State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/14/19 through 4/17/19. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 84 certified bed facility was 75 at the time of the survey. The survey sample consisted of 37 current resident reviews and four closed record reviews.	F 000	**Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under the State and Federal law. This plan of correction will serve as the facility's allegation of substantial compliance.**	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140 Policies and procedures - SEE CITATION BELOW: Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to follow the Code of Virginia for pre-screening prior to hire requirements for ten of 25 reviewed employee records, OSM (other staff members) # 15, #16, #17, #3, #9, #10, LPN (licensed practical nurse) #6, LPN #7, RN (registered nurse) #1 and RN #7. 1. The facility staff failed to obtain a criminal background check at the time of hire for OSM # 15 (receptionist). 2. The facility staff failed to obtain reference checks at the time of hire/transfer for OSM # 16 (business office manager). 3. The facility staff failed to obtain OSM # 17's (activates coordinator) reference checks.	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathon Jorell — TITLE: Executive Director — (X6) DATE: 5/23/19

State of Virginia

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F 001	Continued From Page 1	F 001		

4. The facility staff failed to obtain OSM # 3's (social services director) sworn statement and reference checks at the time of hire.

5. The facility staff failed to obtain OSM #9's (environmental services), sworn statement and reference checks at the time of hire.

6. The facility staff failed to obtain OSM # 10's (environmental services) reference checks at the time of hire.

7. The facility staff failed to verify LPN (licensed practical nurse) # 7's license at the time of hire, and failed to obtain reference checks at the time of hire.

8. The facility staff failed to verify LPN # 6's license and obtain a criminal back ground check at the time of hire, and failed to obtain complete reference checks.

9. The facility staff failed to verify RN (registered nurse) #7's license and obtain a criminal background check at the time of hire.

10. The facility staff failed to obtain RN # 1's reference checks at time of hire.

The findings include:

1. The facility staff failed to obtain a criminal background check at the time of hire for OSM # 15 (receptionist).

OSM # 15 (receptionist) was hired on date 5/2/18. Review of OSM #15's employee record revealed OSM #15's criminal background check completed 4/19/19.
On 4/16/19 at approximately 10:40 a.m., an

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F 001	Continued From Page 2 interview was conducted with OSM #4 (regional director of human resources) regarding the facility process for screening and hiring new employees. OSM #4 stated, "Applicant first schedule an interview to gauge them. Then if good schedule a second interview, and meet administer, to make sure good fit. Offer the job discuss pay. Then start the process, check license make sure current, in good standing, do criminal background check through Virginia State police, do OIG (office of inspector general), drug screen. Wait for the results to come back. If there is something, the company mails it to make sure there are no barrier crimes. Send off two reference checks from previous employer. During this time they (potential employee) stay home pending the 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 #15's criminal background check and OSM #4 was provided OSM #15'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 4/16/19, ASM (administrative staff member) #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	F 001		

State of Virginia

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F 001	Continued From Page 3 OIG and reference checks, go back and correct it but did not document it in the action plan." On 4/17/19 at approximately 2:00 p.m., in a follow up interview OSM #4 stated OSM #15's hire date was 5/2/18, and when reviewing the employee record it was noted the background check was missing and it was obtained on 4/14/19. At this time, OSM #4 was informed of the findings. (Note, this could not be cited as past noncompliance as OSM #9 (environmental services) was hired on date 3/14/19. Review of OSM #9's employee record revealed no sworn statement, and no reference checks in the file and the facility had not self-corrected the deficiency.) The facility policy with an effective date of 11/30/14 and revision date of 11/28/17, titled, "Abuse, Neglect, Exploitation & Misappropriation" documented in part, "1. Screening: Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but is not limited to: Employment history Criminal Background check Abuse check with appropriate licensing board and registries, prior to hire Sworn Disclosure Statement prior to hire Documentation of status of any disciplinary actions form (sic.) licensing or registration boards and other registries Information from former employers." The facility policy with an effective date of 11/30/14 and revision date of 9/1/2017 titled, "Background Checks" documented in part the following, "Policy: It is the policy of The Company to conduct background checks to include criminal background checks, ..." On page five of seven	F 001		

State of Virginia

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F 001	Continued From Page 4 under the heading "Background Check Process" the following is documented in part, "Candidates may be give a conditional offer of employment pending the successful completion of the background check unless otherwise prohibited by law. Under no circumstance is a job candidate to begin work until the candidate's background check is completed and a positive report is received, unless state requirements allows a mechanism to begin employment prior to receipt pf background check (please refer to your state specific requirements)." No further information was presented prior to exit. 2. The facility staff failed to obtain reference checks at the time of hire/transfer for OSM # 16 (business office manager). OSM #16 was hired on 2/14/19. Review of OSM #16's employee record revealed the criminal background check and sworn statement were completed on 10/30/18. OSM #16's employee record failed to evidence any 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 #16's sworn statement, criminal background check and lack of references. OSM #4 was provided OSM #16'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, "OSM #16	F 001		

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F 001	Continued From Page 5 transferred and the hire date with us is 2/14/19. The background check and sworn statement were completed prior to her transfer at the original time of hire, but there are no reference checks." OSM #4 was informed of the findings at this time. The facility policy with a revision date of 1/10/2018, and effective date of 11/30/14 titled, "Employment Application Procedure" documented in part the following: "Policy: It is the policy that all individuals interested in an open position with the company must complete and sign an employment application and provide reference. All employment offers are contingent upon successful completion and satisfactory results of credentialing and reference checks." "The Human Resource Representative must obtain a favorable or neutral reference from at least two of the references listed prior to the applicant starting work. Records of all reference checks, whether successful or not, must be retained with the employment application. Applications for individuals who are hired must be retained in the employee's personnel file." No further information was presented. 3. The facility staff failed to obtain OSM # 17's (activates coordinator) reference checks. OSM #17 was hired on 5/16/18. Review of OSM #17's employee record failed to reveal any reference checks prior to or at the time of hire in the employee file. 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. OSM #4 stated, "Send off two reference checks from previous employer. During this time they (potential employee) stay home pending the	F 001		

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F 001	Continued From Page 6 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 lack of sworn statement and reference checks in the employee file. OSM #4 was provided OSM #3'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 2:05 p.m., in a follow up interview OSM #4 brought OSM #3's employee	F 001		

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F 001	Continued From Page 7 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 failed to obtain OSM #9's (environmental services), sworn statement and reference checks. OSM #9 (environmental services) was hired on date 3/14/19. Review of OSM #9's employee record revealed no sworn statement, and no reference checks in the file. 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 #9's lack of sworn statement and reference checks in the employee file. OSM #4 was provided OSM #9'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 4/16/19, ASM (administrative staff member) #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	F 001		

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F 001	Continued From Page 8 OIG and reference checks, go back and correct it but did not document it in the action plan." However, review of OSM #10's employee file revealed OSM #10 was hired on 3/14/19 after the date the facility had completed the QAPI and education of staff. On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding OSM #9's missing sworn statement and reference checks, OSM #4 stated, "There is no sworn statement and no reference checks." No further information was presented prior to exit. 6. The facility staff failed to obtain OSM # 10's (environmental services) reference checks. OSM # 10 (environmental services) hire date was 3/15/19, review of OSM #10'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 OSM #10's lack of reference checks in the employee file. OSM #4 was provided OSM #10'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 4/16/19, ASM (administrative staff member) #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	F 001		

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F 001	Continued From Page 9 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." In addition, review of OSM #10's employee file revealed OSM #10 was hired on 3/15/19, after the date the facility had completed the QAPI and education of staff. On 4/17/19 at approximately 2:05 p.m., in a follow up interview regarding OSM #10's missing reference checks, OSM #4 stated, "I do not have reference checks." No further information was presented prior to exit. 7. The facility staff failed to verify LPN (licensed practical nurse) # 7's license at the time of hire, and failed to obtain reference checks at the time of hire. LPN #7 was hired on 4/1/19. Review of LPN #7's employee record revealed the criminal background check was completed on 6/7/18, and the license verification was obtained on 9/18/18. 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 LPN #7's criminal records check, license verification at the time of hire and lack of reference checks in the employee file. OSM #4 was provided the employee file for LPN #7, in	F 001		

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F 001	Continued From Page 10 addition to other employee files. OSM #4 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 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." No further information was presented prior to exit. 8. The facility staff failed to verify LPN # 6's license and obtain a criminal back ground check at the time of hire, and failed to obtain complete reference checks. LPN # 6 was hired on 8/23/18. Review of LPN #6's employee record revealed a background check dated, 4/14/19. LPN #6's license look up verification was dated 4/14/19, and only one of two reference verifications could be located 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 LPN #6's criminal records check, license verification at the time of hire and lack of two reference checks in the employee file. OSM #4 was provided the employee file for LPN #6, in addition to other employee files. OSM #4 was asked to provide any additional information	F 001		

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F 001	Continued From Page 11 /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,	F 001		

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F 001	Continued From Page 12 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 Deficiceny - 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	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 001	Continued From Page 13 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 Nusrsing 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. 12VAC5-371-220. Nursing Services cross reference to F686. 12VAC5-371-220. Nursing Services	F 001		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 001	Continued From Page 14 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	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 001	Continued From Page 15 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	F 001		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495236	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/17/2019
NAME OF PROVIDER OR SUPPLIER: ENVOY AT THE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE: 2715 DOGTOWN ROAD GOOCHLAND, VA		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 804	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive 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. 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. 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 Production/Preparation" with a revision date of 7/27/18 documented in

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495236	A. BUILDING: _____ B. WING _____	4/17/2019

