebsite: fessional/geni athy/obstructi a condition in inlarged and s obtained ormation/urol ostate-enlarge aching the i was	F 699			
oxia. 4. The facility staff failed to change I #27's, oxygen tubing according to the orders. Resident # 27 was admitted to the fa 08/24/14 and a readmitted on 10/19/	e physician's				

	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DA	TE SURVEY
		495236	B. WING				
NAMEO	PROVIDER OR SUPPLIER	100200	D. WING		TREET ADDRESS OFF STATE TO SORE	04	1/17/2019
	AT THE MEADOWS			27	TREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD OOCHLAND, VA 23063	SODE:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	diagnoses that inclu	ided but were not limited to:), history of traumatic brain	F6	95			
	(minimum dada set) an ARD (assessmer coded the resident at that Resident # 27 where the section Co600 the "Status" being comple "Cognitive Skills for Resident # 27 a 2 (to impaired-decisions prequired." Resident dependent of one statistically living. Section	poor, cues/supervision # 27 was coded as being aff member for all activities of O "Special Treatments, grams" coded Resident # 27					
	Resident # 27's oxygoxygen concentrator through Resident # 2 label on the oxygen to On 04/15/19 at 4:22. Resident # 27's oxygoxygen concentrator through Resident # 2 label on the oxygen to The POS (physician's 2019" for Resident #	a.m., an observation of the tubing connected the and delivering oxygen 1.7's tracheostomy revealed a ubing dated 04/08/19. a.m., an observation of en tubing connected the and delivering oxygen 7's tracheostomy revealed a ubing dated 04/08/19. s order sheet) dated "April 27 documented, "10/20/18 g; humidifying tubing; and					
;	jetneb tubing every w	eek on Sunday 7P-7A shift." ately 4:34 p. m., an interview					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/	17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			27	FREET ADDRESS, CITY, STATE, ZIP CODE 715 DOGTOWN ROAD OOCHLAND, VA 23063		***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	and observation of was conducted with member) # 2, interin After observing Reswith the label dated "The tubing should asked why it was intubing according to 2 stated, "It is changed on 04/06/19 at appropriate to the conduction of the conduction o	Resident # 27's oxygen tubing ASM (administrative staff in director of clinical services. ident # 27's oxygen tubing 04/08/19, ASM # 2 stated, have been changed." When aportant to change the oxygen the physician's orders, ASM # ged to keep it clean." Toximately 3:43 p.m., ASM member) #1, the executive 2, interim director of clinical 2 aware of the above findings. On was provided prior to exit. Dreathing, and it may occur ons When a patient goes st, they are not getting oxygen and may suffer brain damage nin minutes if not promptly ation was obtained from the presources/base/respiratory respiratory-arrest. bump, blow, jolt, or other lamage to the brain. may not appear until days or injury. A concussion is the ause a headache or neck in the ears, dizziness, and the a moderate or severe TBI	F6	95				

	I MIEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			495236	B. WING			04	04/17/2019	
ł		PROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	1	71772013	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	F 695	speech, Weakness legs, Dilated eye pu obtained from the w	or numbness in the arms and pils. This information was	F 6	95				
		body. It happens wh with the way message and muscles. Parally partial. It can occur obody. It can also occur be widespread. Parabody, including both Paralysis of the arm: This information was https://medlineplus.g5. The facility staff fac CPAP (1) (continuous mask in a sanitary mediane parally mediane).	cle function in part of your en something goes wrong ges pass between your brain risis can be complete or on one or both sides of your cur in just one area, or it can alysis of the lower half of your legs, is called paraplegia. It is and legs is quadriplegia. It is obtained from the website: gov/paralysis.html. It is positive airway pressure) in anner. Resident #70's CPAP uncovered during multiple						
		8/14/2018. Diagnose limited to: spina bifid	dmitted to the facility on es included but were not a (2), pressure ulcer of the I (3), muscle weakness and eg.						
	·	quarterly assessmen reference date) of 4/3 having a score of 15 interview for mental s was cognitively intact	S (minimum data set), a at, with an ARD (assessment 3/19 coded the resident as of 15 on the BIMS (brief status) indicating the resident to make daily decisions. eatment, coded Resident gen therapy.						
		The physician order odecumented "CPAP a	dated April 2019, at 14 (centimeters of water						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT THE MEADOWS	,		STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1172010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	pressure) with 3L (li and off every mornin	ters) of oxygen at bedtime ng."	F6	95		
Anna Anna Anna Anna Anna Anna Anna Anna	administration recor documented "CPAP	at 14 (centimeters of water ers) of oxygen at bedtime ig." (4) The MAR				
	observation was ma #70's CPAP mask w	ximately 3:40 p.m., an de of Resident #70. Resident as observed on her bedside ver and not in use by the			,	-
	second observation Resident #70's CPAI	ximately 11:45 a.m., a was made of Resident #70. In mask was observed on her was any cover and not in use by	,			
	observation was mad (certified nursing ass CPAP mask was obs	kimately 11:56 a.m., a third de of Resident #70 with CNA istant) #6. Resident #70's rerved on her bedside table, d not in use by the resident.			÷	
	interview was conduct nursing assistant) #6 #70's CPAP mask sh use, CNA #6 replied, a bag." CNA #6 was should be covered wi	dimately 11:57 a.m., an obted with CNA (certified and with CNA (certified and with CNA). When asked how Resident could be stored when not in "They are supposed to be in asked why a CPAP mask then not in use. CNA #6 ms from getting on it."				
	According to facility, p Therapy" with a revis					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495236	B. WING				04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD	BE .	(X5) COMPLETION DATE
	as appropriate." On 4/16/19 at approduced (administrative staff Clinical Services and Director of Clinical Sthe findings. No further information. No further information. Positive airway produced a machine to pumpairway of the lungs. Open during sleep. To CPAP (continuous paprevents episodes of the breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea and other breathing in peopapnea if the spinal close completely durpregnancy. This can spinal cord. Screenir can check for spinal discovered only after symptoms of spina between the people normal intelligence. See the problems, or help in the brain. This fluid in the brain. This	ge 152 v infection control procedures, eximately 4:30 p.m., ASM member) #2, the Director of d ASM #3, the Regional Services were made aware of on was provided prior to exit. The sair under pressure into the This helps keep the windpipe The forced air delivered by ositive airway pressure) f airway collapse that block ple with obstructive sleep athing problems. This ained from the website: pov/ency/article/001916.htm eural tube defect - a type of ain, spine, or spinal cord. It d column of the fetus doesn't ing the first month of damage the nerves and ng tests during pregnancy bifida. Sometimes it is the baby is born. The ifida vary from person to with spina bifida are of Some people need assistive ces, crutches, or wheelchairs. bing difficulties, urinary and hydrocephalus, a buildup of s information was obtained	F 6	95				
	from the website: https://vsearch.nlm.n	ih.gov/vivisimo/cgi-bin/query-						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONS		(X	(X3) DATE SURVEY COMPLETED		
		495236	B. WING				• ·		
	PROVIDER OR SUPPLIER			STREET /	ADDRESS, CITY, STATE, ZIP COL OGTOWN ROAD HLAND, VA 23063	DE	04/17	/2019	
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F 695	meta?v%3Aproject	age 153 =medlineplus&v%3Asources= e&query=spina+bifida&_ga=2.1 280.1555684133-764922449.1	F6	95					
	is described below NPUAP stage is us appearance of an appractice of changing known as reverse so [8]. Stage 4 (pressurfull-thickness skin addirectly palpable fast cartilage, or bone in eschar may be visible edges), undermining occur. Depth varies slough or eschar ob loss, this is an unstaunstageable pressurfull-thickness skin a extent of tissue dambe confirmed becauseschar. If slough or or stage 4 pressure 'Debridement' below obtained from the whittps://www.uptodateg-and-management-d-soft-tissue-injury?susage_type=defauout	The NPUAP staging system (table 1 and figure 2) [5]. The ed to describe the initial area of skin damage. The grade the stage as healing occurs, taging, is not recommended re injury) is characterized by and tissue loss with exposed or scia, muscle, tendon, ligament, a the ulcer. Slough and/or ole (picture 1). Epibole (rolled grand/or tunneling often by anatomical location. If scures the extent of tissue ageable pressure injury. The injury is characterized by not tissue loss in which the lage within the ulcer cannot se it is obscured by slough or eschar is removed, a stage 3 injury will be revealed. (See and) This information was ebsite: The com/contents/clinical-stagin of-pressure-induced-skin-an search=pressure%20ulcer%2 earch=result&selectedTitle=1~ult&display_rank=1#H761282 The light to store Resident # 53's in device in a sanitary sannula, a two-pronged tube nose for delivering oxygen tem, was left uncovered on							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495236	B. WING			04/17/2019		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	011112010		
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C C F la T C p A d n T fc bi	was 12/26/18 with were not limited to: with hypoxia (2), per and chronic obstruct Resident # 53's moset), a significant clay with an ARD (asses 01/02/18, coded Resident et also coded as requipmental of the brief interview for also coded "C. Oxygen to also coded as requipmental et also coded as requipmenta	ost recent facility admission diagnoses that included but chronic respiratory failure (1) eripheral vascular disease (3), etive pulmonary disease (4). st recent MDS (minimum data nange in status assessment reference date) of esident # 53 as scoring a 15 on or mental status (BIMS) of a ndicating the resident has impairment for daily decision tion O, Resident # 53 was herapy." Resident # 53 was ring extensive assistance of or activities of daily living but	Fe	395				

NAME OF PROVIDER OR SUPPLIER 495236 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	7/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	772019
ENVOY AT THE MEADOWS 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRE	(X5) COMPLETION DATE
Continued From page 155 On 04/16/19 at 10:32 a.m., an interview was conducted with LPN (license practical nurse) # 2. When asked to describe the process of storing respiratory equipment, specifically the nasal cannula when not in use by the resident, LPN # 2 stated, "It should be stored in a plastic bag with resident's name, date it was stored, the resident's room number, and the name of the squipment being stored. "When asked why it should be covered, LPN # stated, "For infection control and to prevent germs from getting to the nasal cannula." On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) # 1, the executive director, ASM # 2, interim looldirector of nursing, RN (registered nurse) # 1, assistant director of nursing, and ASM # 3, the corporate nurse consultant, were made aware of the findings. When asked what standard the facility follows regarding their nursing care, ASM # 3 stated, "We follow the facility's policios and Potter and Perry." Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry. Mosby, Inc. Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract — Contaminated respiratory therapy equipment." No further information was provided prior to exit. References: 1. A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medilineplus/respiratoryfa	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING	à		04	/17/2019
	F PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	IP CODE		1172013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 69:	ilure.html 2. Deficiency of oxyone the body. This inforwebsite:	ge 156 gen reaching the tissues of mation was obtained from the n-webster.com/dictionary/hyp	F€	595			
	3. The vascular syst blood vessels. It incleased that carry Arteries can become called atheroscleros vessels and blook blood vestels inside the blood from the weather the blood from the weather the blood from the weather the blood from the weather the blood from the weather the blood from the weather than the blood from the weather the blood from the weather than the blood from the weather than the blood from the blood fro	em is the body's network of udes the arteries, veins and blood to and from the heart. It is thick and stiff, a problem is. Blood clots can clog ood flow to the heart or brain. It is sels can burst, causing tody.) This information was ebsite: gov/medlineplus/vasculardise				,	
F 727 SS=F	can lead to shortness was obtained from th https://www.nlm.nih.ç RN 8 Hrs/7 days/Wk	gov/medlineplus/copd.html. , Full Time DON	F 72	27			
	must use the service:						
.]	must designate a reg director of nursing on	f this section, the facility istered nurse to serve as the a full time basis.					
	§483.35(b)(3) The dir	ector of nursing may serve					