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 804	Continued From Page 1 part, "Policy: Food will be prepared ...as outlined in the most current FDA (Federal Drug Administration) Food Code using methods that conserve nutritive value, quality, flavor and appearance." 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 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 4/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000	**Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under the State and Federal law. This plan of correction will serve as the facility's allegation of substantial compliance.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/14/19 through 4/17/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 84 certified bed facility was 75 at the time of the survey. The survey sample consisted of 37 current resident reviews and four closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathan Tonell | TITLE: Executive Director | (X6) DATE: 5/23/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure and promote dignity for one of 41 residents in the survey sample, Resident #69. The facility staff failed to ensure and promote dignity for Resident #69 as it was observed that the Resident's indwelling urinary catheter (1) collection bag was uncovered during observation. The findings include:	F 550	**F550** **1. Resident # 69 continues to require the use of an indwelling urinary catheter collection bag. The current urinary catheter collection bag system used contains an attached occlusive cover that provides privacy and enhances dignity for resident.** **2. Residents with physician orders for indwelling urinary catheters or a visible collection drainage system /device have been assessed for providing privacy as of 5/9/2019. No other residents were affected.** **3. Licensed nursing staff will be re educated by Director of Nursing (DON) or designee on resident's right to privacy with respect to Foley catheter drainage/collection bag being managed to maintain or enhance dignity. DON /designee will conduct quality reviews weekly for eight weeks to ensure privacy drainage system are in place for residents with indwelling catheters and other devices.** **4. The results of the quality monitoring data to be reviewed by the quality assurance committee team monthly for review, analysis and further recommendations.**	**5-28-2019**

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 550	Continued From page 2 Resident #69 was admitted to the facility on 3/28/19 with the diagnoses of but not limited to obstructive and reflux uropathy (2), benign prostatic hyperplasia (BPH) (3) with lower urinary tract symptoms, acute kidney failure, and retention of urine. The most recent MDS (Minimum Data Set), a five day Medicare assessment, with an ARD (Assessment reference date) of 4/4/19, coded the resident as scoring a 9 on the BIMS (Brief interview for mental status) score, indicating the resident has moderate cognitive impairment for daily decision making. The MDS coded Resident #69 as requiring extensive assistance for hygiene, dressing, transfers, and eating; total assistance for bathing. In Section H - Bladder and Bowel, the resident was coded as having an indwelling urinary catheter during the look back period. Resident #69's care plan dated 3/13/19, documented the potential for bladder incontinence related to physical limitations, BPH, and renal failure and as having an indwelling urinary catheter. On 4/14/19 at 2:00 p.m., and on 4/15/19 at 8:00 a.m., 8:53 a.m., and 12:15 p.m., Resident #69's indwelling urinary catheter collection bag was observed uncovered, exposed, and hanging on the bed frame and/or on the floor. During each observation, urine was observed in the bag and the bag was visible to others. On 4/14/19 at 4:00 p.m., an interview was conducted with Resident #69. When asked about his catheter bag being uncovered and visible to others, Resident #69 stated, "Sometimes it bothers me." On 4/16/19 at 6:38 a.m., an interview was conducted with CNA (Certified Nurse Assistant)	F 550		

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	495236	A. BUILDING _____ 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

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F 550	Continued From page 3 #10. When asked about the process staff follows for residents with indwelling urinary catheter collection bags, CNA #10 stated, "When I get them up in the wheelchair, I am to cover them (indwelling urinary catheter collection bag). They are to be covered at all, times when residents are up in the wheelchair. If the bag is facing the door, it is to be covered. If my boss comes down the hall, she is going to tell me to cover it. They should be covered even if they are facing the window." On 4/16/19 at 10:28 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked about the process staff follows to ensure and promote dignity for residents with indwelling urinary catheters, LPN #2 stated, "We keep the Foley (indwelling urinary catheter) bag covered at all times, unless emptying it." A review of the facility's policy "Residents' Rights and Responsibilities" documented in part, "Each nursing facility resident has a right to a dignified existence ...A facility must protect and promote the rights of each resident ...Privacy ...To be treated in a manner and in an environment that maintains or enhances your dignity, and respect in full recognition of your individuality and privacy." 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 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. (1) An indwelling catheter is a tube that drains	F 550		

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	495236	A. BUILDING _____ 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

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F 550	Continued From page 4 urine from the bladder to a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm (2) obstructive and reflux uropathy: Obstructive uropathy is structural or functional hindrance of normal urine flow, sometimes leading to renal dysfunction (obstructive nephropathy) The information was obtained from the website: https://www.merckmanuals.com/professional/genitourinary-disorders/obstructive-uropathy/obstructive-uropathy (3) benign prostatic hyperplasia: is a condition in men in which the prostate gland is enlarged and not cancerous. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostate-enlargement-benign-prostatic-hyperplasia	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 41 residents in the survey sample, Resident # 73.	F 558		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 558	Continued From page 5 The facility staff failed to ensure Resident # 73's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. During an observation, Resident #73's call bell was lying on the floor underneath his bed out of the residents reach. The findings include: Resident # 73 was admitted to the facility on 08/06/12 with a re-admission of 04/27/15 with diagnoses that included but were not limited to dementia (1), heart failure (2), atrial fibrillation (3) and diabetes mellitus (4). Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/19, coded Resident # 73 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 73 was coded as requiring supervision with setup for all activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 73 as "No impairment" on both sides of her upper extremities (shoulder, elbow, wrist, hand). On 04/14/19 at 2:30 p.m., an observation of Resident # 73 revealed he was sitting on the edge of his bed. Observation of the call bell revealed it was lying on the floor underneath his bed. When asked if he could locate his call bell Resident # 73 stated, "It's over there" and pointed to a white cord under the privacy curtain toward the opposite side of the room. Further	F 558	**F558** **1. Resident # 73 has a call bell at the bedside and it is kept within reach to allow him to call for assistance as needed.** **2. Residents who reside in the facility are provided with a call bell device that is placed in reach to alert staff when assistance is need. A quality review has been conducted as of 5-9-2019 by the interdisciplinary team to ensure call bells were within reach for residents in the facility. No other residents were affected.** **3. Nursing staff will be re educated by DON/ designee on providing each resident with call bell device that needs to be within reach for resident's utilization. Quality reviews will be conducted five times weekly by the interdisciplinary team to observe for proper placement of call bell device for resident usage to allow the request for assistance.** **4. The results of the quality monitoring tool data to be reviewed by members of the quality assurance committee team meeting for review, analysis and further recommendations.**	**5-28-2019**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 558	Continued From page 6 observation revealed Resident # 73 was unable to reach for the call bell under his bed. The comprehensive care plan for Resident # 73 dated 02/07/2019 documented, "Focus. (Resident # 73) is able to make his needs known, has clear speech, vision and hearing are adequate without devices. He does need assistance with ADLs (activities of daily living) due to impaired cognitive status. He is ambulatory and uses a wheeled walker [sic] with as eat on it. He sits on a chair by his bed when he is out of bed. He has 2 ¼ (two and a quarter) handrails on each side of the bed and he reports he uses them to help transfer and move around in the bed. Date Initiated: 02/07/2019." Under "Interventions" it documented, "Encourage the resident to use bell to call for assistance. Date Initiated: 02/07/2019." On 04/16/19 at 8:55 a.m., an observation of Resident # 73 revealed he was sitting in a chair next to his bed. Observation of the call bell revealed it was attached to the bed's upper side rail. When Resident # 73 was asked to locate and press his call bell Resident # 73 was observed to reach for the call and depress the button independently. On 04/16/19 at 9:00 a.m., an interview was conducted with CNA (certified nursing assistant) # 5. When asked to describe the procedure for the placement of a resident's call bell, CNA # 5 stated, "The call bell should be within reach of the resident." When asked how often the placement of the call bell is checked, CNA # 5 stated, "When you go into the room on rounds, every two hours and whenever you go into the resident's room."	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 558	Continued From page 7 On 04/16/19 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan, LPN # 4 stated, "Monitor the progress of the resident and to maintain a healthy level of living." When asked if something is documented on the care plan to be followed or implemented and it is not followed is the care plan was being implemented, LPN # 4 stated, "No." When asked about Resident # 73's call bell being observed on the floor under his bed and the care plan documenting Resident # 73 should be encouraged to use his call bell, LPN # 4 stated, "The care plan is not being followed. He can't be encouraged to use the call bell if it is not within reach. On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (3) A problem with the speed or rhythm of the	F 558		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 558	Continued From page 8 heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		

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F 580	Continued From page 9 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to notify the physician that medications were unavailable and not administered per the physician's order for one of 41 residents in the survey sample, Resident #52. The facility staff failed to notify the physician when the medication Ativan was not administered to Resident #52 per the physician order and when the medication Methadone was not available for administration on multiple dates. The findings include:	F 580	**F 580** **1. The MD was notified on 4-15-2019 of the medication omission of Ativan and Methadone for resident #52. An order was given to administer once received from Pharmacy, later that same evening resident #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 medication availability and administration as of 5/9/2019, no residents noted to be affected. No other residents in the facility are prescribed Methadone.** **3.Licensed nursing staff will be re educated on following physician orders to include; the physician must be notified for any changes in condition to include medication omission by DON/designee. Random medication administration observations will be conducted weekly for eight weeks by the DON or designee to ensure medications are available and medication administration is completed in accordance with physician order.** **4.The results of the quality monitoring will be presented to the quality assurance committee monthly for review, analysis and further recommendations.**	**5-28-2019**

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F 580	Continued From page 10 Resident #52 was admitted to the facility on 9/17/18 with diagnoses that included but were not limited to lung cancer, COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic. (1)], high blood pressure, anxiety, chronic pain and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/13/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired to make daily cognitive decisions. The resident was coded as having periods of disorganized thinking that comes and goes. Resident #52 was coded as having periods of hallucinations and delusions. The resident was coded as requiring limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antianxiety medication. The physician order dated, 2/14/19, documented, "Reduce am (morning) dose of Ativan (used to treat anxiety) (2), to 0.5 mg (milligram), cont (continue) pm (evening) dose of Ativan @ (at) 1 mg." The February MAR 2019 (medication administration record) documented the above physician medication orders. The Ativan dose scheduled for 2/15/19 at 9:00 a.m. had the nurse's initials with a circle around them. There was nothing documented on the reverse side of the MAR. The MAR also documented the Ativan 1	F 580		

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F 580	Continued From page 11 mg dose to be administered at 5:00 p.m. with the nurse's initials circled on 2/14/19, 2/15/19, 2/19/19, and 2/24/19. The reverse side of the MAR documented on 2/14/19 at 5:00 p.m. "Pending arrival from pharmacy." On 2/14/19 at 5:00 p.m., the reverse side of the MAR documented, "Sleeping." There were no other notes on the reverse side of the MAR regarding the circled doses of Ativan listed above. The comprehensive care plan dated, 3/26/19, documented in part, "Focus: The resident uses anti-anxiety medications r/t (related to) Anxiety disorder." The "Interventions" documented in part, "Administer ANT-ANXIETY medications as ordered by physician. Monitor for side effects and 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."	F 580		

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F 580	Continued From page 12 The physician order dated, 12/31/18, documented, "Methadone* HCL (hydrochloride) 5 MG (milligram) Tablet; 3 tabs (tablets) by mouth three times daily at 0600 (6:00 a.m.) 1400 (2:00 p.m.), 2200 (10:00 p.m.) for pain." *Methadone is used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications (3). Review of the January 2019 MAR (medication administration record) documented the above physician order. On 1/14/19 at 2200 (10:00 p.m.) the nurse initialed the medication and circled their initials, indicating it wasn't given. There was no documentation on the reverse side of the MAR regarding the missed dose of Methadone. Review of the nurse's notes failed to evidence nursing documentation on 1/14/19. The February 2019 MAR documented the above physician order. The Methadone was circled as not administered on 2/9/19 at 10:00 p.m., 2/10/19 at 10:00 p.m., 2/18/19 at 6:00 a.m., and 2/21/19 at 10:00 p.m. The reverse side of the MAR failed to evidence documentation regarding why the medication was not administered as ordered by the physician. Review of the nurse's notes for the above dates and times, failed to evidence the reason why the medication was not administered or notification to the physician. The March 2019 MAR documented the above physician order. The Methadone was circled as not administered on 3/8/19 at 6:00 a.m. and 2:00 p.m., 3/12/19 at 2:00 p.m. and 3/13/19 at 2:00	F 580		

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F 580	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 notification to the physician.	F 580		

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F 580	Continued From page 14 The comprehensive care plan dated, 3/14/19, documented in part, Focus: The resident has acute/chronic pain r/t (related to) complaints of pain to right ankle with warmth/swelling/ CA (cancer)." The "Interventions" documented in part, "Administer analgesics as per orders." 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." When asked what a circle around the nurse's initials indicate, RN #1 stated it means that nurse did not give the medication. When asked if a nurse should document why a medication is not given, RN #1 stated, "Yes, they can either document it on the reverse side of the MAR or in a nurse's note." When asked if a medication is not give, refused or not available, should the physician be notified, RN #1 stated, "Absolutely and a note should be documented." The box of emergency medications stored in the medication room was observed on 4/15/19 at 4:16 p.m. accompanied by RN (registered nurse) #2. The narcotics emergency box failed to document the storage of Methadone. Administrative staff member (ASM) #1, the	F 580		

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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 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice 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.	F 582		

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F 582	Continued From page 16 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide notice of Medicare non-coverage for one of 41 residents in	F 582		

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F 582	Continued From page 17 the survey sample, Resident #228. Resident #228's last covered day of Medicare Part A services was 11/28/18. The facility staff failed to notify Resident #228 (and/or the resident's representative) of the last covered day and the right to appeal. The findings include: Resident #228 was admitted to the facility on 11/4/18. Resident #228's diagnoses included but were not limited to muscle weakness, high blood pressure and major depressive disorder. Resident #228's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 11/17/18, coded the resident's cognition as severely impaired. On 4/15/19at 10:40 a.m., an interview was conducted with OSM (other staff member) #3 (the director of social services). OSM #3 confirmed Resident #228's last covered day of Medicare Part A services was 11/28/18 and stated she did not have a notice of non-coverage on file. OSM #3 stated in November 2018, she was in training, and the business office and the social services departments were both responsible for completing the notices of non-coverage. OSM #3 stated the responsibility of issuing the notices later transitioned to the social services department and it was then that she realized Resident #228's notice was not provided. OSM #3 stated training regarding the notices was provided after she realized the notice was not issued. On 4/15/19 at approximately 2:00 p.m., review of	F 582	**F582 Medicaid/Medicare coverage/liability notice** **1.Resident #228 was discharged on 11/28/19.** **2.Social Services Director or Designee will review resident discharge from skilled services within past 60 days to ensure form Medicare Non-Coverage notification was provided. Follow-ups will be done based on findings.** **3.Social Services Director will be educated by Vice President of Revenue Cycle on ensuring residents are notified timely when care needed does not meet Medicare coverage requirements. Executive Director or Designee to conduct quality monitoring of ABN notification weekly x 8 weeks and as needed.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations**	5-28-19

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F 582	Continued From page 18 a facility plan of correction regarding ABNs (advance beneficiary notices)/ Medicare non-coverage forms was conducted. The third point of the plan of correction documented, "Executive Director or Designee to conduct quality monitoring of ABN notification weekly x (times) 4 weeks and as needed..." On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the interim director of clinical services) were made aware of the above concern. ASM #1 and ASM #2 were asked to provide evidence of the monitoring as documented in the above plan of correction. On 4/16/19 at approximately 10:35 a.m., ASM #3 (the regional director of clinical services) stated she knew a former executive director completed the monitoring piece of the plan of correction but she could not provide the evidence. The facility policy titled, "SNF (Skilled nursing facility) Advance Beneficiary Notification (ABN) & Notice of Medicare Provider Non-Coverage" documented, "The SNF Advance Beneficiary Notification (SNF ABN) & The Notice of Non-Coverage will be used to properly notify a Medicare Part A resident and/or responsible party of the clinical team decision that the resident, no longer meets the Medicare criteria for daily skilled services...SNFs must provide the Notice of Medicare Provider Non-Coverage and the SNF ABN to Medicare beneficiaries no later than two days (48 hours) before the effective date of the end of the coverage that their Medicare coverage will be ending..." No further information was presented prior to exit.	F 582		

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 583	Continued From page 20 was determined the facility staff failed to maintain confidentiality of personal information for four of 41 residents in the survey sample, Residents #5, #60, #74 and #45. 1. Personal information for Residents #5, #60, and #74 was observed on top of the medication cart on the 100 hall, not covered, visible to anyone passing by the medication cart. 2. Resident #45's private information on a medication reorder sticker was left on the pill crusher handle on the medication cart on the 100 hall of the facility. The label was easily visible to people walking past the medication cart. The findings include: 1. Personal information for Residents #5, #60, and #74 was observed on top of the medication cart on the 100 hall, not covered, visible to anyone passing by the medication cart. Resident #5 was admitted to the facility on 11/14/18 with diagnoses that included but were not limited to: COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. (1)], anxiety disorder, and muscle weakness. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/28/19, coded the resident as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. Resident #60 was admitted to the facility on 2/22/19 with diagnoses that included but were not	F 583	**F583** **1.The personal information for resident #5, # 60, # 74, and # 45 is being maintained in a manner to provide privacy and honor confidentiality.** **2.The personal information of residents has been reviewed via observation for licensed nurses' practice of inappropriate placing personal information not covered and visible to public. A folder has been provided to licensed nurses with reorder forms enclosed for pharmacy communication of medication requests.** **3. Facility licensed nurses will be re educated on "Notice of Privacy Practice" by DON / designee. The medication reorder labels will be placed in a covered folder for privacy until the information is submitted to pharmacy for medication renewal. Random quality review observations will be conducted by quality assurance committee members on privacy practices with respect to information collected and maintained about residents, weekly for eight weeks.** **4. The results of the quality monitoring will be presented to the quality assurance committee monthly for review, analysis and further recommendations.**	5-28-19

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F 583	Continued From page 21 limited to: atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. (2)], and COPD. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 3/22/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #74 was admitted to the facility on 9/28/18 with diagnoses that included but were not limited to: high blood pressure, low back pain and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/26/19, coded the resident as having both short and long-term memory difficulties and as severely impaired to make daily cognitive decisions. An observation was made of the medication cart for the 100 hall on 4/15/19 at 8:07 a.m. There was no staff member near the cart. A piece of white paper was sitting on top of the medication cart. On that piece of paper were three labels for reordering medication for the residents. The piece of paper contained the names and medications for Residents #5, #60 and #74. The medication for Resident #5 was furosemide [a diuretic used to treat edema, high blood pressure and heart disease (3)]. The medication for Resident #60 was Vitamin D [used as a supplement for deficiency and to help the body absorb calcium (4)]. The medication for Resident #74 was furosemide.	F 583		