FORM APPROVED
OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	A. BUILDING			E SURVEY PLETED	
		495236	B. WING_			04	/17/2019
	ROVIDER OR SUPPLIER			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 727	average daily occupa This REQUIREMENT by: Based on staff interv review, it was determ failed to ensure the source of the source	ly when the facility has an noy of 60 or fewer residents. is not met as evidenced iew and facility document ined that the facility staff ervices of a RN (registered ecutive hours a day, seven if to ensure RN coverage for ars on 3/14/19, 3/30/19 and revealed no RN was on 3/14/19 and 3/30/19. The staffing schedules and revealed a RN was present four hours on 4/14/19. I.m., an interview was (other staff member) #2 (the OSM #2 was asked the suring RN coverage. OSM is that I have to have a RN every 24 hours. If I don't currently, I reach out to have one as well and reach we to see if I can get them to it'm still at zero, I let the ing) know immediately if I keep her updated, then I in from her as to what the metimes using our MDS	F	727	1. The facility currently has eight ho RN scheduled daily. 2. The staffing coordinator reviews to nursing schedule to ensure eight conhours of RN coverage is scheduled. up based on findings. 3. Executive Director, Director of Nu DON and staff coordinator have been educated on monitoring RN coverage facility daily by Regional Director of Nursing as of 5/9/2019. The nursing coordinator and director of nursing meet daily to review RN staffing covensure there is at least eight hours of coverage. 4. The results of the quality monito be reported to the quality assurance committee team monthly for review and further recommendations.	he daily secutive Follow rsing n re ge in the f staff will verage to f	5.28.19

PRINTED: 04/30/2019

STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	O. 0938-039 ⁻ ATE SURVEY DMPLETED
NAMEO	F PROVIDER OR SUPPLIER	495236	B. WING			0	<u>4/17/2</u> 019
	AT THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD DOCHLAND, VA 23063	· · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) RE	(X5) COMPLETION DATE
}	On 4/15/19 at 11:13 facility did not have on 3/14/19 and 3/30 building for four hou On 4/16/19 at 8:51 a staff member) #1 (th ASM #2 (the director made aware of the a On 4/17/19 at 10:32 director of clinical seriot have a policy reg federal regulations so No further information Nurse Aide Peform FCFR(s): 483.35(d)(7) Regulations and must complete amonths, and must preducation based on treviews. In-service to the requirements of §483. This REQUIREMENT by: Based on staff interview, it was determinated to complete and assistant) performance CNA records reviewer.	a.m., OSM #2 confirmed the a RN present in the building 1/19, and only had a RN in the irs on 4/14/19. a.m., ASM (administrative ne executive director) and r of clinical services) were above concern. a.m., ASM #3 (the regional process) stated the facility did garding RN coverage and the hould be followed. In was presented prior to exit. Review-12 hr/yr In-Service ar in-service education. In the plete a performance review at least once every 12 ovide regular in-service he outcome of these raining must comply with the 19.95(g). The is not met as evidenced in the process of the facility staff and that the facility staff and CNA (certified nursing the reviews for four of tend of, CNAs #7, #9, #10 and	F 7		DETOLINGY		
İ	(hired on 1/11/17), CN	nce reviews for CNA #7 IA #9 (hired on 10/13/97), 7/18), and CNA #11 (hired				i	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY MPLETED	
		495236	B. WING		04/	/17/2019	
	ROVIDER OR SUPPLIER THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	, , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE C		
	were employed at the year was provided by #4 (the regional direct this surveyor's reques A sample of ten CNAs and on 4/15/19 at 10:3 (administrative staff m director of clinical servithe annual performance selected CNAs. Review of the annual pto reveal reviews for CCNA #9 (hired on 10/1 2/7/18), and CNA #11 On 4/15/19 at 1:06 p.n aware of the above co provide the annual per #7, CNA #9, CNA #10 confirmed performance could not be located. On 4/16/19 at 8:46 a.m conducted with ASM # and ASM #2 (the interiservices) (both respon performance reviews a and ASM #2 were askeensuring annual perforcompleted. ASM #2 st	ompleted. .m., a list of CNAs who facility for more than one OSM (other staff member) or of human resources), per t. .was selected from the list 36 a.m., ASM ember) #3 (the regional rices) was asked to provide the reviews for the ten .performance reviews failed (NA #7 (hired on 1/11/17), 3/97), CNA #10 (hired on 6/3/04). .n., ASM #3 was made neem and was asked to formance reviews for: CNA and CNA #11. ASM #3 ereviews for some CNAs .n., an interview was 1 (the executive director) of clinical sible for ensuring annual recompleted). ASM #1 ed the facility process for mance reviews are ated the facility staff has a	F 730	1.Employee CNA#7 has a completed performance review as of 5/9/2019. Employee CNA#9 has a completed as performance review as of 5/9/2019. Employee CNA#10 has a completed as performance review as of 5/9/2019 Employee CNA#11 has a completed as performance review as of 5/9/2019. 2.Human Resource Manager or Desi will review all actively employed nur to ensure that an annual performance review was conducted within the last and in-service education was provide on the outcome. Follow ups will be do based on findings. 3.Human Resources Manager will be educated on ensuring that the facility completes a performance review of e nurse aide once every 12 months and provide regular in-service education on the outcomes by Executive Direct Designee. Human Resource Manager Designee to review all nurse aides to performance review was completed of annual basis and in-service education provided monthly x 3 Months. 4. The results of the Quality Monitori reviewed at the monthly Quality Assi Performance Improvement (QAPI) in	annual an	5.28.19	
	completed. ASM #2 stated the facility staff has a schedule that coincides with employees' hire dates and ensures annual performance reviews			for review, analysis, and further recommendations.		•	

PRINTED: 04/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WNG 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XA) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 730 Continued From page 160 F 730 are completed. ASM #1 and ASM #2 were made aware of the above concern. The facility policy titled. "Employee i= Job Performance Evaluations" documented. "It is the policy of The Company to evaluate each employee's job performance on a continual and on-going basis. Employees will receive an evaluation of their performance prior to the completion of their Introductory Period and annually thereafter. "No further information was presented prior to exit. F 732 Posted Nurse Staffing Information F 732 \mid F 732 SS=C CFR(s): 483.35(g)(1)-(4) 5-28-19 1. The facility nursing staff information is §483.35(g) Nurse Staffing Information. being posted daily with accurate §483.35(g)(1) Data requirements. The facility information. must post the following information on a daily basis: 2.No residents were affected. (i) Facility name. (ii) The current date. 3. The nursing staff coordinator and DON (iii) The total number and the actual hours worked have been re educated on maintaining and by the following categories of licensed and posting accurate nursing information and unlicensed nursing staff directly responsible for RN coverage by the Regional Director of resident care per shift: Clinical Services as of 5/6/2019. The DON or (A) Registered nurses. designee will ensure that staff posting (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). correctly reflects the staff in the facility per (C) Certified nurse aides. shift. (iv) Resident census. 4. The results of the quality monitoring will §483.35(g)(2) Posting requirements. be reported to the quality assurance (i) The facility must post the nurse staffing data committee team monthly for review, analysis specified in paragraph (g)(1) of this section on a and further recommendations daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED			
		495236	B. WING			 Ω4	/17/2019		
1	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, Z 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	IP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD THE APPROPE	BE	(X5) COMPLETION DATE		
	residents and visito §483.35(g)(3) Publistaffing data. The fivritten request, mal available to the publexceed the community of the folial states of the posted daily nurses the months, or as register. This REQUIREMENT by: Based on observation document review, it facility staff failed to accurate nurse staff. The facility staff failed to accurately document staff on the day shift. The facility staff failed to accurately document staff on the day shift. The facility staff failed to accurately document staff on the day shift. The facility staff failed to accurately document staff on the day shift. The facility staff failed to accurate the total numer staffing form on 3/28 ensure the total numer staff on the to	c access to posted nurse acility_must, upon oral or ke nurse staffing data lic for review at a cost not to nity standard. ty data retention facility must maintain the staffing data for a minimum of quired by State law, whichever IT is not met as evidenced on, staff interview and facility was determined that the ensure complete and postings. alled to ensure the 4/14/19 form (nurse staff posting) ted RN (registered nurse) tiled to ensure the evening ented on the daily nursing lift and 3/29/19 and failed to ber and actual hours of RN was documented on the form on 3/30/19 and	F 7	732					
	The facility staff fa daily nursing staffing	iled to ensure the 4/14/19 form (nurse staff posting) ed RN (registered nurse)				-	,		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	. (TE SURVEY MPLETED
		495236	B. WING			04	/17/0010
	PROVIDER OR SUPPLIER AT THE MEADOWS		-	STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	<u> </u>	/17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD B E APPROPRI	BE ATE	(X5) COMPLETION DATE
F 732	Continued From pa	ge 162	F 7	'32			
	facility daily nursing lobby, revealed doci in the building for eight	p.m., observation of the staffing form, posted in the umentation that one RN was ght hours on day shift.			 :		
	nurses was conduct	re observed in the facility.	ι				
	On 4/14/19 at 1:15 p and another LPN we facility.	o.m., LPN #5 confirmed he ere the only two nurses in the					
	conducted with OSN employee responsible staffing form). OSM above observations a process for ensuring nursing staffing form the form, based on the when she will not be Sunday, or fills out the scheduled staff, on Sthe facility on Sunday responsible for posting she filled out the 4/14 day based on the starday but the RN who work osm #2 stated she seeponsible she say but the RN who work who work who work was a stated she say but the RN who work was a stated she say above the start of	Saturday if she will not be in y, and the receptionist is ng the form. OSM #2 stated 1/19 form on the previous ff that was scheduled for this was scheduled called out. hould have called the ed her to change the form					
	staff member) #1 (the	m., ASM (administrative executive director) and of clinical services) were concern.				,	

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			TE SURVEY MPLETED
		495236	B. WING	·	04	1/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 732	On 4/17/19 at 10:32 director of clinical so not have a policy re	p.m., ASM #3 (the regional ervices) stated the facility did garding nurse staff postings.	F 73	32		,
	2. The facility staff facensus was docume staffing form on 3/26 ensure the total nun staff on the day shift daily nursing staffing 3/31/19. Review of daily nurs postings) revealed the The 3/28/19 and 3/3 documentation of the The 3/30/19 and 3/3	29/19 forms failed to reveal e facility census. 31/19 forms failed to reveal e total number and actual				
	conducted with OSM employee responsibl staffing forms). OSM information should be staffing forms. OSM are scheduled or in-they have worked, the name of the facility prostaffing forms are constaffing forms are constaffing forms are constaffing forms are constaffing forms.	a.m., an interview was (other staff member) #2 (the e for completing the nurse f #2 was asked what e documented on the nurse #2 stated, "The nurses that louse daily, how many hours e number of CNAs (certified and their hours, the date and ty and the census." When cess for ensuring nurse mplete and accurate, OSM to me to maintain it." OSM of the above concerns. m., ASM (administrative e executive director) and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495236	B. WING_		04/17/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	0.7.17.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 755 SS=E	ASM #2 (the director of made aware of the able on 4/17/19 at 10:32 prodirector of clinical services and have a policy regal of the provision o	of clinical services) were ove concern. .m., ASM #3 (the regional vices) stated the facility did arding nurse staff postings. was presented prior to exit. edures/Pharmacist/Records 1)-(3) ervices de routine and emergency to its residents, or obtainment described in the may permit unlicensed er drugs if State law or the general supervision of s. A facility must provide es (including procedures te acquiring, receiving, instering of all drugs and eneeds of each resident. Insultation. The facility the services of a licensed es consultation on all the pharmacy services in these a system of records of of all controlled drugs in	F 7:		cility by ated on t box be e are n is

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 165	F 75	5		
1 17 Marine	order and that an act is maintained and portion This REQUIREMENT by: Based on family introdument review and was determined the medications were as	mines that drug records are in account of all controlled drugs eriodically reconciled. IT is not met as evidenced erview, staff interview, facility ad clinical record review, it facility staff failed to ensure vailable for administration for in the survey sample,	-			
	The facility staff faile physician prescribed available for adminis	ed to ensure Resident #52's I medication Methadone was stration.				
	The findings include	:				
	9/17/18 with diagnos limited to lung cance pulmonary disease - nonreversible lung d combination of emph	dmitted to the facility on ses that included but were not er, COPD (chronic obstructive general term for chronic, isease that is usually a hysema and chronic) (1), high ety, chronic pain and				To the second se
	assessment, a quart assessment reference resident as scoring a interview for mental s resident is severely in cognitive decisions. The having periods of dis comes and goes. Re having periods of hal	S (minimum data set) erly assessment, with an ce date of 3/13/19, coded the to "1" on the BIMS (brief status) score, indicating the mpaired to make daily The resident was coded as organized thinking that sident #52 was coded as lucinations and delusions. ded as requiring limited				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B, WING	<u> </u>	0,	1/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, Z 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		W1172013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	assistance of one sactivities of daily live Medications, the reseven days of an analysis of analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an analysis of an anal	staff member for most of her ring. In Section N - sident was coded as receiving ntianxiety medication. In Section N - sident was coded as receiving ntianxiety medication. In Section N - sident was conducted on 4/14/19 at ly member expressed acility didn't order her mother's so she missed doses of it. In dated, 12/31/18, hadone* HCL (hydrochloride) 5 let; 3 tabs (tablets) by mouth 0600 (6:00 a.m.) 1400 (2:00 p.m.) for pain." Ind to relieve severe pain in sected to need pain medication or a long time and who cannot er medications (2). In ary 2019 MAR (medication red) documented the above 1/14/19 at 2200 (10:00 p.m.) he medication and circled their wasn't given. There was no the reverse side of the MAR and dose of Methadone.	F 7	755			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			TE SURVEY MPLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1772019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 167	F 7	55		
		e's notes for the above dates evidence the reason why the administered.	-	-		-
·	physician order. Th not administered or p.m., 3/12/19 at 2:0 p.m. There was not	AR documented the above e Methadone was circled as a 3/8/19 at 6:00 a.m. and 2:00 p.m. and 3/13/19 at 2:00 hing documented on the MAR regarding the missed				
	"Methadone HCL (h	dated, 3/14/19 documented, ydrochloride) 5 mg; give 4 y mouth) TID (three times a				- Andrews
	physician order. The administration of the	AR documented the above MAR failed to document the Methadone on 3/16/19, at 2:00 p.m. The reverse ed to evidence any				
		's notes for the above dates ocumentation of why the administered.				
		dated, 3/26/19, documented, mg tab (tablet) PO (by nes a day)."				
	order. On 3/26/19 at the medication was On 3/28/19, the 6:00 as not administered.	R documented the above 2:00 p.m. and 10:00 p.m., circled as not administered. a.m. dose was documented The reverse side of the MAR 9 - 1400 (2:00 p.m.),				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING			n4	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, O 2715 DOGTOWN RO GOOCHLAND, VA		1 01	111/2019
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F 755	Medication - Methan in from pharmacy." Review of the nurse failed to evidence dimedications were not the comprehensive documented in part acute/chronic pain repain to right ankle with (cancer). The "Interpart, "Administer and An interview was conurse) #1 on 4/15/19 about the process ordered medication administration, RN # a circle around their on the back of the Migiving it. If it's not avillated that they can't get it to notify the doctor and something else in the facility has an enem #1 stated that there aroom that contains a	done - meds (medications) not e's notes for the above dates ocumentation of why the ot given as ordered. e care plan dated, 3/14/19, focus: The resident has e't (related to) complaints of eith warmth/swelling/ CA rventions" documented in algesics as per orders." nducted with RN (registered 9 at 4:07 p.m. When asked taff follows if a physician	F 7	55			
	nurse's initials indicathat nurse did not given asked if a nurse sho medication is not given either document MAR or in a nurse's	tte, RN #1 stated it means we the medication. When uld document why a en, RN #1 stated, "Yes, they it on the reverse side of the note."					
	medication room wa	cy medications stored in the s observed on 4/15/19 at ied by RN (registered nurse)					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
		495236	B. WING	•	04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		,	STREET ADDRESS, CITY, STATE, ZIP CODI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	Ξ.	71172019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	#2. The narcotics e document the stora	mergency box failed to	F 75	55		
	executive director, A clinical services and	ASM #2, the interim director of ASM #3, the regional director were made aware of the above				
	(1) Barron's Diction	on was provided prior to exit. eary of Medical Terms for the				
F 750	Chapman, page 12- (2) This information following website: https://medlineplus.tml	was obtained from the gov/druginfo/meds/a682134.h				
F 758 SS=E	Free from Unnec Ps CFR(s): 483.45(c)(3	sychotropic Meds/PRN Use)(e)(1)-(5)	F 75	8		
	affects brain activities processes and beha	chotropic drug is any drug that es associated with mental vior. These drugs include, e, drugs in the following				
	Based on a comprehresident, the facility r	nensive assessment of a must ensure that				
	psychotropic drugs a	ents who have not used tre not given these drugs n is necessary to treat a				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY PLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	DE.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 758	in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medication diagnosed specific co in the clinical record; a §483.45(e)(4) PRN or are limited to 14 days. §483.45(e)(5), if the a prescribing practitione appropriate for the PR beyond 14 days, he or rationale in the reside indicate the duration for §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the at prescribing practitione the appropriateness o This REQUIREMENT by: Based on staff intervice and facility document that the facility staff fai	nts who use psychotropic if dose reductions, and ins, unless clinically reffort to discontinue these ints do not receive ursuant to a PRN order in is necessary to treat a indition that is documented and intending physician or iter believes that it is it is it is should document their int's medical record and or the PRN order. I days and cannot be itending physician or revaluates the resident for revaluates the resident for	F 75	1.Resident # 31 was assessed nurse practitioner on 4-23-20 zolpidem (Ambien) medication discontinued. 2. No other residents in facility prescribed as needed psychoty medications. 3. Licensed nursing staff will be on implementing non pharmal interventions prior to administ medications by the director of interdisciplinary team will mereview residents with prescrib psychotropic medication to valcontinued usage to prevent unmedication. This will continue eight weeks. 4. The results of the quality mobe reported to the quality assume committee team monthly for reand further recommendations.	and on was Ey are Topic hypnotic Topic hypn	5.28.19
	The facility staff failed non-pharmacological i	•				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	I com		
		495236	B. WING	·			04/17/2019	
	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 758	administration of pr [Ambien] (1) to Res	n (as needed) Zolpidem ident #31.	F7	758				
	o3/15/18 and a read diagnoses that incluinsomnia (2), respir obstructive pulmonal hypertension (5). Resident # 31's moset), a quarterly assigned (assessment refere Resident # 31 as sinterview for mental - 15, 15 - being cog decisions. Resident independent for all a The physician's ord Resident # 31 docu coated) 5MG (millig tab (tablet) by mout sleep. 03/16/19." The MAR (medication dated March 2019 for the above physician dated 03/16/19 thro Resident # 31 receiving the above physician dated 03/16/19 thro Resident # 31 receiving the above physician dated "March 2019" documentation of no approaches being a administration of Zonal control of the administration of Zonal control of	admitted to the facility on dmitted of 03/16/19 with uded but were not limited to atory failure, (3), chronic ary disease (4), and st recent MDS (minimum data sessment with an ARD note date) of 02/13/19, coded coring a 15 on the brief status (BIMS) of a score of 0 nitively intact for making daily t # 31 was coded as being activities of daily living. ers dated "April 2019" for mented, "Zolpidem F/C (film ram) Tablet (Ambien). 1 (one) that bedtime as needed for or Resident # 31 documented order. Review of the MAR ugh 03/31/19 revealed wed Zolpidem ten out of s. Further review of the MAR failed to evidence on-pharmacological ttempted prior to the						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	_	495236	B. WING			04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CI 2715 DOGTOWN RO GOOCHLAND, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORI	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	dated April 2019 for the above physiciar Tablet (Ambien). R	Resident # 31 documented on order for Zolpidem F/C 5MG eview of the MAR dated	F 7	58			
	04/01/19 through 04/01/19 through 04/01/19 through 04/01/19 through 04/01/19 through 04/01/19 failed to non-pharmacological attempted prior to the facility's "Interd dated 03/16/19 through 04/01/19 through 04/0	4/11/19 revealed Resident # Im seven out of eleven her review of the MAR dated be evidence documentation of al approaches being he administration of Zolpidem. disciplinary Progress Notes" ugh 04/11/19 failed to ation of non-pharmacological ttempted prior to the lipidem. care plan for Resident # 31 bocumented failed to evidence					
	Zolpidem. On 04/16/19 at 10:4 conducted with LPN When asked to describe the proced prn (as needed), LP different approach comfortable, turn off make sure they are keeping them awake she would attempt o interventions, before medication, LPN # 2 every time they ask the attempted non-p	LPN # 2 stated, "It's for a sleep." When asked to ure for administering Ambien N # 2 stated, "I would try a make sure the room is the television and lights, not having pain that might be e." When asked how often ther non-pharmacological administering the stated, "I would attempt it for it." When asked where harmacological interventions N # 2 stated, "It should be					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG			E SURVEY IPLETED
		495236	B. WING_			04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, S 2715 DOGTOWN ROAD GOOCHLAND, VA 230			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD DED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
	documented can't s # 2 was then asked MAR dated March 2 "Interdisciplinary Pr through 04/11/19. I where other approa times it (Ambien) w The facility's policy Management-Psych documented, "Proce non-pharmacologica initiated as indicated On 04/06/19 at appl (administrative staff director, and ASM # services, were made No further information References: (1) Comes as a table extended-release (Ic CR) to take by mout sublingual tablet (Ec under the tongue an which is sprayed intel If you are taking the tablets, sublingual ta you will take the me than one time a day If you are taking the (Intermezzo), you wi needed, not more th if you wake up and I sleep. Zolpidem will with a meal or imme	ay it is being attempted." LPN to review Resident # 31's 2019 and April 2019 and the ogress Notes" dated 03/16/19 LPN # 2 stated, "I don't see ches were attempted at the as administered." "Medication notropic Medications" it edure: 5. Resident centered al interventions should be d." "oximately 3:43 p.m., ASM member) #1, the executive 2, interim director of clinical e aware of the above findings. On was provided prior to exit. et (Ambien) and an ong-acting) tablet (Ambien dan oral spray (Zolpimist), of the mouth over the tongue. Itablets, extended-release ablets (Edluar), or oral spray, dication as needed, not more immediately before bedtime.	F 75	58			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	and ask your doctor part you do not und as directed. You wi sleepy-soon after-your remain sleepy for some dication. Plan to zolpidem tablets, exsublingual tablets (Estay in bed for 7 to sublingual tablets (I already in bed and of 4 more hours. Do not unable to remain as of hours after taking experience drowsing memory, alertness, information was obtined.	r or pharmacist to explain any erstand. Use zolpidem exactly II probably become very but take zolpidem and will ome time after you take the go to bed right after you take stended-release tablets, Ediuar), and oral spray and to B hours. Take zolpidem intermezzo) only when you are can remain in bed for at least of take zolpidem if you will be leep for the required number the medication. If you get up	F 75	58		
	may have trouble fa or both. As a result, have poor-quality sle refreshed when you was obtained from t https://www.nlm.nih. ml. (3) When not enoug lungs into your blood obtained from the w	gov/medlineplus/insomnia.ht h oxygen passes from your d. This information was ebsite:				
	ilure.html. (4) Disease that mal	gov/medlineplus/respiratoryfa kes it difficult to breath that s of breath. This information ne website:				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		TE SURVEY MPLETED
		495236	B. WING			04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	https://www.nlm.nih	.gov/mediineplus/copd.html.	F 7	'58			
F 759 SS=E	essure.html. Free of Medication I	.gov/medlineplus/highbloodpr Error Rts 5 Pront or More	F 7	'59			
	percent or greater; This REQUIREMEN by: Based on the medic observation, staff int review and clinical re determined the facili medication error rate There were 29 oppo medication administ errors, which equals 12.9 percent. 1. The facility staff ac dose of Vitamin D 2	ation error rates are not 5 IT is not met as evidenced cation administration cerview, facility document ecord review, it was ity staff failed to ensure a e of less than five percent. rtunities made during the ration observation, with three a medication error rate of dministered the incorrect to Resident # 26.					
	dose of calcium with administer Tamsulos Resident # 59. The findings include:	dministered the incorrect					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB
i	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING_		04/	17/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE	
	Resident #26 was ad 4/3/15 with diagnose limited to: muscular hereditary disease of characterized by well groups of skeletal midisability (2)], depresident deficiency. The most recent MD assessment, an annuassessment, an annuassessment reference resident as scoring a interview for mental stresident was capable decisions. Observation was ma #2, on 4/15/19 at 7:4 medications to Resident following medications Breo Ellipta 100-25 in (used to treat asthmatical Aliopurinol 300 mg (resident to treat gout) (4) Baciofen 10 mg - 1/2 and improve muscle Buspirone HCL (hydroused to treat anxiety Carvedilol 6.25 mg heart failure) (7) Duloxetine HCL 30 midepression and anxieteliquis 5 mg - one talled to treat and treat and treat and the second treat anxiety carvedilol 5.25 mg - heart failure) 5 mg - one talled to treat anxiety 5 mg - one talled treat anxiety 5 mg	dmitted to the facility on the strat included but were not dystrophy [any of a group of a group of the muscular system akness and wasting of uscles, leading to increasing asion, diabetes and vitamin D S (minimum data set) usal assessment, with an active date of 2/21/19, coded the artist on the BIMS (brief status) score, indicating the erof making daily cognitive and coff RN (registered nurse) are and copp) (3) milligrams) - one tablet (used tablet (used to relieve pain movement) (5) cochloride) 10 mg - one tablet are disorders) (6) one tablet (used to treat and copp) (8) one tablet (used to prevent are grapsule - (Used to treat and copped) (8) one to the component of the compo	F 7	1.A) The physician was not medication error as on 4/1 orders were received. Rescurrently receiving vitamin by physician. B) Resident # 59 physicia vitamin D medication dost new prescription on 4-15-vitamin D 500mg/400u. The administration time for Tareviewed by physician on 4 desires given at 1600. 2. Resident's with physician Vitamin D, Calcium with v Tamulosin has been reviewed for nursing to ensure medica available and being adminitian accordance with the physic 5/9/2019. Follow up based 3. Licensed nurse will be re DON/ designee on following by utilizing the six rights of administration for consistent medication administration conducted weekly for eight DON or designee to ensure available and medication at completed in accordance worder.	otified of the 15/2019 and no new sident # 26 is in D2 as ordered in D2 as ordered in D2 as ordered in D2 as ordered in D2 as ordered in D3 and in Orders for itamin D3 and itamin D3 and itamin D4 and itamin D5 and itamin D5 and itamin D5 and itamin D5 and itamin D5 and itamin D5 and itamin D6 and itamin D6 and itamin D6 and itamin D6 and itamin D6 and itamin D7 and itamin O7 are istered in itam order as of itamin order as of itamin order as of itamin orders it	5.78.19	
	strokes and blood clo Fexofenadine HCL 18 treat allergies) (10)			4. The results of the quality be reported to the quality a committee team monthly fo and further recommendation	ssurance r review, analysis		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING	i	,	4/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZI 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		, M. 1772.013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	seizures and pain) Metformin HCL 500 diabetes) (12) Oxycodone 10 mg moderate to severe Pravastatin Sodium treat elevated chole Rexulti 0.5 mg - one symptoms of schize Thera Tab - one tab (16) Topiramate 50 mg - prevent migraine he Vitamin D 3 5,000 II capsule Review of the physic renewed on 3/26/19 capsule 50,000 Unit ergocalciferol). 1 ca Monday and Friday The April 2019 MAR record) documented D2. An interview was conurse) #2 on 4/15/13 which bottle of Vitam medication that she #26. RN #2 verified I (medication adminis dose of Vitamin D2. physician order docuread, RN #2 was asl medication per the p stated, "No, but I dor	(11) mg - one tablet (used to treat pain) (13) 40 mg - one tablet (used to pain) (14) e tablet (used to treat phrenia) (15) let (multivitamin supplement) one tablet (used to help padaches) (17) J (international units) - one cian orders dated 9/16/17 and d, documented, "Vitamin D 2 capsule (Gen [generic] - p (capsule) by mouth every for deficiency." It (medication administration I the above order for Vitamin Inducted with RN (registered D at 10:07 a.m. RN#2 verified D she used to obtain the had administered to Resident her initials on 4/15/19 MAR tration record) for the ordered RN #2 was asked to read the umented on the MAR. Once	F 7	759			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		'E SURVEY MPLETED
		495236	B. WING		04	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS		2	BTREET ADDRESS, CITY, STATE, ZIP CODE 1715 DOGTOWN ROAD GOOCHLAND, VA 23063	1 0-1	1112013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F.759	On 4/15/19 at 10:30 was observed with	a.m., the medication room RN #2. There was no bottle of	F 759	·		
	informed the survey medication card on correct medication.	units. At this time, RN #2 or that she had found a her medication cart with the None of the capsules had the card. RN #2 stated, "It's	.			
	Record (MAR) and I outside resident's romedication on Medic (MAR). Read label of TIMES; BEFORE Ricontainer or card, be med (medication) cacontainer; and BEFO	locumented in part, edication Administration Medication Cart to hallway formCompare unit/dose cation Administration Record on the container THREE (3) EMOVING the drug from the efore returning the drug to the art or disposing of the DRE HANDING the drug to from touching powders,				
-	Edition, 2009: by Pe "Medication Adminis read: "Professional a American Nurses As and Standards of Nuto the activity of medication administryou administer medicerrors can be linked, inconsistency in adhemedication administry medication admini	mentals of Nursing", Seventh rry and Potter Chapter 35 tration" Chapter 35, pg. 707 standards, such as the sociation's Nursing: Scope trsing Practice (2004) apply lication administration. To perrors, follow the six rights ration consistently every time cations. Many medication in some way, to an ering to the six rights of ration. The six rights of ration include the following: 1. 2. The right dose, 3. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495236	B. WING	· · · · · · · · · · · · · · · · · · ·	04/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 759	and 6. The right doo	ight route, 5. The right time, cumentation."	F 78	59		
***************************************	executive director, A	member (ASM) #1, the ASM #2, the interim director of I ASM #3, the regional director were made aware of the above at 4:58 p.m.				
	No further information	on was provided prior to exit.				
	following website: https://vsearch.nlm.i meta?v%3aproject= medlineplus-bundled (2) Barron's Dictiona Non-Medical Reade Chapman, page 381 (3) This information following website: https://vsearch.nlm.t meta?v%3Aproject= medlineplus-bundled (4) This information following website: https://medlineplus.g tml (5) This information following website: https://medlineplus.g tml (6) This information following website: https://medlineplus.g tml	was obtained from the nih.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources=				The state of the s