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F 583	Continued From page 22 An interview was conducted with LPN (licensed practical nurse) #1, on 4/15/19 at 8:16 a.m. When asked about the piece of paper on the top of the medication cart, LPN #1 stated, "It's when I have to reorder medications from the pharmacy. I pull the sticky off the medication card." LPN #1 was asked to review the list. After reviewing the list, LPN #1 was asked if the information on that piece of paper should be exposed for others to see that pass by the medication cart. LPN #1 stated, "No, Ma'am. It should be covered." The facility policy, "Notice of Privacy Practice" documented in part, "Policy: The intent of the Notice of Privacy Practices is to describe how medical information about the resident may be used and disclosed and how the resident can get access to this information. Procedure: The facility is responsible to: maintain the privacy of the resident health information. Provide the Resident with a copy of this notice (policy) of our responsibilities and privacy practices with respect to information we collect and maintain about the Resident. Abide by the terms of this notice (policy)." 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. 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 55. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 583		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 583	Continued From page 23 Chapman, page 124. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html (4) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Vitamin+D&_ga=2.75729367.334979157.1555434117-938173006.1468851256 2. Resident #45's private information on a medication reorder sticker was left on the pill crusher handle on the medication cart on the 100 hall of the facility. The label was easily visible to people walking past the medication cart. Resident #45 was admitted to the facility on 11/29/18 with the diagnoses of but not limited to high blood pressure, dementia, anxiety, and depressive disorder with psychotic symptoms. Resident #45's Minimum Data Set (MDS), a quarterly review assessment with an Assessment Reference Date (ARD) of 3/6/19, coded Resident #45 with a BIMS (Brief Interview for Mental Status) of 14 indicating that she has no cognitive impairment in her ability to make daily life decisions. The resident was coded as requiring limited assistance for hygiene, bathing, dressing, transfers, and eating; and as occasionally incontinent of bladder and always continent of bowel. On 4/14/19 at 4:10 p.m., an observation on the 100 hall's medication cart revealed a medication reorder sticker for Risperidone (1) 0.5 mg tablet, for Resident #45. The medication reorder sticker was left on the pill crusher handle on the	F 583		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 583	Continued From page 24 medication cart in the hallway. The label was easily visible to people walking past the medication cart. A review of the clinical record revealed a physician order, dated 1/4/19, for Risperidone 0.5 mg tablet, one tab (tablet) by mouth twice daily for psychosis/delusional disorder. Further review of the clinical record revealed a MAR (medication administration record) for Resident #45 that documented the Risperidone 0.5 mg tablet was administered at 9:00 a.m., on 4/14/19. On 4/16/19 at 9:41 a.m., a telephone interview was conducted with LPN #3, regarding the above observation. LPN #3 stated, "I recall a reorder label on the pill crusher. I did not place the sticker there and I should have removed it [the reorder sticker]. The reorder label discloses patient information and is a HIPAA (Health Insurance Portability and Accountability Act) violation." A review of the facility's policy "Residents' Rights and Responsibilities" documented in part, " ...Confidentiality ...To have your personal and medical records treated confidentially ..." 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 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. (1) Risperidone: Risperidone is in a class of	F 583		

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F 583	Continued From page 25 medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was retrieved from https://medlineplus.gov/druginfo/meds/a694015.html	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	**F584** **I** **1.Maintenance Director and Housekeeping Services Director completed repairs #9 by removing the old caulking ring on floor, cleaning the green blue discoloration inside tub, and removing the unconnected shower 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 providing residents a safe/clean/comfortable environment and reporting of any findings that require repair. Executive Director or 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 be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5.28.19

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F 584	Continued From page 26 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide a clean, comfortable, and homelike environment for one of 41 residents in the survey sample, Resident #9. The facility staff failed to provide a clean, comfortable, and homelike environment in Resident #9's bathroom. The findings include: 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 was coded as requiring setup and supervision for eating; extensive assistance for hygiene, dressing, transfers, and toileting; and total care for bathing; and was coded as always	F 584		

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F 584	Continued From page 27 incontinent of bladder and bowel. On 4/14/19 at 2:20 p.m., an observation was made of Resident #9's bathroom. The toilet appeared to have been changed to a smaller size toilet and a ring of old caulking remained on the floor around the new toilet. The bathtub appeared to have a bright green blue discoloration inside the tub bottom and sides. A shower handle was observed hanging from the wall above the tub and the hose extended into the bottom of the tub and was not connected to anything. On 4/16/19 at 9:02 a.m., an interview was conducted in Resident 9's bathroom with OSM (Other staff member) #1 (Director of Maintenance). When OSM #1 was asked if there were any issues in the bathroom, he stated, "The toilet needs re-caulking. The tub could be scrubbed. The hose is not used anymore. It may need a light bulb and a re-touch of paint on the wall." When OSM #1 was asked if Resident #9's bathroom was homelike, he stated, "It could be better and touched up." OSM #1 was asked about the process for reporting environmental or maintenance issues within the facility. OSM #1 stated, "There is a log book at the nursing station where issues are placed and then I go from hall to hall and address the issues." When OSM #1 was asked to review the logbook, no evidence of Resident #9's bathroom was entered as an issue. On 4/16/19 at 9:27 a.m., an interview was conducted in Resident 9's bathroom with OSM #9 (housekeeper). When OSM #9 was asked if there were any issues in the bathroom, she stated, "It needs some cleaning over there (OSM #9 pointed to Resident #9's toilet and tub), it	F 584		

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F 584	Continued From page 28	F 584		

needs basic cleaning and has cleaning issues." When OSM #9 was asked what department is responsible for cleaning resident's bathrooms, she stated, "Housekeeping. The bathroom looked like that last week." When asked about the bright green blue discoloration inside the tub, she stated, "It was from wear and tear." When OSM #9 was asked if toilet area was reported to the maintenance department, she stated, "I don't know if the toilet has been reported."

A review of the facility's policy "Hospitality Services" with an effective date of 11/30/14 documented in part, "Policy: Standards for routine cleaning of all interior spaces will be followed, ...patient rooms, patient ...baths ...Procedure: The Hospitality Services Supervisor will: ...Ensure the cleanliness of all interior areas as indicated above ..."

A review of the facility's policy "General Hospitality Services Policy" with an effective date of 11/30/14 documented in part, "Policy: To provide clean, ...surrounding for residents ...A clean environment is essential in preventing transmission of infection in the facility ...1. Residents Rooms: Routine cleaning is to be done on a daily basis ...Bathrooms: handwashing facilities are to be cleaned daily ...bathroom tubs ...are to be cleaned daily ...Safety: Needed repairs ...toilets ...are to be reported to the Maintenance Supervisor for attention and repair."

A review of the facility's policy "Residents' Rights and Responsibilities" documented in part, "Each nursing facility resident has a right to a dignified existence ...A facility must protect and promote the rights of each resident ...Environment and Quality of Care/Life: To live a safe, clean,

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 584	Continued From page 29 comfortable and homelike environment. To have housekeeping and maintenance services available to maintain a sanitary, orderly, and comfortable interior ..." 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 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and employee record review, it was determined that facility staff failed to implement policies and procedures for the protection of residents from abuse and neglect for four of 41 residents in the survey sample; Residents #42, #72, #9, and #30; and for ten of twenty five employee records reviewed, (LPN (licensed practical nurse) #6, LPN #7, RN	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 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 within the two-hour time frame and 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. 3. 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 employee records reviewed LPN (licensed practical nurse) #6, LPN #7, RN (registered nurse) #1 and RN #7, OSM (other staff members) # 15, #16, #17, #3, #9, #10). The findings include: 1. The facility staff failed to implement the policy and procedures to complete an investigation for a resident-to-resident altercation between	F 607	**F 607** **1.Executive Director will conduct a follow-up investigation of the resident to resident altercation between resident #42 and #72 occurring on 10/16/18 and submit findings to the OLC.** **Executive Director will conduct a follow-up investigation on the allegation of abuse for resident #9 occurring on 3/11/19 and submit findings to the OLC by 5/14/2019.** **Executive Director will conduct a follow-up investigation on the allegation of abuse for resident #30 occurring on 9/19/18 and submit findings to the OLC by 5/14/2019.** **Human Resource Manager or Designee will ensure that the abuse policy and procedure for screening new hires is completed for LPN#6, LPN#7, RN #1, RN#7, OSM#15, OSM#16, OSM#17, OSM#3, OSM#9, and OSM#10.** **2.Executive Director or Designee will interview residents to ensure that they are free from abuse. Follow ups will be done based on findings.** **Human Resource Manager or Designee will review new hires in last 60 days to ensure background checks, sworn statements, license verification, and reference checks were completed. Follow ups will be done based on findings.**	5-28-19

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 31 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. Resident #42 was admitted to the facility on 11/29/17 with the diagnoses of but not limited to traumatic brain injury, hypothyroidism, high blood pressure, alcohol abuse, hepatitis C, epilepsy, depression and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/4/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing and supervision only for all other areas of activities of daily living. Resident #72 was admitted to the facility on 9/16/16 with the diagnoses of but not limited to chronic obstructive pulmonary disease, frontotemporal dementia, adjustment disorder, anxiety disorder, schizophrenia, high blood pressure, benign intracranial hypertension, benign neoplasm of the prostate and prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing and supervision only for all other areas of activities of daily living. A review of a FRI (Facility Reported Incident) date stamped by the State Agency on 10/17/18, for an incident that occurred on 10/16/18 between Residents #42 and #72 documented, "(Resident #42) started hitting (Resident #72) in the head and (Resident #42) took $10 from (Resident	F 607	**3.Facility staff will be educated on Resident Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspected incidents 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 day follow up.** **Human Resources Manager will be educated on obtaining background checks, sworn statements, license verification, and reference checks on employees prior to employment by Executive Director or Designee. Human Resource Manager or Designee to review new hire files prior to start date weekly x8 weeks.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 607	Continued From page 32 #72)'s front shirt pocket. Residents immediately separated and put on 1:1 (one-to-one staff supervision) with staff. Investigation initiated immediately." There was no evidence that the follow up results of an investigation were provided to the State Agency within the required period of 5 working days. On 4/14/19 during the entrance conference, the investigation of any FRI's was requested from ASM #1 (Administrative Staff Member - the Executive Director). On 4/15/19 at 3:00 p.m., ASM #1 stated the FRI investigation for (Resident #42 and #72) could not be located. He was not able to evidence that the investigation was ever initiated, completed, and submitted to the required State Agency. On 4/16/19 at 8:45 a.m., an interview was conducted with ASM #3 (the Regional Director of Clinical Services). ASM #3 stated, "Abuse is reported to upper management; if an abuse allegation is suspected, it is reported to the state agency within 2 to 24 hours, and have 5 days to investigate and submit a follow up." Regarding the investigation and follow up for this FRI, ASM #3 stated, "We don't have any evidence it was done." A review of the facility policy, "Freedom from Abuse Notice to Employees; Resident Abuse, Neglect & Mistreatment of Belongings" documented, "....The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse....Investigation: *The Abuse Coordinator and/or Director of Clinical Services	F 607		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 33 shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. *Any suspect(s), who is an employee, once he/she has (have) been identified, will be suspended pending the investigation. Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken...." 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 facility staff failed to evidence that policy and procedures were followed to report an allegation of abuse within the two-hour time frame and 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. 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	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 607	Continued From page 34 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 transferring her. Investigation initiated... If applicable, date notification provided to: Responsible party 3/11/16..." It was noted that the facility staff failed to report the allegation of abuse within the required two-hour time frame. Upon further review of the facility's FRI, it was noted that there was no evidence of the facility reporting a follow up to the initial FRI to the SA. In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the 3/11/19 incident involving Resident #9. On 4/15/19 at approximately 1:30 p.m. ASM (administrative staff member) #3 (Regional Director of Clinical Services), was asked for the facility's investigation for the 3/11/19 FRI and follow up report, ASM #3 stated, "The previous DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. AMS #1 stated, "I use a guidance	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 607	Continued From page 35 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 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 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 ...to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ...to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the	F 607		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 36 Director of Clinical Services is the designated abuse coordinator ....Once 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	F 607		