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ESURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
į	tml (8) This information following website: https://medlineplus. tml (9) This information following website: https://medlineplus. tml (10) This information following website: https://medlineplus. tml (11) This information following website: https://medlineplus. tml (12) This information following website: https://medlineplus. tml (13) This information following website: https://medlineplus. tml (13) This information following website: https://medlineplus. tml (14) This information following website: https://medlineplus. tml	ge 180 gov/druginfo/meds/a697042.h was obtained from the gov/druginfo/meds/a604030.h was obtained from the gov/druginfo/meds/a613032.h n was obtained from the gov/druginfo/meds/a697035.h n was obtained from the gov/druginfo/meds/a694007.h n was obtained from the gov/druginfo/meds/a694005.h n was obtained from the gov/druginfo/meds/a696005.h n was obtained from the gov/druginfo/meds/a682132.h n was obtained from the gov/druginfo/meds/a692025.h n was obtained from the	F 7	,		
	following website: https://medlineplus.g tml (16) This information following website: https://www.heart.org	gov/druginfo/meds/a615046.h was obtained from the g/en/healthy-living/healthy-eat n-basics/vitamin-supplement				

	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495236	B. WING		04/17/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETION
	(17) This informatio following website: https://medlineplus.tml	gov/druginfo/meds/a697012.h ailed to administer the correct n vitamin D and failed to sin per the physician order to dmitted to the facility on ses that included but were not d pressure, diabetes, ession. The most recent MDS assessment, a Medicare 30 th an assessment reference d the resident as scoring a ef interview for mental status) was moderately impaired to e decisions. ade of LPN (licensed practical 9 at 8:11 a.m. administering dent #59. LPN #1 prepared ations: nilligrams) - one capsule ssion and anxiety disorders) to capsules (is an omega - 3 ablet (used to treat diabetes) in 500 mg - one tablet (used	F 7		
	treat enlarged prosta	drochloride) 0.4 mg (used to ate and frequent urination) (5) ng - one tablet (used to treat			

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		E SURVEY APLETED
		495236	B. WING		04,	/17/2019
-	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	• ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	The physician order in part, "Calcium (a 'with') D (vitamin D) and 200_mg of Vitar (every day). Tamsul (capsule) PO @ (at The review of the M Administration Recabove orders. On the was scheduled for 1 The review of the Al the above orders. O Tamsulosin was prir someone had hand across the 1600 (4:0 An interview was co 4/15/19 at 10:13 a.n which calcium suppl Resident #59 the Oy was confirmed. The vitamin D was review asked if she follower #1 stated she did not reviewed with LPN # calcium with vitamin cart. The order for the with LPN #2. When change a physician's medication-schedule you would need a physician or administration time of (4:00 p.m.) to 0900 (4:00 p.m.) to 0900 (4:00 p.m.) to 0900 (4:00 p.m.)	rs dated, 3/8/19, documented C with a line over it indicating 500/200 (500 mg of calcium nin D) one PO (by-mouth) QD osin 0.4 mg one cap 1600 (4:00 p.m.)." arch 2019 Medication ord (MAR) documented the e March MAR the Tamsulosin 600 (4:00 p.m.). oril 2019 MAR documented in the April MAR the nited for 1600 (4:00 p.m.) but written 0900 (9:00 a.m.) but written 0900 (9:00 a.m.) op p.m.) time. Inducted with LPN #1 on h. LPN #1 was asked to verify ement she administered to vster Shell Calcium 500 mg above order for calcium with wed with LPN #1. When the physician's order, LPN to the physician's order, LPN to the medication cart was and there was no bottle of D 500/200 on the medication he Tamsulosin was reviewed asked if a nurse can just a order for a set time, LPN #2 stated, "No, by sician order to change the cord was reviewed and there der to change the of the Tamsulosin from 1600 9:00 a.m.).	F 759			
	An interview was coi	nducted with administrative				

STATEMENT AND PLAN (FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/	17/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
	clinical services, on asked if the physicia administer a medica change the adminis "Only after she has the resident request they still need a phy time." Administrative staff executive director, A clinical services and of clinical services we concern on 4/15/19 No further information following website: https://medlineplus.gtml (2) This information following website:) #3, the regional director of 4/15/19 at 10:43 a.m. When an order documents to ation at 1600 can a nurse tration time, ASM #3 stated, spoken to the doctor. Unless and it at a certain time, but sician order to change the as member (ASM) #1, the ASM #2, the interim director of ASM #3, the regional director are made aware of the above	F7	DEFICIEN			
	following website: https://medlineplus.g tml (4) This information of following website: https://medlineplus.g (5) This information of following website: https://medlineplus.g tml	was obtained from the rov/druginfo/meds/a696016.h was obtained from the rov/ency/article/007477.htm was obtained from the ov/druginfo/meds/a698012.h was obtained from the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

PRINTED: 04/30/2019

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 7			(X3) DATE SURVEY COMPLETED	
NAME OF D	DOWNER OF MIRRIER	495236	B. WING			/17/2019	
	ROVIDER OR SUPPLIER T THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 761 SS=E	https://medlineplus.tml. Label/Store Drugs at CFR(s): 483.45(g)(labeling Drugs and biological labeled in accordant professional principal appropriate accessor instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptable and laws, the fabiologicals in locked temperature controls personnel to have at \$483.45(h)(2) The fabiologicals in locked temperature controls personnel to have at \$483.45(h)(2) The fabiologicals in locked permanently storage of controllecting the Comprehensive Control Act of 1976 abuse, except when package drug distribuguantity stored is milbe readily detected.	gov/druginfo/meds/a604006.h and Biologicals an)(1)(2) g of Drugs and Biologicals als used in the facility must be ce with currently accepted les, and include the bry and cautionary expiration date when of Drugs and Biologicals cordance with State and cility must store all drugs and I compartments under proper s, and permit only authorized cess to the keys. accility must provide separately or affixed compartments for I drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the nimal and a missing dose can	F 78		and the unopened 200 was discarded t is in usage is ments were e nourishment and appropriately ritional nutritional se 4/8/19 was facility have been se and any insulin the manufacturer a discarded. The checked to ensure ave appropriate	5.76.19	
	be readily detected. This REQUIREMEN by: Based on observation document review, it facility staff failed to according to profess three medications cannot be readily to the readily of the	nimal and a missing dose can T is not met as evidenced on, staff interview and facility was determined that the label and store medications ional standards in one of arts, the wing 200 medication sure expired biological's		ap vaseu ou imonego.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED	
		495236	B. WING	_		04	/17/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	room and nutritional re 100 hallway. 1. The facility staff fail and failed to store und refrigerator. 2a. The facility staff fail nutritional supplement Resident use in the failed. The facility staff failed page 12b. The facility staff failed page 12b. The facility staff failed page 12b. The facility nourishment redocumented open date the proper temperature to the manufacturer re 04/12/19. The findings include: 1. On 4/15/19 at 3:49 wing 200 medication of following opened insular labeled open date: One vial of Novolog (Control Three Novolog flex plabeled with a sticker to 28 days after opening. Two Lantus solostar labeled with a sticker to 28 days after opening. Two Levemir flextouch at the sticker to 28 days after opening. Two Levemir flextouch at the sticker to 28 days after opening.	use in the facility nutritional efrigerator, located on the ed to label opened insulin opened insulin in the opened insulin in the ed to ensure expired its were not available for cility nourishment room. Iled to ensure that a MED upplement observed in the frigerator with a e of 04/08/19 was stored at e and discarded according accommended date of eart was conducted. The in's were observed without ens. The pens were hat documented, "Discard pens (2). The pens were hat documented, "Discard en (3). The pen was hat documented, "Discard en (3). The pen was hat documented, "Discard en (3). The pen was hat documented, "Discard en (3). The pen was hat documented, "Discard en (3). The pen was hat documented, "Discard en (3).	F	761	3. Licensed nurses will be reeducate DON/designee on following manufaguidelines for insulin storage and manupplements as well as discarded whexpired. The dietary manager will quality review of the kitchenette are unit weekly to ensure proper storag supplements. Random medication administration reviews will be cond weekly for eight weeks by the DON designee to ensure insulin is availab properly stored and administration completed in accordance with physi order. The director of nursing will and monitor tool will be completed for eight weeks. 4. The results of the quality monitor be reported to the quality assurance committee team monthly for review, and further recommendations.	cturing attritional acen complete es on the e of ucted or le, is cian complete weekly		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING			E SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT THE MEADOWS		• •	STREET ADDRESS, CITY, STATE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	, ZIP CODE	U-4/	17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	•	CTION SHOULD I	BE	(X5) COMPLETION DATE
	kwikpen and a Lant unopened (as evide around the opening sticker that docume opened." The Novolog manuf documented, "Throw 28 days after first us inside." This inform website: https://www.rapidac.novolog/storage-and. The Lantus solostar documented, "The Lantus solostar documented, "The Lantus solostar documented, "The Lantus volog/storage-and." The Lantus volog/storage-and." The Lantus volog/storage-and." The Lantus volog/storage-and." The Lantus volog/storage-and." This if manufacturer's instruction" This if from the website: http://products.sanof.n-16.2 The Basaglar manuf documented, "Store refrigerator at 36°F to away the Pen you ar	t also contained a Basaglar us solostar-pen that was enced by a sticker wrapped). Both pens contained a nted, "Refrigerate until acturer's website w away open vials and pens se, even if there is insulin left ation was obtained from the tinginsulin.com/novolog/usingd-handling.html manufacturer's website ANTUS vials you are using way after 28 days, even if it it." The Lantus solostar uctions further documented, itals, cartridge systems and uld be stored in a information was obtained it.us/lantus/lantus.html#sectio acturer's website unused Pens in the o 46°F (2°C to 8°C). Throw e using after 28 days, even if in it." This information was	F 7	761			
	The Levemir manufa	asaglar/basaglar.html#ug cturer's website se after 42 days, even if					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04.	/17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE	1 042	11/12019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 761	obtained from the v	n it." This information was	F 7	61			
	conducted with RN was asked about the insulin vials and per them when you ope When asked why, F expire." RN #1 was know if an insulin wafter being opened labeled with an oper you should throw it a because you don't ke When asked if there that should be refrigerated she knew the describe which insulated aware of and concerns. RN #1 streorder the insulin's process for checking and storage, RN #1 nurse should check unit manager complication once a month. Whe manager was, RN # was no unit manage. On 4/16/19 at 8:51 a staff member) #1 (th ASM #2 (the interim were made aware of	.m., ASM (administrative e executive director) and director of clinical services)					

AND PLAN	OF CORRECTION	I IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		495236	B. WING		0/	4/1 7/2 019
·	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CO 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		#111 <u>2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	and Expiration Dati Syringes and Need any medication or the Facility should follor guidelines with responenced medication the date opened on when the medication date once opened medications and bid appropriate tempers States Pharmacope ranges" No further informati (1) Novolog is insuli This information wan https://medlineplus.tml (2) Lantus is insulin information was obthe https://medlineplus.gtml (3) Basaglar is insuli This information was obthe https://medlineplus.gtml (4) Levemir is insulir information was obta https://medlineplus.gtml 2a. The facility staff in utritional suppleme	inge 188 Ing of Medications, Biologicals, les" documented, "5. Once biological package is opened, w manufacturer/supplier pect to expiration dates for s. Facility staff should record the medication container in has a shortened expiration at their actures according the United pia guidelines for temperature on was presented prior to exit. In used to treat diabetes, sobtained from the website: gov/druginfo/meds/a605013.h used to treat diabetes. This ained from the website: gov/druginfo/meds/a600027.h in used to treat diabetes. sobtained from the website: gov/druginfo/meds/a600027.h in used to treat diabetes. This ained from the website: gov/druginfo/meds/a600027.h a used to treat diabetes. This ained from the website: gov/druginfo/meds/a600027.h a used to treat diabetes. This ained from the website: gov/druginfo/meds/a606012.h failed to ensure expired ints were not available for facility nourishment room.	F7	761		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTE	RUCTION		TE SURVEY
		495236	B. WING		•	04	1/17/2019
ENVOY	PROVIDER OR SUPPLIER AT THE MEADOWS			2715 DOGT	DRESS, CITY, STATE, ZIP COD FOWN ROAD AND, VA 23063	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[(E.	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	facility nourishment -Two cans of Gluces observed on the top temperature with an -Two one-quart carts nutritional suppleme room on the right co room temperature w On 4/16/19 at 11:51 conducted with OSN dietary manager. Wi for stocking the nour 5 stated, "I'm not sur responsible for the ju When asked if the e shelf available for us should not.' On 4/16/19 at 11:58 in the nourishment re logistic staff. When a for stocking the nour stated she was. OSN nourishment supplies supplies and marks to items were placed or the above-expired ite	a.m., an observation of the room revealed the following: ma (3)-1.2 calories were— left shelf stored at room expiration date 04/01/19 ons of "Thick and Easy" (4) ont located in the nourishment mer of the second shelf at with an expiration date 3/7/19. a.m., an interview was a (other staff member) # 5, nen asked who responsible rishment supply room, OSM # re but the kitchen is only vices and the apple sauces." Expired items should be on the re, OSM # 5 stated, "No it with the date the responsible with the staff when the sarrive she rotates the old he supplies with the date the responsible with the date wit	F 7	61	DLITOLINGTY		
1	PASS (1) nutritional s facility nourishment re documented open da	ailed to ensure that a MED supplement observed in the efrigerator with a te of 04/08/19 was stored at re and discarded according					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		· 495236	B. WING	B. WING			04/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			2718	EET ADDRESS, CITY, STATE, ZIP CO 5 DOGTOWN ROAD OCHLAND, VA 23063	DDE		11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B	BE ATE	(X5) COMPLETION DATE
	On_4/16/19 at appropheness, RN # 1 stated, "No, at appreasing the open date of once opened. Aft RN # 1 stated, "No, at appreasing the open date, and open date, and open date of once opened. Aft RN # 1 stated, "No, at appreasing the open date, and open date, and open dependent of the open date of open date, and open dependent of the open date of open date, and open	eximately 11:22 a.m., an account and the potential supplement of the on the bottom shelf of the one	F 7	761		_		
,	why it should be thro	thrown away." When asked own away, RN # 1 stated, "It t could be growing bacteria."						
	documented, "5. ME NSA needs to be ke (34-40 degrees F) or temperature range, p from the time opener not refrigerated, prod	facturer's instructions D PASS® 2.0/MED PASS® of at refrigerated temperature nce opened. If kept at this product is good for 4 days d. If product is opened and duct should be discarded information was obtained						

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA RECTION IDENTIFICATION NUMBER:		TIPLE	1	(X3) DATE SURVEY COMPLETED		
		495236	B. WING				04/	17/2019
	PROVIDER OR SUPPLIER AT THE MEADOWS			271	EET ADDRESS, CITY, STATE, ZIP C 5 DOGTOWN ROAD OCHLAND, VA 23063	ODE		1172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD F	3E	(X5) COMPLETION DATE
F 761	Continued From pa from the website: http://www.hormelh /product-protocols/r	ealthlabs.com/product-support	F 7	61				
	(administrative staff director, ASM # 2, i services, and ASM	roximately 3:45 p.m., ASM member) # 1, the executive nterim director of clinical # 3, regional director of clinical e aware of the findings.			<u>-</u>	_		
	No further informati	on was obtained prior to exit.						
,	Reference:							
	help meet the nutriti dialysis. This inform website: https://www.amazon anilla-8-Ounce-Cont sr_1_4?hvadid=153 hy=9008455&hvnetv rand=103501540948	trition specifically designed to onal needs of people on ation was obtained from the n.com/Nutrition-Homemade-Vainers/dp/B000ARPKAS/ref=739360550&hvdev=c&hvlocpv=g&hvpos=1t1&hvqmt=e&hvB13125827&hvtargid=kwd-13ds=nepro+shakes&qid=15558sr=8-4						
	that helps manage b was obtained from the	/nutrition-products/glucerna-s						
	body requires extra p balance of good for y help gain or maintair use during surgical n	n that tastes great when your protein and calories. A you nutrients formulated to an optimal weight and for ecovery.						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		49 <i>5</i> 236	B. WING_		04/47/0040
1.	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	04/17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 761 F 803 SS=B	needs with fortified nu consistency makes it: diets. This information website: https://www.walgreensass-2.0-fortified-nutriti 0-product?ext=gooKB pla&adtype=pla&kpid=QobChMl8Zimnurf4QlABEgJA3PD_BwE_k_mnurf4QlVhYWzCh0T_BwE 4. Instant Food & Bev to use and safe for tho difficulties. Thicken up foods and liquids to be the taste. This informal website: http://www.hormelhealnr-100-4-5g Menus Meet Resident CFR(s): 483.60(c)(1)-(1)	tritional shake. The nectar suitable for a variety of was obtained from the s.com/store/c/hormel-med-ponal-shake/ID=prod610611 M_PLAHome_Medical& esku6094120&sst=_k_EAlal VhYWzCh0TPAZIEAQYAS &gdid=EAlalQobChMI8Zi PAZIEAQYASABEgJA3PD erage Thickeners are easy se with swallowing all varieties of hot and cold enjoyed without affecting tion was obtained from the shiabs.com/t-e-inst-food-thk Nds/Prep in Adv/Followed 7)	F 70	F 803 Menu Meet Resident Needs/Prep Advance/Followed 1.Food Service Director updated publis menu to accurately reflect what was be served for the lunch and dinner meal. 2.Food Service Director will round the facility to include the dinning room and bulletin board across the nurse's station ensure all menus are accurate in reflect	whole
	§483.60(c) Menus and Menus must- §483.60(c)(1) Meet the residents in accordance guidelines.;	nutritional needs of e with established national		what is being served for lunch and dinn Follow-ups done based on findings. 3. Food Service Director will be educated Healthcare Services District Manager of Daily manager rounds and closing roun Food service director will sign off on daily audit sheet 5 times a week for 5 weeks.	d by
	§483.60(c)(3) Be follow §483.60(c)(4) Reflect, b reasonable efforts, the	ed; pased on a facility's		4. The results of the Quality Monitoring reviewed at the monthly Quality Assura Performance Improvement (QAPI) mee for review, analysis, and further recommendations.	nce