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F 607	Continued From page 37 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. Resident #30 was admitted to the facility on 6/16/17 with the diagnoses of but not limited to spina bifida (1), high blood pressure, paraplegia (2), depression, and anxiety. The most recent MDS (Minimum Data Set), an annual Medicare assessment, with an ARD (Assessment reference date) of 3/1/19, coded the resident as scoring a 15 on the BIMS (Brief interview for mental status) score, indicating no cognitive impairment for daily decision-making. The resident was coded as requiring setup and supervision for eating; extensive assistance for hygiene and dressing; total assistance for transfers, toileting, and bathing; and as always incontinent of bladder and bowel. A review of the Facility Reported Incident (FRI) faxed to the OLC (Office of Licensure and Certification) on 9/19/18, revealed the initial reporting of an allegation of abuse for Resident #30. The FRI documented in part, "Report Date 9/19/18. Incident Date: 9/19/18. Resident Involved: Name of (Resident #30)." "Incident Type": an X was marked on the box next to "Allegation of abuse/mistreatment". "Describe incident, including location, and action taken: Resident felt she was 'bullied' by the CNA (certified nursing assistant) name of CNA, CNA license # suspended pending investigation." Under the heading: "Facility internal investigation": the FRI documented, "Will be conducted/Report forward to VDH/OLC (Virginia Department of Health Office of Licensure and	F 607		

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	495236	A. BUILDING _____ 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

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F 607	Continued From page 38 Certification [State Agency])". Next to this heading 9/26/18 was had written. Upon further review of the initial FRI record submitted to the State Agency, it was noted that there was no evidence of the facility reporting a follow up for the 9/19/18 FRI, to the the SA (state agency). In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the Resident #30's 9/19/18 above allegation. On 4/15/19 at approximately 1:30 p.m. ASM (administrative staff member) #3 (Regional Director of Clinical Services), was asked for the facility's investigation for the 9/19/18 FRI and follow up report, ASM #3 stated, "The previous DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. ASM #1 stated, "I use a guidance 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	F 607		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 39 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 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." 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 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 employee records reviewed LPN (licensed practical nurse) #6, LPN #7, RN (registered nurse) #1 and RN #7, OSM (other staff members) # 15, #16, #17, #3, #9, #10).	F 607		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 40 On 4/15 and 4/16/19 a review of twenty-five employee records randomly selected from a list of newly hired employees since the last survey was conducted and revealed the following: LPN (licensed practical nurse) #7 was hired on 4/1/19. Review of LPN #7's employee record revealed the criminal background check was completed on 6/7/18, and the license verification was obtained on 9/18/18. LPN # 6 was hired on 8/23/18. Review of LPN #6's employee record revealed a background check dated, 4/14/19. LPN #6's license look up verification was dated 4/14/19, and only one of two reference verifications could be located in the record. RN (registered nurse) #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. 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. OSM # 15 (receptionist) was hired on date 5/2/18. Review of OSM #15's employee record revealed OSM #15's criminal background check completed 4/19/19. OSM #16 was hired on 2/14/19. Review of OSM #16's employee record revealed the criminal background check and sworn statement were completed on 10/30/18. OSM #16's employee record failed to evidence any reference checks. OSM #17 was hired on 5/16/18. Review of OSM #17's employee record failed to reveal any reference checks prior to or at the time of hire in the employee file. 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	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 41 checks. OSM #9 (environmental services) was hired on date 3/14/19. Review of OSM #9's employee record revealed no sworn statement, and no reference checks in the file. OSM # 10 (environmental services) hire date was 3/15/19, review of OSM #10'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. OSM #4 stated, "Applicant first schedule an interview to gauge them. Then if good schedule a second interview, and meet administer, to make sure good fit. Offer the job discuss pay. Then start the process, check license make sure current, in good standing, do criminal background check through Virginia State police, do OIG (office of inspector general), drug screen. Wait for the results to come back. If there is something, the company mails it to make sure there are no barrier crimes. Send off two reference checks from previous employer. During this time they (potential employee) stay home pending the 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 identified concerns. OSM #4 was provided the employee files and was asked to provide any additional information /clarification. OSM #4 stated she would look to see what she could locate. On 4/16/19, ASM (administrative staff member)	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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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." 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." 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	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 607	Continued From page 43 hire, "No reference checks and she (RN #1) does still work here as needed (PRN)." OSM #4 stated OSM #15's hire date was 5/2/18, and when reviewing the employee record it was noted the background, check was missing and it was obtained on 4/14/19. OSM #16 transferred and the hire date with us is 2/14/19. The background check and sworn statement were completed prior to her transfer at the original time of hire, but there are no reference checks." In regards to OSM #17's missing reference checks, OSM #4 stated, "Accurate we do not have reference checks." OSM #4 brought was observed looking through OSM #3's employee record. OSM #4 then stated, "There is no sworn statement and no reference checks." In regards to the missing sworn statement and reference checks for OSM #9, OSM #4 stated, "There is no sworn statement and no reference checks." Regarding OSM #10, missing reference checks, OSM #4 stated, "I do not have reference checks." (*Note OSM #10 and OSM #9 were hired on 3/14 and 3/15/19, after the date the facility stated they had completed the QAPI and education of staff. Therefore, this cannot be past non-compliance). The facility policy with an effective date of 11/30/14 and revision date of 11/28/17, titled, "Abuse, Neglect, Exploitation & Misappropriation" documented in part, "1. Screening: Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but is not limited to: Employment history Criminal Background check Abuse check with appropriate licensing board and registries, prior to hire	F 607		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 607	Continued From page 44 Sworn Disclosure Statement prior to hire Documentation of status of any disciplinary actions form (sic.) licensing or registration boards and other registries Information from former employers." The facility policy with an effective date of 11/30/14 and revision date of 9/1/2017 titled, "Background Checks" documented in part the following, "Policy: It is the policy of The Company to conduct background checks to include criminal background checks, ..." On page five of seven under the heading "Background Check Process" the following is documented in part, "Candidates may be give a conditional offer of employment pending the successful completion of the background check unless otherwise prohibited by law. Under no circumstance is a job candidate to begin work until the candidate's background check is completed and a positive report is received, unless state requirements allows a mechanism to begin employment prior to receipt pf background check (please refer to your state specific requirements)." The facility policy with a revision date of 1/10/2018, and effective date of 11/30/14 titled, "Employment Application Procedure" documented in part the following: "Policy: It is the policy that all individuals interested in an open position with the company must complete and sign an employment application and provide reference. All employment offers are contingent upon successful completion and satisfactory results of credentialing and reference checks." "The Human Resource Representative must obtain a favorable or neutral reference from at least two of the references listed prior to the applicant starting work. Records of all reference checks, whether	F 607		

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F 607	Continued From page 45 successful or not, must be retained with the employment application. Applications for individuals who are hired must be retained in the employee's personnel file." No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		

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F 609	Continued From page 46 by: Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure an allegation of abuse was reported to the SA (State Agency) and other officials within the required timeframe and failed to report the results of all investigations within 5 working days of the incident for two of 41 residents in the survey sample; Resident #9 and Resident #30. 1. The facility staff failed to report an allegation of abuse immediately and or within the two-hour time frame and 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. The allegation was not reported to the State Agency until 3/12/19. 2. The facility staff failed 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. The findings include: 1. The facility staff failed to report an allegation of abuse immediately and or within the two-hour time frame and 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. The allegation was not reported to the State Agency until 3/12/19. 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	F 609	**F 609** **1.Executive Director will conduct a follow-up investigation on the allegation of abuse for resident #9 occurring on 3/11/19 and submit findings to OLC by 5/14/2019.** **Executive Director will conduct a follow-up investigation on the allegation of abuse for 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 are free from abuse. Follow ups will be done based on findings.** **3.Executive Director and Director of Nursing have been re educated on guidelines for abuse reporting and investigation by the Regional Director of Clinical Services. Facility staff will be educated on Resident Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspected incidents 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 day follow up.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5.28.19

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 609	Continued From page 47 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 transferring her. Investigation initiated... If applicable, date notification provided to: Responsible party 3/11/16..." It was noted that the facility staff failed to report the allegation of abuse within the required two-hour time frame. Upon further review of the facility's FRI, it was noted that there was no evidence of the facility reporting a follow up to the initial FRI to the SA. In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the 3/11/19 incident involving Resident #9. On 4/15/19 at approximately 1:30 p.m., ASM (administrative staff member) #3 (Regional Director of Clinical Services), was asked for the facility's investigation for the 3/11/19 FRI and follow up report, ASM #3 stated, "The previous	F 609		

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F 609	Continued From page 48 DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. AMS #1 stated, "I use a guidance 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 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 9/21/17 documented in part, " ...Procedure for Reporting Abuse ...Any	F 609		

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F 609	Continued From page 49 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 is made, if the events that cause the allegation involve abuse ...to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator ....Once 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	F 609		

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F 609	Continued From page 50 Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. 2. The facility staff failed 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. Resident #30 was admitted to the facility on 6/16/17 with the diagnoses of but not limited to spina bifida (1), high blood pressure, paraplegia (2), depression, and anxiety. The most recent MDS (Minimum Data Set), an annual Medicare assessment, with an ARD (Assessment reference date) of 3/1/19, coded the resident as scoring a 15 on the BIMS (Brief interview for mental status) score, indicating no cognitive impairment for daily decision-making. The resident was coded as requiring setup and supervision for eating; extensive assistance for hygiene and dressing; total assistance for transfers, toileting, and bathing; and as always incontinent of bladder and bowel. A review of the Facility Reported Incident (FRI) faxed to the OLC (Office of Licensure and Certification) on 9/19/18, revealed the initial reporting of an allegation of abuse for Resident #30. The FRI documented in part, "Report Date 9/19/18. Incident Date: 9/19/18. Resident Involved: Name of (Resident #30)." "Incident Type": an X was marked on the box next to "Allegation of abuse/mistreatment". "Describe incident, including location, and action taken: Resident felt she was 'bullied' by the CNA	F 609		

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F 609	Continued From page 51 (certified nursing assistant) name of CNA, CNA license # suspended pending investigation." Under the heading: "Facility internal investigation": the FRI documented, "Will be conducted/Report forward to VDH/OLC (Virginia Department of Health Office of Licensure and Certification [State Agency])". Next to this heading 9/26/18 was had written. Upon further review of the facility's FRI record, it was noted that there was no evidence of the facility reporting a follow up for the 9/19/18 FRI, to the the SA (state agency). In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the Resident #30's 9/19/18 above allegation. On 4/15/19 at approximately 1:30 p.m., ASM (administrative staff member) #3 (Regional Director of Clinical Services), was asked for the facility's investigation for the 9/19/18 FRI and follow up report, ASM #3 stated, "The previous DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. ASM #1 stated, "I use a guidance 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	F 609		

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F 609	Continued From page 52 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 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." 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	F 609		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 609	Continued From page 53 obtained from the following website: https://medlineplus.gov/paralysis.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 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and employee record review, it was determined that facility staff failed investigate and report to the required State Agency allegations of abuse and neglect for four of 41 residents in the survey sample; Residents #42, #72, #9 and #30.	F 610		

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F 610	Continued From page 54 1. The facility staff failed to evidence an investigation was conducted, and the follow up of an investigation was reported within 5 working days to the required state agency, for a resident-to-resident altercation that occurred on 10/16/18 between Residents #42 and #72. 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. 3. The facility staff failed 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 on and failed to evidence an investigation for the resident's allegation of abuse. The findings include: 1. The facility staff failed to evidence an investigation was conducted, and the follow up of an investigation was reported within 5 working days to the required state agency, for a resident-to-resident altercation that occurred on 10/16/18 between Residents #42 and #72. Resident #42 was admitted to the facility on 11/29/17, with the diagnoses that included but are not limited to, traumatic brain injury, hypothyroidism, high blood pressure, alcohol abuse, hepatitis C, epilepsy, depression and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/4/19. The	F 610	**F 610** **1.Executive Director will conduct a follow-up investigation of the resident to resident altercation between resident #42 and #72 occurring on 10/16/18 and submit findings to the OLC by 5/14/2019.** **Executive Director will conduct a follow-up investigation on the allegation of abuse for resident #9 occurring on 3/11/19 and submit findings to the OLC by 5/14/2019.** **Executive Director will conduct a follow-up investigation on the allegation of abuse for resident #30 occurring on 9/19/18 and submit findings to the OLC by 5/14/2019.** **2.Executive Director or Designee will interview residents who reside in the facility to ensure that they are free from abuse. Follow ups will be done based on findings.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 55 resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing and supervision only for all other areas of activities of daily living. Resident #72 was admitted to the facility on 9/16/16 with the diagnoses that included but are not limited to, chronic obstructive pulmonary disease, frontotemporal dementia, adjustment disorder, anxiety disorder, schizophrenia, high blood pressure, benign intracranial hypertension, benign neoplasm of the prostate and prostatic hyperplasia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/22/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing and supervision only for all other areas of activities of daily living. A review of a FRI (Facility Reported Incident) date stamped by the State Agency on 10/17/18, for an incident that occurred on 10/16/18 between Residents #42 and #72 documented, "(Resident #42) started hitting (Resident #72) in the head and (Resident #42) took $10 from (Resident #72)'s front shirt pocket. Residents immediately separated and put on 1:1 (one-to-one staff supervision) with staff. Investigation initiated immediately." There was no evidence of follow-up provided to this investigation within the required 5 working days. On 4/14/19 during the entrance conference, the	F 610	**3.Executive Director and Director of Nursing have been re educated on guidelines for abuse reporting and investigation by the Regional Director of Clinical Services as of 4/17/2019. Facility staff will be educated on Resident Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspected incidents 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 day follow up.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 610	Continued From page 56 investigation of any FRI's was requested from ASM #1 (Administrative Staff Member - the Executive Director). On 4/15/19 at 3:00 p.m., ASM #1 stated the FRI investigation for (Resident #42 and #72) could not be located. He was not able to evidence that the investigation was ever initiated, completed, and submitted to the required State Agency. On 4/16/19 at 8:45 a.m., in an interview with ASM #3 (the Regional Director of Clinical Services), she stated, "Abuse is reported to upper management; if an abuse allegation is suspected, it is reported to the state agency within 2 to 24 hours, and have 5 days to investigate and submit a follow up." Regarding the investigation and follow up for this FRI, she stated, "We don't have any evidence it was done." A review of the facility policy, "Freedom from Abuse Notice to Employees; Resident Abuse, Neglect & Mistreatment of Belongings" documented, "....The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse....Investigation: *The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared. *Any suspect(s), who is an employee, once he/she has (have) been identified, will be suspended pending the investigation. Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State	F 610		

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F 610	Continued From page 57 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	F 610		

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F 610	Continued From page 58 transferring her. Investigation initiated... If applicable, date notification provided to: Responsible party 3/11/16..." It was noted that the facility staff failed to report the allegation of abuse within the required two-hour time frame. Upon further review of the facility's FRI, it was noted that there was no evidence of the facility reporting a follow up to the initial FRI to the SA. In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the 3/11/19 incident involving Resident #9. On 4/15/19 at approximately 1:30 p.m. ASM (administrative staff member) #3 (Regional Director of Clinical Services), was asked for the facility's investigation for the 3/11/19 FRI and follow up report, ASM #3 stated, "The previous DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. AMS #1 stated, "I use a guidance 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	F 610		

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F 610	Continued From page 59 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 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 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 ...to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse ...to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Clinical Services is the designated abuse coordinator ....Once 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	F 610		

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F 610	Continued From page 60 ...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 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 on and failed to evidence an investigation for the resident's allegation of abuse. Resident #30 was admitted to the facility on 6/16/17 with the diagnoses of but not limited to spina bifida (1), high blood pressure, paraplegia (2), depression, and anxiety. The most recent MDS (Minimum Data Set), an annual Medicare assessment, with an ARD (Assessment reference date) of 3/1/19, coded the resident as scoring a 15 on the BIMS (Brief interview for mental status)	F 610		

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F 610	Continued From page 61 score, indicating no cognitive impairment for daily decision-making. The resident was coded as requiring setup and supervision for eating; extensive assistance for hygiene and dressing; total assistance for transfers, toileting, and bathing; and as always incontinent of bladder and bowel. A review of the Facility Reported Incident (FRI) faxed to the OLC (Office of Licensure and Certification) on 9/19/18, revealed the initial reporting of an allegation of abuse for Resident #30. The FRI documented in part, "Report Date 9/19/18. Incident Date: 9/19/18. Resident Involved: Name of (Resident #30)." "Incident Type": an X was marked on the box next to "Allegation of abuse/mistreatment". "Describe incident, including location, and action taken: Resident felt she was 'bullied' by the CNA (certified nursing assistant) name of CNA, CNA license # suspended pending investigation." Under the heading: "Facility internal investigation": the FRI documented, "Will be conducted/Report forward to VDH/OLC (Virginia Department of Health Office of Licensure and Certification [State Agency])". Next to this heading 9/26/18 was had written. Upon further review of the facility's FRI record, it was noted that there was no evidence of the facility reporting a follow up for the 9/19/18 FRI, to the SA (state agency). In addition, there was no evidence that the facility reported to the SA that they performed a complete and thorough investigation of the Resident #30's 9/19/18 above allegation. On 4/15/19 at approximately 1:30 p.m. ASM (administrative staff member) #3 (Regional	F 610		

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F 610	Continued From page 62 Director of Clinical Services), was asked for the facility's investigation for the 9/19/18 FRI and follow up report, ASM #3 stated, "The previous DON (director of nursing) is no longer here and a lot of other things are not here too." No follow up could be produced. On 4/16/19 at 11:39 a.m., an interview was conducted with AMS (Administrative Staff Member) #1. AMS #1 was asked the process for reporting a FRI. ASM #1 stated, "I use a guidance 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 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."	F 610		