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495236	B. WING		na	/17/2019
1	PROVIDÉR OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		711/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 803	input received from groups;	residents and resident	F 80	03		
	§483.60(c)(6) Be redietitian or other clir professional for nutrely \$483.60(c)(7) Nothing construed to limit the personal dietary choostrued the served and the limit the personal dietary choostrued to limit the food served for reflect the foods listed menu. The findings include the findings include on 4/14/19 at 1:04 professional findings include the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member) # 7, constitution of the staff member in t	on, staff interview, and facility are facility staff failed to ensure according to the published diner on 4/15/19 did not ed on the published lunch				
	food menu. When as posted, OSM # 7 sta on the bulletin board the wall across from of the menu posted a station was obtained was typed on a letter black and white letter approximately 14 to	in the dining room was missing the sked where the menus are posted in the dining room and on the nursing station. A copy across from the nursing from OSM # 7. The menu size piece of paper with a character size of 16 font. On the bottom of the tten, "All menus are subject				

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVE COMPLETED		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
		495236	B. WING				0/	1/17/2019	
ENVOY	PROVIDER OR SUPPLIER AT THE MEADOWS			2715	EET ADDRESS, CITY, STATE, ZIP C 5 DOGTOWN ROAD OCHLAND, VA 23063	ODE	J 02	W1772019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	NC
	to change- Dietary." On 4/14/19 at appropheness of the second of the se	eximately 4:30 p.m., team table in the kitchen perature check revealed the exprepared for dinner: green stuffing, hamburger paddies, eas, and steamed carrots. It sunday presented by OSM country fried chicken with ead potatoes, and e." eximately 2:07 p.m., a group cted with six alert and when asked about the dining cility, Resident # 28 stated, is, [pointing to the menus on ot right. They only change eak, sometime they are right are wrong." All other table nodded in agreement	F 8	03	DEPICIENCY)				
1	stated, "Yes, but we f week, I agree that the When asked to descr	orgot to change it to the right menu was not correct." ibe the process of notifying e menu changes, OSM # 5			· .		-		96

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3	B) DATE SURVEY COMPLETED
	495236 B. WING			04/17/2019	
NAME OF PROVIDER OR SUPPLE	S		STREET ADDRESS, CITY, STATE, ZIP 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	CODE	041112019
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
inform the resident inform the resident information in a large state in the ment in the me	page 195 nu is printed, posted, and we ents through the resident council. room to inform the residents." y it is important for the residents u in advance, OSM # 5 stated, s know what food to expect."	F 8	303		
On 04/16/19 at a phone interview dietitian. When a posting the ment posted on the buthe nursing static resident's tray list served." When a informed when the stated, "We let the meetings. Chancommittee include supervisor, and reshould be followed is being followed menu should have aware of the fact posted." OSM # will ensure better and the dietary mand the diet	pproximately 10:05 a.m., a was conducted with OSM # 6, sked to describe the process of a, OSM # 6 stated, "The menu is letin board in the dining room, at an and we put a ticket on the ting the food items being asked how residents are kept as menu changes, OSM # 6 em know during resident council ges are approved by a ing the dietary manager, her myself." When asked if the menu d and how to ensure the menu OSM # 6 stated, "Yes, the e been followed and I was not that the correct menu was not added that going forward she communication between herself anager regarding the menu. was important that the residents by balanced food at all times, If the nutrition schedule is not good practice."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495236	B. WING_			04	/17/2019
NAME OF F	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	
ENVOY A	T THE MEADOWS			2715	DOGTOWN ROAD		
	· · · · · · · · · · · · · · · · · · ·			G00	CHLAND, VA 23063		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETION DATE
				4.	The results of the Quality Monitorin	g to be	
				T re	eviewed at the monthly Quality Assu	rance	, , , , , , , , , , , , , , , , , , ,
F 803	Continued From page	196	F8		erformance Improvement (QAPI) m		1
	were made aware of t	he findings.			or review, analysis, and further	9-	
		•		re	ecommendations,		ļ
	No further information			1	F 812		
F 812		ore/Prepare/Serve-Sanitary	F8				
SS=E	CFR(s): 483.60(i)(1)(2	2)			.Food Service Director ensured that		5.78.19
				S	tored items were wrapped individua	lly and	" ' '
	§483.60(i) Food safety The facility must -	y requirements.			tored in a sanitary manner.		
	0.400.000747				food service director made sure that		
ı	§483.60(i)(1) - Procure				itchen equipment that was cleaned a		
	state or local authoritie	ed satisfactory by federal,		u	se was allowed to fully dry before st	oring.	
ĺ		od items obtained directly					
		subject to applicable State			.Food Service Director rounded who		
	and local laws or regul				acility to ensure that food was indivi	lually	İ .
		s not prohibit or prevent			rapped and that food processing		1
	facilities from using pro				quipment was dry prior to storing. F	ollow-	
		mpliance with applicable		u	ps done based on findings.		
	safe growing and food			١,	TO 10 1 TO 1		
		s not preclude residents			Food Service Director will be educa		
	from consuming foods	not procured by the facility.			lealthcare Services District Manager	on the	
	0.400.00(")(0)				nportance of storing food items		
	§483.60(i)(2) - Store, p				dividually to optimize sanitary cond		
Ì	serve food in accordar standards for food serv				ood Service Director will be educate		
		is not met as evidenced			lealthcare Services District Manager		1
	by:	is not met as evidenced			nportance of storing food preparatio		
		, staff interview, and facility			quipment after it has been allowed to		
i	document review it was				ry after being washed. Executive Dir		
	facility staff failed to sto				ill complete random kitchen inspecti	on	
	food in a sanitary mani				eekly for eight weeks. Food service		
	•				rector will sign off on daily audit she	et 5	
		ed to ensure a cart with		ti	mes a week for 5 weeks.		ŀ
		12 slices of cake on each		A	The worder of the O-12- NA	_ ,	
	tray was not left open t				The results of the Quality Monitorin	_ [
	refrigerator in the kitche	en.			eviewed at the monthly Quality Assu	I	1
	O The County of 200 H	-11			erformance Improvement (QAPI) m	eetings	ľ
	2. The facility staff faile	ed to maintain the food		- 1	r review, analysis, and further		
		-		re	commendations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			C	(X3) DATE SURVEY COMPLETED	
	495236						04/17/2019	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				2715	EET ADDRESS, CITY, STATE, ZIP COD 5 DOGTOWN ROAD OCHLAND, VA 23063	E	04.	117/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		OULD BI	ULD BE COMPLETION		
F 812	Continued From page 197 blender in a sanitary manner in the kitchen.		F8	12				
	The findings include:							
	1. The facility staff failed to ensure a cart with three trays containing 12 slices of cake on each tray was not left open to the air in the walk-in refrigerator in the kitchen.							
	facility's kitchen was staff member) # 7, t walk-in refrigerator with a sheet pan on the sheet pans reve with a slice of froste a total of 36 slices of observation of the strevealed a sheet of the cakes, but exposible the walk-in refrigeration of the slices of cake. Over the cake reveal fan was activated or was opened the covicake would be lifted the cakes to the control of the cakes to the control of the slices of cake.	p.m., an observation of the conducted with OSM (other he cook. Observation of the revealed a three shelf cart each shelf. Observation of aled twelve dessert plates d cake on each sheet pan for f cake on the cart. Further neet pans containing the cake wax paper covering the top of sing the sides of the cake. on of the rest of the items in cor, the refrigeration fan would toward the cart containing Observation of the covering ed that when the refrigeration the walk-in refrigerator door erings over the sheet pans of and moved further exposing taminates from the asked who prepared and						
j	covered the desserts On 4/14/19, at appro interview was conduc asked about the she of cake on the cart in OSM # 11 stated she	ximately 1:30 p.m., an oted with OSM # 11. When et pans containing the slices the walk-in refrigerator had prepared and covered g the sheet pans containing						

STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		_
		495236	B. WING			04/17/2019		
ENVO	NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CI 2715 DOGTOWN RO. GOOCHLAND, VA	AD	1 0	#11/2019	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)	BF	(X5) COMPLETION DATE	-
F 812	the slices of cake or refrigerator OSM #	ge 198 n the cart in the walk-in 11 stated, "They're not fully uld be wrapped separately."	F8	12				
	3. The facility staff the blender in a sanitary	ailed to maintain the food manner in the kitchen.						
	blender sitting on a factorial conducted. When a ready for use OSM # Observation of the factorial conducted inside of the pitcher describe the procedure.	ood blender revealed the was wet. When asked to ure for storing the pitcher for stated, "It should be dry						
	conducted with OSM OSM #5 was informed trays of cake slices of refrigerator OSM # 5 have been individual describe the procedu	a.m., an interview was # 5, dietary manager. After ed of the observation of the on the cart in the walk-in stated, "The cakes should y wrapped." When asked to ure for storing the food ted, "It is put it on the drying I then reassemble it."			•			
	(administrative staff r	oximately 3:43 p.m., ASM nember) #1, the executive , director of clinical services, the above findings.						
F 814 SS=F	No further information Dispose Garbage and CFR(s): 483.60(i)(4)	n was provided prior to exit. d Refuse Properly	F 81	1				
	§483.60(i)(4)- Dispos properly.	e of garbage and refuse						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION ÆACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 814 Continued From page 199 F 814 F 814 5.78.19 This REQUIREMENT is not met as evidenced 1.Food Service Director closed all dumpster by: lids and picked all debris to include gloves in Based on observation and staff interview, it was the surrounding area. determined that the facility staff failed to maintain the dumpster area in a sanitary manner. 2. Food Service Director conducted a comprehensive sweep of the dumpster area The facility staff failed to close the sliding doors to ensure that there was not any trash or on the facility's two dumpsters and maintain the area around the dumpsters free of trash. debris on the ground and that the dumpsters were tightly closed. Follow-ups done based The findings include: on findings. On 04/14/19 at approximately 1:40 p.m., an 3.Food Service Director will be educated by observation of the facility's dumpsters was Healthcare Services District Manager on conducted with OSM (other staff member) #7, Daily manager rounds and closing rounds the cook. with a focus on ensuring that the dumpster area is free of debris and that the dumpster Observation revealed the facility had two trash lids are closed. Executive Director will dumpsters and one cardboard recycling dumpster complete dumpster inspections weekly to located behind the facility. Observations of the ensure no food or debris is noted outside the area around the trash dumpsters revealed three dumpster. Food service director will sign off pairs of used plastic gloves, a piece of plastic on daily audit sheet 5 times a week for 5 bubble wrap and a used plastic bag lying on the ground next to and behind the trash dumpsters. weeks. Further review of the two trash dumpsters 4. The results of the Quality Monitoring to be revealed the sliding door on each dumpster was open. When asked about the debris lying on the reviewed at the monthly Quality Assurance ground around the dumpsters OSM stated, it Performance Improvement (QAPI) meetings should be picked up." When asked about the for review, analysis, and further dumpster doors being left open OSM stated, recommendations. "They should be closed" and was observed closing the sliding doors of the two trash dumpsters. On 04/16/19 at 8:03 a.m., an interview was conducted with OSM 5, dietary manager. When asked who was responsible for maintaining the dumpster area OSM # 5 stated, "The dietary

department is responsibility for taking care of the

PRINTED: 04/30/2019

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) E	DATE SURVEY OMPLETED
495236 B. WING			4/17/2019			
1	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP (2715 DOGTOWN ROAD GOOCHLAND, VA 23063		4/1//2019
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F 814	dumpster area. Whe the dumpster, if the staff should be picked dumpster and the deall times." On 04/06/19 at apprenticular appr	ge 200 nen you take the trash out to re is stuff on the ground the ing it and putting it in the pors should be kept closed at roximately 3:43 p.m., ASM member) #1, the executive	F8	14		
F 868 SS=F	director, and ASM #. were made aware o	2, director of clinical services, f the above findings. on was provided prior to exit.	F 86	58	·	
	§483.75(g) Quality a §483.75(g)(1) A facil assessment and ass at a minimum of: (i) The director of nu (ii) The Medical Direction (iii) At least three oth staff, at least one of	ssessment and assurance. ity must maintain a quality surance committee consisting rsing services; ctor or his/her designee; er members of the facility's who must be the , a board member or other				
	assurance committee (i) Meet at least quar identifying issues with assessment and ass	terly and as needed to a respect to which quality				
	by: Based on staff interv review, it was determ failed to ensure the C	is not met as evidenced iew and facility document ined that the facility staff API (quality assurance and ment) committee met at		Past noncompliance: no pla correction required.	an of	