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F 610	Continued From page 63 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 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §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	F 622		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 622	Continued From page 64 status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include:	F 622	**F 622** **1.Resident #49 transferred to the hospital on 3/24/19 and returned the same day from ER.** **Resident #69 transferred to the hospital on 3/24/19 and returned 3/28/19** **Resident #61 transferred to the hospital on 1/27/19 and returned 1/28/19.** **Resident # 53 transferred to the hospital on 12/18/18 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 provided to the receiving facility/hospital. Follow up based on findings.** **3.Director of Nursing or Designee to educate licensed nurses on providing receiving facility/hospital required documentation to include care plan goals, bed hold policy and physician documentation. Director of Nursing or Designee will review information provided during resident transfers to receiving facility/hospital for 8 weeks and as** **4.The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 622	Continued From page 65 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed provide the required information to the receiving facility and failed to ensure physician documentation in the clinical record for four of 41 residents in the survey sample; Residents #49, #69, #61, and	F 622		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 622	Continued From page 66 #53. 1. The facility staff failed to evidence that any of the required documentation was provided to the hospital when Resident #49 was transferred to the hospital on 3/24/19. 2. The facility staff failed to provide evidence that the comprehensive care plan goals and physician required documentation, were sent to the receiving facility when Resident #69 was transferred to the hospital on 3/24/19. 3. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #61 was transferred to the hospital on 1/27/19. 4. The facility staff failed to evidence that Resident # 53's comprehensive care plan goals were sent with the resident to the hospital for the transfer dated 12/18/2018. The findings include: 1. The facility staff failed to evidence that any of the required documentation was provided to the hospital when Resident #49 was transferred to the hospital on 3/24/19. Resident #49 was admitted to the facility on 11/1/18 with the diagnoses including, but not limited to, dysphagia, macular degeneration, high blood pressure, osteoarthritis, depression, chronic kidney disease, spondylosis, aphasia, anxiety disorder, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of	F 622		

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F 622	Continued From page 67 3/7/19. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 3/24/19 that documented, "Noted resident in respiratory distress. Obtained VS (vital signs) 177/89 (blood pressure), 30 (respirations), 97.0 (temperature), 72 (pulse), O2 sat (oxygen saturation) 90% (out of 100%) via O2 therapy. Notified NP (Nurse Practitioner). Lung sounds diminished (with) slight wheezing noted. Resident using abdominal muscle. Respiration rapid. N.O. (new order) to send resident out to the hospital for eval (evaluation). Granddaughter (name) aware. 911 (emergency services) called. Bed hold policy given." Further review of the clinical record failed to reveal any evidence of what, if any, required resident information was provided to the hospital, including but not limited to physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals. On 4/15/19 at 3:55 p.m., in an interview with RN #1 (Registered Nurse), when asked about the process for sending a resident to the emergency room / hospital, RN #1 stated, ".... send a copy of demographics sheet, the med (medication) sheet, the bed hold, call the family, send a copy of the care plan and transfer form." When asked if the facility keeps a copy of the transfer form, RN #1 stated, "We keep the yellow copy in the chart." When asked about evidence of what documentation is sent to the hospital, RN #1 stated, "We have a packet with a checklist on the	F 622		

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	495236	A. BUILDING _____ 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

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F 622	Continued From page 68 outside, which has a copy of the checklist form on it. We pull off the copy and keep it in the chart." On 4/16/19 at 7:54 a.m., in an interview with ASM #3 (Administrative Staff Member - the Regional Director of Clinical Services), ASM #3 stated, "We don't do a checklist. Information that is sent to the hospital should be documented in a nurse's note." A review of the facility policy "Transfer / Discharge Notification & Right to Appeal" documented, "Information provided to the receiving provider must include but is not limited to: *Contact information of the practitioner responsible for the care of the resident, *Resident representative information including contact information, *Advanced Directives, *Special Care instructions or precautions for ongoing care as indicated, *Comprehensive care plan goals, *All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care." 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 facility staff failed to provide evidence that the comprehensive care plan goals and physician required documentation were sent to the receiving facility when Resident #69 was transferred to the hospital on 3/24/19. Resident #69 was admitted to the facility on 3/28/19 with the diagnoses of but not limited to obstructive and reflux uropathy (2), benign prostatic hyperplasia (BPH) (3) with lower urinary tract symptoms, acute kidney failure, and	F 622		

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F 622	Continued From page 69 retention of urine. The most recent MDS (Minimum Data Set), a five day Medicare assessment, with an ARD (Assessment reference date) of 4/4/19, coded the resident as scoring a 9 on the BIMS (Brief interview for mental status) score, indicating the resident has moderate cognitive impairment for daily decision making. A review of the clinical record revealed a nurse's note that was dated 3/24/19 at 6:00 p.m., which documented in part, "Observed resident with less than 60 milliliters output in four hours. Attempted to change Foley catheter (indwelling urinary catheter) ...Attempted to reinsert Foley catheter (indwelling urinary catheter) had no urine return. Notified MD (medical doctor) of change. MD stated to send to ER (Emergency Room) for possible urine retention and distention. RP (responsible person) was notified and bed hold policy was explained. Resident was notified of condition change and bed hold policy explained ...Resident was transported via (name of ambulance) to (name of hospital) ..." Further review of the clinical record revealed a verbal physician's order that was dated 3/24/19, that documented in part, "May send to ER for evaluation." The review failed to evidence any documentation of what was provided to the receiving hospital for Resident #69's 3/24/19 transfer to the hospital. On 4/16/19 at 10:28 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked about the process for what documents are sent with the resident who is transferred to the hospital, LPN #2 stated, "I send the face sheet, the last progress notes, any relevant labs [laboratory tests], the bed hold	F 622		

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F 622	Continued From page 70 policy, a list of the care plan, physicians contact 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 4/16/19 at 3:15 PM, ASM (Administrative Staff Member) #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) Obstructive and reflux uropathy: Obstructive uropathy is structural or functional hindrance of normal urine flow, sometimes leading to renal dysfunction (obstructive nephropathy) The information was obtained from the website: https://www.merckmanuals.com/professional/genitourinary-disorders/obstructive-uropathy/obstructive-uropathy 3. The facility staff failed to evidence what, if any of the required documentation was provided to the hospital when Resident #61 was transferred to the hospital on 1/27/19. Resident # 61 was admitted to the facility on 01/26/2019 with diagnoses that included but were not limited to chest pain, atrial fibrillation (1) and diabetes mellitus (2). Resident # 61's most recent MDS (minimum data set), a 5-Day assessment with an ARD (assessment reference date) of 03/26/19, coded Resident # 3 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score	F 622		

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F 622	Continued From page 71 of 0 - 15, 9 (nine) - being moderately impaired of cognition intact for making daily decisions. The nurse's "Progress Notes," dated 01/27/2019 for Resident # 61 documented, "11:30 a.m., Temp (temperature) 101.9, alert to name, slow to respond. Saturation O2 (oxygen) 91% @ (at) 2L (two liters) via (by) n/c (nasal cannula). Skin is warm and moist. ASM (altered mental status) changes to self, time and surroundings. Speech not clear, garbled at times, Grip strength weaker than yesterday. (Name of Physician) notified with n.o. (new order) to send to (Name of Hospital) Med (medical) ctr (Center) ...911 called for transfer. 11:50 a.m. (Name of Emergency Squad) ems (emergency medical technician) here to transfer." The facility's nurse's "Admission/Readmission Data Collection) dated 01/28/2019 at "Time 1530 pm (3:30 p.m.)" for Resident # 61 documented, "15:40 (3:40 p.m.) Resident admitted to unit via ambulance transport. Readmitted to (Room Number)." Review of the clinical record for Resident # 61 failed to evidence documentation that Resident # 61's comprehensive care plan goals were provided to the receiving facility at the time of transfer to the hospital on 01/27/19. On 04/15/19 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator and ASM # 3, regional director of clinical services, were provide the date of 01/27/19, when Resident # 61 was transferred from the facility to the hospital. A request was made at that time to provide documentation that Resident # 61's comprehensive care plan goals were provided to	F 622		

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F 622	Continued From page 72 the receiving facility (hospital). On 04/16/19 at 7:54 a. m., ASM # 3, regional director of clinical services stated in regards to the request for documentation that Resident # 61's comprehensive care plan goals were provided to the receiving facility, "If we provided the documentation it is in the nurse's notes." On 4/16/19 at 10:28 AM, an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked about the process for what documents are sent with the resident who is transferred to the hospital, LPN #2 stated, "We send the facesheet, the last progress notes, any relevant labs [laboratory tests], the bed hold policy, a list of the care plan, physicians contact information, and any special instructions." When LPN #2 was asked about how the information is evidenced, she stated, "I put it in my notes, a copy of the bed hold policy, and the transfer information in the chart." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This	F 622		

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F 622	Continued From page 73 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 5. The facility staff failed to evidence that Resident # 53's comprehensive care plan goals were sent with the Resident to the hospital for the transfer dated 12/18/2018. Resident # 53's most recent facility admission was 12/26/18 with diagnoses that included but were not limited to: chronic respiratory failure (1) with hypoxia (2), peripheral vascular disease (3), and chronic obstructive pulmonary disease (4). Resident # 53's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 01/02/18, coded Resident # 53 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 indicating the resident has moderate cognitive impairment for daily decision making. A review of Resident # 53's clinical record revealed the admission record documented Resident # 53 was sent to [hospital] for acute care from 12/18/18 to 12/26/18 related to a fall. The resident clinical record did not specify if comprehensive care plan goals were sent along with the resident to the hospital. On 4/16/19 at 10:28 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked about the process for what documents are sent with the resident who is transferred to the hospital, LPN #2 stated, "I send the face sheet, the last progress notes, any relevant labs [laboratory tests], the bed hold policy, a list of the care plan, physicians contact	F 622		

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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 # 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/respiratoryfailure.html 2. Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 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 called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing	F 622		

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F 622	Continued From page 75 bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 4. Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		