	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONS		(X3) D	X3) DATE SURVEY COMPLETED	
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1	PROVIDER OR SUPPLIER AT THE MEADOWS		• • • • • • • • • • • • • • • • • • • •	2715 DOC	ADDRESS, CITY, STATE, ZIP CO GTOWN ROAD LAND, VA 23063	DDE	4/17/2019	
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F 868	least quarterly. The facility staff fails committee met at le through April 2019. The findings include On 4/17/19 at 10:33 QAPI was conducted staff member) #1 (the staff member) #1 (the #2 (the interim direct ASM #3 (the regional ASM #1 was asked the process. ASM #1 st	ed to evidence the QAPI ast quarterly from April 2018 a.m., an interview regarding d with ASM (administrative are executive director), ASM tor of clinical services) and all director of clinical services). to explain the facility QAPI atted the QAPI committee	F 8	68				
	medical director, the nursing staff and dep stated the committed looks at any new are improvement, review corrections, develops reviews systematic dactions that are need At this time, ASM #1 provide evidence that	consists of himself, the director of clinical services, partment heads. ASM #1 ediscusses old business, as of opportunity for any outstanding plans of s new plans of correction, ata and engages in any led to be done as a result. confirmed he could not the QAPI committee met at april 2018 through April 2019.						
	QAPI sign-in sheet do could not provide any meetings until Januar identified an issue wit meetings and develop The plan of correction "1. Facility leadership	n dated 1/11/19 documented, will be educated having gs by the RDCS (regional						

STATEME AND PLAR	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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ŀ	F PROVIDER OR SUPPLIER			2715	ET ADDRESS, CITY, STA DOGTOWN ROAD OCHLAND, VA 2306		<u> U4</u>	/17/2019	
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F 868	2. Residents that repotential to be affected. 3. The facility will had document minutes will monthly." This plan of correctian approved by the surfound to be in compound to be in compound to be in compound the facility QAPI plane.	side in the facility have the sted. ave monthly meetings and and signature sheets. I be reviewed by the RDCS on was reviewed, verified and vey team. The facility was liance during the survey. an documented, "QAPI is will be conducted.	. F &	68					
F 880 SS=D	CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must estrinfection prevention designed to provide comfortable environry development and tradiseases and infection §483.80(a) Infection program. The facility must esta and control program a minimum, the follow §483.80(a)(1) A syste reporting, investigating and communicable d	ontrol ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at	F 84	30					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		3) DATE SURVEY COMPLETED	
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	conducted according accepted national star \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveill possible communicabin infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and transto be followed to preve (iv) When and how isol resident; including but (A) The type and durate depending upon the ininvolved, and (B) A requirement that least restrictive possibic circumstances. (v) The circumstances must prohibit employed disease or infected ski contact with residents contact will transmit the (vi) The hand hygiene possibility staff involved in directions.	der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a not limited to: tion of the isolation, ifectious agent or organism the isolation should be the le for the resident under the under which the facility es with a communicable in lesions from direct or their food, if direct e disease; and procedures to be followed ect resident contact. In for recording incidents stility's IPCP and the	FE	1. The incentive spirometer deresident # 60 was removed from due to no physician ord meals are served with proper includes not touching the edg while serving food. 2. Resident's rooms with physician respiratory equipment have be for proper infection control proper infection control proper infection control proper infection. Follow conducted for proper hand he to prevent infection. Follow conducted based on findings. 3. Licensed nurse will be recensuring residents have phys for respiratory devices in use of Nursing or designee. The nursing staff will be re-educated meal delivery in accordance with the infection control practices by designee. A quality review of room will be conducted to en respiratory equipment is mais sanitary condition by the DO weekly for eight weeks. A quinciple meal delivery will be completed to entre infection control practices by the DON or densure infection control practices followed.	om resident ler. Resident's ler. Resident's le technique that le of the plate sician orders for been assessed bractices as of ing staff. Staff ve been lygiene etiquette up to be ducated on ician's order by the Director certified leted of proper with good the DON or f resident's sure intained in a N or designee lality review of leted weekly for lesignee to	5.28.19	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495236	B. WING_	·		04	1/17/2019	
	ROVIDER OR SUPPLIER T THE MEADOWS			271	REET ADDRESS, CITY, STATE, ZIP CODE 15 DOGTOWN ROAD OCHLAND, VA 23063	- <u></u>		
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F 880	infection.	e, store, process, and to prevent the spread of	F 8		4. The results of the quality monitoring be reported to the quality assurance committee for review, analysis and fur recommendations.	_		
	IPCP and update their This REQUIREMENT by: Based on observation interview and clinical r determined that the far implement infection co 41 residents in the sur and in the facility dining. 1. The facility staff faile incentive spirometer (1 and sanitary manner to 2. The facility staff faile incentive spirometer (2 and sanitary manner to 2. The facility staff faile hands after touching the then touched the edge serving food in the dinit The findings include: 1. Resident #60 was a 2/22/19. Resident #60' were not limited to chrodisease (2), heart failur #60's most recent MDS day Medicare assessm (assessment reference	at an annual review of its program, as necessary. is not met as evidenced at necessary, is not met as evidenced at program, as necessary. It is not met as evidenced at necessary, it is not met as evidenced at the staff failed to a not practices for one of every sample, Resident #60, and the staff failed to a clean at the prevent infection. The staff failed to a clean a clean a prevent infection. The food service cart, and a for resident's plate, while and room. In a diagnoses included but the staff failed at the staff						
	dressing, toilet use and	personal hygiene.					!	

MME OF PROVIDER OR SUPPLIER ENVOYAT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES PRECED BY FULL REGULATION OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 205 Review of physician's order sheet for Resident #60 signed by the physician on 4/15/19 falled to reveal an order for an incentive spirometer. Resident #60's comprehensive care plan dated 3/13/19 documented, "The resident #so was exposed to patential contaminates in the air. On 4/15/19 at 8:59 a.m., an interview was exposed to patential contaminates in the air. On 4/15/19 at 8:59 a.m., an interview was conducted with Resident #60 stated he has not had to use the incentive spirometer fately, but he uses it when he feels like he needs to. On 4/15/19 at 10:27 a.m., an interview was conducted with Resident #60 stated he has not had to use the incentive spirometer fately, but he uses it when he feels like he needs to. On 4/15/19 at 10:27 a.m., an interview was conducted with RN (registered nurso) #1. RN #1 was asked how an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored the bedside in a respiratory bag with the date and the resident's name on it. When asked why, RN #1 stated, Contamination and to keep dust off oil and make sure it doesn't get used by another resident and we have to keep dates on overything." On 4/16/19 at 8:51 a.m., ASM (administrative staff membor) #1 (the executive director) and ASM #2 (the director of clinical services) were		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ENVOY AT THE MEADOWS SUMMARY STATEMENT OF DEFICIENCIES PRECIDENCY MUST BE PRECEDED BY FULL REGULATION YOR LES IDENTIFYING INFORMATION) F 880 Continued From page 205 Review of physician's order sheet for Resident #60 signed by the physician or 4/15/19 falled to reveal an ordor for an incentive spirometer, Resident #60's comprehensive care plan dated 3/13/19 documented, "The resident has potential for altered respiratory status/difficulty breathing" The care plan failed to document specific information regarding an incentive spirometer. On 4/14/19 at 2:43 p.m., 4/14/19 at 3:49 p.m., and 4/15/19 at 8:59 a.m., Resident #60 was observed lying in bed. An uncovered incentive spirometer was observed on a table in the resident #60 stated he has not had to use the incentive spirometer lately, but he uses it when he feols like he needs to. On 4/15/19 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how an incentive spirometer should be stored at the bedside in a respiratory bag with the date and the resident's name on it. When asked why, RN #1 stated, "Contamination and to keep dust of of it and make sure it doesn't get used by another resident and we have to keep dats on everything." On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and			495236	B. WING)		1/17/0010	
F8EPX TAG HEGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 205 Review of physician's order sheet for Resident #600 signed by the physician on 4/15/19 failed to reveal an order for an incentive spirometer, Resident.#602 comprehensive.care plan dated 3/13/19 documented, 'The resident has potential for altered respiratory status/difficulty breathing" The care plan failed to document specific information regarding an incentive spirometer. On 4/14/19 at 2:43 p.m., 4/14/19 at 3:49 p.m., and 4/15/19 at 8:59 a.m., Resident #60 was observed lying in bed. An uncovered incentive spirometer was observed on a table in the resident's room. The mouthplace was exposed to potential contaminates in the air. On 4/15/19 at 8:59 a.m., an interview was conducted with Resident #60 stated he has not had to use the incentive spirometer lately, but he uses it when he fools like he needs to. On 4/15/19 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored at the bedside in a respiratory bag with the date and the resident's name on it. When asked why, RN #1 stated, 'Contamination and to keep dust off of it and make sure it doesn't get used by another resident and we have to keep dates on everything." On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and	ł				2715 DOGTOWN ROAD		#1772019 	
Review of physician's order sheet for Resident #80 signed by the physician on 4/15/19 failed to reveal an order for an incentive spirometer. Rasident.#60's comprehensive.care plan dated 3/13/19 documented, "The resident has potential for altered respiratory status/difficulty breathing" The care plan failed to document specific information regarding an incentive spirometer. On 4/14/19 at 2:43 p.m., 4/14/19 at 3:49 p.m., and 4/15/19 at 8:59 a.m., Resident #60 was observed lying in bed. An uncovered incentive spirometer was observed on a table in the resident's room. The mouthpiece was exposed to potential contaminates in the air. On 4/15/19 at 8:59 a.m., an interview was conducted with Resident #60, regarding the incentive spirometer. Resident #60 stated he has not had to use the incentive spirometer lately, but he uses it when he feels like he needs to. On 4/15/19 at 10:27 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked how an incentive spirometer should be stored. RN #1 stated an incentive spirometer should be stored at the bedside in a respiratory bag with the date and the resident's name on it. When asked why, RN #1 stated, "Contamination and to keep dust off of it and make sure it doesn't get used by another resident and we have to keep dates on everything." On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF.	IX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE		
made aware of the above concern. The facility policy titled, "Incentive Spirometer" failed to document information regarding		Review of physiciar #60 signed by the preveal an order for a Resident #60's com 3/13/19 documente for altered respirato. The care plan failed information regardin. On 4/14/19 at 2:43 pand 4/15/19 at 8:59 observed lying in be spirometer was observed lying in be spirometer was observed lying in the spirometer was observed lying in the spirometer was observed lying in the spirometer was observed lying in the spirometer was observed lying in the spirometer was observed lying in the potential contaminat 8:59 a.m., an interesident #60, regard Resident #60 stated incentive spirometer feels like he needs to the spirometer feels like he needs to the spirometer feels like he needs to a stated with RN (was asked how an instored. RN #1 states should be stored at the bag with the date and When asked why, Rl and to keep dust off get used by another keep dates on every the condition of the altered and a ware of the altered and a ware of the altered and a ware of the altered and the facility policy title.	aris order sheet for Resident physician on 4/15/19 failed to an incentive spirometer. Incertive spirometer plan dated down, "The resident has potential ry status/difficulty breathing" It to document specificing an incentive spirometer. D.m., 4/14/19 at 3:49 p.m., a.m., Resident #60 was down at able in the enduthpiece was exposed that in the air. On 4/15/19 rview was conducted with ding the incentive spirometer. The has not had to use the lately, but he uses it when he down an incentive spirometer should be down an incentive spirometer should be down an incentive spirometer should be down an incentive spirometer should be down and incentive spirometer should be down and make sure it doesn't resident and we have to thing." D.M., ASM (administrative executive director) and of clinical services) were bove concern.	FE	380			

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495236	B. WING	ì	-	04	17/2019
	NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CITY, STAT 2715 DOGTOWN ROAD GOOCHLAND, VA 23063		1 04/	17/2019
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	incentive spiromed No further information (1) "An incentive shelp you keep you when you have a! pneumonia. Using teaches you how to Deep breathing keep and healthy while yproblems, like pneemont with the you take deep breathing by the device called an inyou take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take deep breathing to take the lings of the lings are demphysema. The national to the lings of the lings, smoke. Air pollutions	ter storage. Ition was presented prior to exit. pirometer is a device used to r lungs healthy after surgery or ung illness, such as the incentive spirometer to take slow deep breaths. eps your lungs well-inflated you heal and helps prevent lung umonia.	F8	BEFICI 380	ENCY)		
	https://vsearch.nlm. meta?v%3Aproject= medlineplus-bundle	nih.gov/vivisimo/cgi-bin/query- -medlineplus&v%3Asources= &query=copd&_ga=2.106270 -5589628-1667741437.15501					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495236	B. WING		İ	04/17/2019	
	PROVIDER OR SUPPLIER AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP C 2715 DOGTOWN ROAD GOOCHLAND, VA 23063	ODE	04/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION E DATE	
F 880	The facility staff hands after touchir	failed to wash or sanitize their g the food service cart, and dge of resident's plate, while	Fa	380			
	observation was m breakfast meal. The CNA (Certified nurse opening the kitcher from table to table, sanitizing her hands drinks. CNA #2, #3 member) #3 were oplates with bare harrim of the plate frootable, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plate from table, placing the plates from table, plate from table, place from table, plate from table, plate from table, plate from table, plate from table, plate from table, plate from table, plate from table, plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates, it would be considered in the plates.	in 7:30 a.m. and 8:04 a.m., an ade of the dining room for the de following was observed: The assistant) #1 was observed a door, pushing a serving tray and without washing or as, she served residents their and their					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
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	hands before or you and get a new one of the plate or the inference of the plate or the inference of the plate or the inference of the plate, shiplastic plate under CNA #3 was asked were on the top rimproblem, she state not be where the form of the facility's policy for of the facility's policy for of the facility's policy for of the facility's policy for of the facility's policy for of the facility is policy for of the facility in a revision date part, "Overview: The Control) defines hat hands by using eith hand rubsPurpos germs in the health hygiene should be planimate objects vicinity"	would need to toss the plate. You don't ever touch the top im of the plate." When CNA emonstrate how to hold a e demonstrated holding a neath the plastic plate. When I if a server's bare thumbs of the place, would that be a d, "Yes, your thumbs should bod is." 2 p.m., a request for the lining and serving meals was lity's policy for "Hand Hygiene" of 8/29/17 that documented in e CDC (Center for Disease and hygiene as cleaning your mer handwashing, antiseptic set to reduce the spread of care settingProcess: Hand performed: After contact with in the immediate patient. 2 AM, ASM (Administrative tated, "There is no policy for	F 8	80				
	Patricia A. Potter ar Inc; Page 655. "The principles and proce precautions, to prev its spread. During ouses basic medical	f Nursing" 7th edition, 2009: ad Anne Griffin Perry: Mosby, e nurse follows certain edures, including standard eent and control infection and faily routine care, the nurse aseptic techniques to break A major component of client						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA CO	TE SURVEY WPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From particular Contaminated hand primary source of in care settings."	ge 209 s of health care workers are a fection transmission in health	F 8	80		
F 925 SS=C	Director), AMS #3 (I Services), and ASM Clinical Services) we findings. No further the end of the surve	Pest Control Program	F 92	25	w	
	program so that the rodents. This REQUIREMEN by: Based on observation interview, and facility determined the facility determined the facility determined the facility effective pest control is free of pests, A blasize, on the floor on thall from the nourish. The findings include: During the initial pool alert and oriented resident and oriented resident six alert on 4/15/19 at 2:07 p. conducted with six alert residents voiced one resident stated,	m., a group interview was ert and oriented residents. concern of spider sightings. "I've been here for four ed once, 2 years ago, and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495236	B. WING		0.	1/17/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	of a black spider, a que floor on the 100 hallwar nourishment room. An interview was concurring assistant) #1 of When asked about the follows if they see a be would get a paper town dead and tell houseked document any bug sight stated, "Not that I'm average of the same black spider approximately four tile the original sighting. An interview was conducted practical nurse) #1, on asked staff are suppossor spider, LPN #1 states squish it. I tell maintenas When asked if they write maintenance or housely stated, "I honestly don't observation was made on 4/15/19 at 2:29 p.m. hall approximately eigh the original tile. At 2:30 and disposed of the spider.	e on 4/15/19 at 2:22 p.m., arter round in size, on the ay across the hall from the flucted with CNA (certified on 4/15/19 at 2:23 p.m. a facility process staff ag/spider, CNA #1 stated, "I sel, squish it to ensure it's seping." When asked if they have of." a on 4/15/19 at 2:25 p.m. of moving down the hallway lengths or four feet from the same black spider, anything down for seeping anywhere, LPN #1 at know." of the same black spider, moving again down the tiles or eight feet, from p.m., a staff member went der. acted with other staff director of maintenance, When asked how the	F 92	1.Professional exterminator tre for spiders on 4/29/2019. 2.Maintenance Director or Desiconduct facility rounds to inclurooms and external points of enidentify any other signs of pest needed. 3.Residents will be asked in the resident counsel meeting to repsightings of pest for 3 months. Staff will be educated on approcommunicating any pest sighting Maintenance Director or Execut Maintenance Director will main relationship with professional eservice and have them treat the regular periodic cycle based on recommendations and findings 4. The results of the Quality Moreviewed at the monthly Quality Performance Improvement (Quality Performance Improveme	ignee will de residents' atry to and treat as e monthly oort any priately ngs to the ative Director. atain a exterminator e facility on a their onitoring to be ty Assurance API) meetings	5.28.19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/30/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING 495236 B. WING 04/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD **ENVOY AT THE MEADOWS** GOOCHLAND, VA 23063 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 925 Continued From page 211 F 925 OSM #1 stated, "They tell me or write a note in the maintenance log book." When asked if the facility has had any problems with bugs lately, OSM #1 stated, "No, not this year." The above observations and resident interviews were shared with OSM #1. He stated no one has said anything to him. OSM #1 was asked to bring the documentation of the pest control company visits to the facility. The maintenance logbook at the nurse's station was reviewed. There was no documentation of bug/spider sightings documented back through November 2018. The pest control reports were reviewed. The pest control company was in the facility on 4/9/19, 3/12/19, 2/5/19 and 1/2/19. The documentation failed to evidence anything related to spiders. The facility policy, "Pest Control" documented in part, "Policy: The facility will maintain a pest control program, which includes inspection. reporting and prevention. Procedure: 1. A pest control contract will be maintained with a licensed exterminator. 2. The contract will include routine quarterly inspections. 3. Treatment will be

rendered as required to control insects and vermin. 4. Any unusual occurrence or sighting of insects should be reported immediately to the Supervisor (See Policy - Maintenance Repair Request Form). Proper action will be taken."

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of clinical services and ASM #3, the regional director of clinical services were made aware of the above

concern on 4/15/19 at 4:58 p.m.

STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED			
			A BOILDING		COM LETE			
495236			B. WING	B. WING			04/17/2019	
NAMEOF	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	17/2019	
ENVOY	AT THE MEADOWS	•		2	715 DOGTOWN ROAD			
				GOOCHLAND, VA 23063				
(X4) ID) ID SUMMARY STATEMENT OF DEFICIENCIES			I	PROVIDER'S PLAN OF CORRECTION		(Y5)	
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BF	(X5) COMPLETION DATE	
					DEFICIENCY)	PAIE		
_	D047 D		E 047 D	F 047 December 11				
F 925	No further information was provided prior to exit.		F 9	925	F 947 Required In-service training for aides	nurse		
					atues			
F 947	Required In-Service	Training for Nurse Aides	F9	947	1.Employee CNA#2 will complete the	12		
SS≕E	CFR(s): 483.95(g)(1)-(4)			hours of annual training by May 20, 20	19.	5.28-14	
	8483.95(a) Required	in-service training for purco	1				_	
	aides.	483.95(g) Required in-service training for nurse des.			Employee CNA#7 will complete the 12	hours		
	In-service training must-			ľ	of annual training to include Dementia training by May 20, 2019.			
			}					
	§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.				Employee CNA#8 will complete the 12	hours	į	
ł					of annual training to include Dementia			
ĺ	00 110 1000 than 12 ft	ours per year.	1		training by May 20,2019.			
]	§483.95(g)(2) Include dementia management			ļ	Employee CNA#9 will complete the 12 i	<u> </u>		
	training and resident		ł	of annual training to include Dementia	iours			
	\$ 400 OF/-\/O\ A -L-I				training by May 20, 2019.			
}	§483.95(g)(3) Address areas of weakness as						1	
	determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may			Employee CNA#10 will complete the 12			1	
1	address the special n	eeds of residents as		1	hours of annual training by May 20, 20	19.		
1	determined by the fac	cility staff.			Employee CNA#11 will complete the 12	ŀ		
	2400 OF (-) (4) F			İ	hours of annual training to include		1	
	9483.95(g)(4) For nur to individuals with see	se aides providing services politive impairments, also	ļ	-	Dementia training by May 20, 2019.			
	address the care of th	e cognitively impaired			Employee CNA #42			
address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced			İ	Employee CNA#12 will complete the 12 hours of annual training to include	-			
by:				Dementia training by May 20, 2019.				
	Based on staff intervi	ew and facility document			2 months of anning by 141ay 20, 2019.	ļ		
review, it was determined that the facility staff				Employee CNA#13 will complete the 12				
failed to provide the required annual in-service trainings for ten of ten CNA (certified nursing			1	hours of annual training to include		ŀ		
'	assistant) record revis	SMS.			Dementia training by May 20, 2019.	.		
					Employee CNA#14 will complete the 12	. }		
7	The facility staff failed	to provide the required			hours of annual training to include			
E	innual 12 hours and/o	or dementia management			Dementia training by May 20, 2019.			
1	rainings for CNAs #2, 113, #14 and #15.	#7, #8, #9, #10, #11, #12,			•			
#	10, # 14 allu # 15.				Employee CNA#15 will complete the 12	.		
T	he findings include:				hours of annual training to include			
1	Ģ		•		Dementia Training by May 20, 2019.	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495236	B. WING	à		04	/17/2010	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	On 4/15/19 at 10:20 were employed at t year was provided I #4 (the regional dire this surveyor's requivers and on 4/15/19 at 10 (administrative staff director of clinical set the annual 12 hours annual dementia mac CNAs. Review of trainings 12 hours of annual recons of annual recons 12 hours of annual recons 12 hours of annual recons 12 hours of annual recons 12 hours of annual recons 14 (hired on 1/2 CNA #2 (hired on 1/2 CNA #10 (hired on 2 CNA #11 (hired on 5 CNA #12 (hired on 3 CNA #14 (hired on 1 CNA #15 (hired on 9)) Review of trainings factors are recons 10 cna #15 (hired on 9).	Da.m., a list of CNAs who he facility for more than one by OSM (other staff member) ector of human resources), per est. As was selected from the list 0:36 a.m., ASM member) #3 (the regional ervices) was asked to provide to frequired training and anagement training for the ten for the CNAs failed to reveal required training for all ten (21/18) (11/17) (1/29/14) (1/3/04) (1/4/00) (1/27/14) (1/3/04) (1/4/00) (1/27/14) (1/3/18) (1/21/16)	FS	347	2. Human Resource Manager or Design will review all actively employed nurse to ensure that 12 hours of in-service education to include dementia manager training was conducted in the last 12 months. Follow ups will be done based findings. 3. Human Resources Manager will be educated on ensuring that every activel employed nurse aide has 12 hours of inservice training to include dementia management within the last 12 months Executive Director or Designee. Huma Resource Manager will ensure that more forward nurse aides have 12 hours of its service training to include dementia management yearly. Monthly annivers dates will be reviewed by the executive director to ensure 12 hours of education have been completed for three months. 4. The results of the Quality Monitoring reviewed at the monthly Quality Assura Performance Improvement (QAPI) meet for review, analysis, and further recommendations.	aides ment on by n ving n- sary to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		495236	B. WING			04/47/0040	
NAME OF PROVIDER OR SUPPLIER ENVOY AT THE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2715 DOGTOWN ROAD GOOCHLAND, VA 23063				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH	(X5) COMPLETION DATE		
F 947	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 9	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE		
	followed accordingly.	r Local regulations are ." n was presented prior to exit.					