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F 623	Continued From page 76 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623	**F 623** **1.Resident #49 transferred to the hospital on 3/24/19 and returned the same day from ER. Written notification has been sent to the ombudsman and the resident representative as of 4/25/2019.** **Resident #61 transferred to the hospital on 1/27/19 and returned 1/28/19. Written notification will be sent to resident representative and Ombudsman on 5/9/2019.** **2.Social Services Director or Designee will review resident transfers to hospital within past 60 days to ensure resident representative and Ombudsman were provided with written notification of a hospital transfer. Follow-ups will be done based on findings.** **3.Executive Director or Designee to educate Director of Social Work on providing resident representative and Ombudsman written notification on hospital transfers. Executive Director or Designee will review written notification to resident representative and Ombudsman for 8 weeks and as needed to ensure required notification is provided.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

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F 623	Continued From page 77 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed evidence written notification was provided to the Resident Representative and/or the Ombudsman of a hospital transfer for two of 41 residents in the survey sample; Residents #49 and #61. 1. The facility staff failed to evidence that Resident #49's resident representative and the	F 623		

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F 623	Continued From page 78 Ombudsman were provided with written notification of a hospital transfer when the resident was sent to the hospital on 3/24/19. 2. The facility staff failed to provide Resident # 61 or Resident # 61's representative written notification when the resident was transferred to the hospital on 01/27/19. The findings include: 1. The facility staff failed to evidence that Resident #49's resident representative and the Ombudsman were provided with written notification of a hospital transfer when the resident was sent to the hospital on 3/24/19. Resident #49 was admitted to the facility on 11/1/18 with the diagnoses of but not limited to dysphagia, macular degeneration, high blood pressure, osteoarthritis, depression, chronic kidney disease, spondylosis, aphasia, anxiety disorder, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/7/19. The resident was coded as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a nurse's note dated 3/24/19 that documented, "Noted resident in respiratory distress. Obtained VS (vital signs) 177/89 (blood pressure), 30 (respirations), 97.0 (temperature), 72 (pulse), O2 sat (oxygen saturation) 90% (out of 100%) via O2 therapy. Notified NP (Nurse Practitioner). Lung sounds diminished (with) slight wheezing noted. Resident using abdominal muscle. Respiration rapid. N.O. (new order) to send resident out to	F 623		

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F 623	Continued From page 79 the hospital for eval (evaluation). Granddaughter (name) aware. 911 (emergency services) called. Bed hold policy given." Further review of the clinical record failed to reveal any evidence that written notification of this hospital transfer was provided to the Resident Representative and the Ombudsman. On 4/15/19 at 3:55 p.m., in an interview with RN #1 (Registered Nurse), when asked about notifying the family in writing of the hospital transfer, RN #1 stated, "Nurses just call the family, we don't do a written notification." When asked about notifying the Ombudsman, RN #1 stated, "Nurses do not notify Ombudsman." On 4/15/19 at 4:01 p.m., in an interview with OSM #3 (Other Staff Member - Director of Social Services), when asked about notifying the Ombudsman, OSM #3 stated, "I notify the Ombudsman for every discharge including hospital." When asked how she provides the notification, OSM #3 stated, "Every 2 weeks to a month, I email a notice." OSM #3 was asked to provide evidence that notification for Resident #49 was provided. OSM #3 looked and found the list sent on 4/8/19, which included the dates of 3/22/19 to 4/8/19 (resident was sent to the hospital on 3/24/19), did not include Resident #49. OSM #3 stated, "The list I sent that date were admissions and discharges from 3/22 to 4/8/19. I don't see her (Resident #49) on the list, I assume because she did not get admitted to the hospital." OSM #3 was asked if the Ombudsman was notified of Resident #49's hospital transfer on 3/24/19, OSM #3 stated, "No, the Ombudsman was not made aware of that transfer." When asked about providing written notification to the	F 623		

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	495236	A. BUILDING _____ 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

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F 623	Continued From page 80 family, OSM #3 stated, "I don't do the written notification to the family." She was not sure who did. On 4/16/19 at 8:36 AM, in a follow up interview with ASM #3 (Administrative Staff Member - the Regional Director of Clinical Services) about written notification to the family, ASM #3 stated, "(ASM #2 - the Interim Director of Clinical Services) fills them out, makes a copy for the book. The letter should be done for any transfer or discharge. If it isn't in the book it wasn't done." There was none located in this book for Resident #49. A review of the facility policy, "Transfer / Discharge Notification & Right to Appeal" documented, "Notice Before Transfer....Notify the resident and resident representative(s) of the transfer or discharge and the reasons for the move in writing (in a language and manner they understand.). The Center must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Record the reasons for the transfer or discharge in the resident's medical record.....Timing of the Notice...Notice must be made as soon as practicable before transfer or discharge. Note: Notices to the Ombudsman in these situations can be sent when practicable, such as a list of residents on a monthly basis...." 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 facility staff failed to provide Resident # 61 or the Resident # 61's representative written notification when the resident was transferred to	F 623		

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F 623	Continued From page 81 the hospital on 01/27/19. Resident # 61 was admitted to the facility on 01/26/2019 with diagnoses that included but were not limited to chest pain, atrial fibrillation (1) and diabetes mellitus (2). Resident # 61's most recent MDS (minimum data set), a 5-Day assessment with an ARD (assessment reference date) of 03/26/19, coded Resident # 3 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 61 was coded as requiring extensive assistance of one staff member for activities of daily living. The nurse's "Progress Notes," dated 01/27/2019 for Resident # 61 documented, "11:30 a.m., Temp (temperature) 101.9, alert to name, slow to respond. Saturation O2 (oxygen) 91% @ (at) 2L (two liters) via (by) n/c (nasal cannula). Skin is warm and moist. ASM (altered mental status) changes to self, time and surroundings. Speech not clear, garbled at times, Grip strength weaker than yesterday. (Name of Physician) notified with n.o. (new order) to send to (Name of Hospital) Med (medical) ctr (Center) ...911 called for transfer. 11:50 a.m. (Name of Emergency Squad) ems (emergency medical technician) here to transfer." The facility's nurse's "Admission/Readmission Data Collection) dated 01/28/2019 at "Time 1530 pm (3:3:30 p.m.)" for Resident # 61 documented, "15:40 (3:40 p.m.) Resident admitted to unit via ambulance transport. Readmitted to (Room Number)."	F 623		

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F 623	Continued From page 82 Review of the clinical record for Resident # 61 failed to evidence documentation that written notification was provided to Resident # 61 or Resident # 61's responsible party in regard to the transfer to the hospital on 01/27/19. On 04/15/19 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator and ASM # 3, regional director of clinical services, were provide the date of 01/27/19, when Resident # 61 was transferred from the facility to the hospital. A request was made at that time to provide documentation of written notification of the transfers to Resident# 61 and Resident # 61's responsible party. On 04/16/19 at 7:54 a.m., ASM # 3, regional director of clinical services stated in regard to the request for documentation of written notification of the transfers to Resident# 61 and Resident # 61's responsible party, "If we provided the documentation it is in the nurse's notes." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This	F 623		

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F 623	Continued From page 83 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record	F 625		

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F 625	Continued From page 84 review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for one of 41 residents in the survey sample, Residents #61. The facility staff failed to send a copy of the bed hold policy with Resident #61 at the time of transfer to the hospital and or provide a copy to Resident #61's responsible party on 01/27/19. The findings include: Resident # 61 was admitted to the facility on 01/26/2019 with diagnoses that included but were not limited to chest pain, atrial fibrillation (1) and diabetes mellitus (2). Resident # 61's most recent MDS (minimum data set), a 5-Day assessment with an ARD (assessment reference date) of 03/26/19, coded Resident # 3 as scoring a 9 (nine) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 61 was coded as requiring extensive assistance of one staff member for activities of daily living. The nurse's "Progress Notes," dated 01/27/2019 for Resident # 61 documented, "11:30 a.m., Temp (temperature) 101.9, alert to name, slow to respond. Saturation O2 (oxygen) 91% @ (at) 2L (two liters) via (by) n/c (nasal cannula). Skin is warm and moist. ASM (altered mental status) changes to self, time and surroundings. Speech not clear, garbled at times, Grip strength weaker than yesterday. (Name of Physician) notified with n.o. (new order) to send to (Name of Hospital)	F 625	**F 625** **1.Resident #61 transferred to the hospital on 1/27/19 and returned 1/28/19. A copy of the facility's bed hold policy was provided to the resident #61 and their responsible party on 5/7/2019.** **2.Director of Nursing or Designee will conduct a Quality Review of residents discharged over the last thirty days to determine if Bed Hold Policy was sent with resident when transferring to hospital and or provided to the residents responsible party. Follow up based on findings.** **3.Director of Nursing or Designee to educate licensed nurses on providing resident and resident representative a copy of facility's bed hold policy upon hospital transfer. Executive Director or Designee will review hospital transfers to ensure the bed hold policy was provided to the resident and or resident responsible party for 8 weeks and as needed to ensure required notification is provided.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

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F 625	Continued From page 85 Med (medical) ctr (Center) ...911 called for transfer. 11:50 a.m. (Name of Emergency Squad) ems (emergency medical technician) here to transfer." The facility's nurse's "Admission/Readmission Data Collection) dated 01/28/2019 at "Time 1530 pm (3:3:30 p.m.)" for Resident # 61 documented, "15:40 (3:40 p.m.) Resident admitted to unit via ambulance transport. Readmitted to (Room Number)." Review of the clinical record for Resident # 61 failed to evidence documentation the a bed hold policy was provided to Resident # 61 or Resident # 61's responsible party in regard to the transfer to the hospital on 01/27/19. On 04/15/19 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator and ASM # 3, regional director of clinical services, was provide the date of 01/27/19, when Resident # 61 was transferred from the facility to the hospital. A request was made at that time, to provide documentation the bed hold policy was sent with to Resident # 61 to the hospital and/or provided to Resident # 61's responsible party at the time of transfer. On 04/16/19 at 7:54 a.m., ASM # 3, regional director of clinical services stated in regard to the request for documentation the bed hold policy was sent with Resident # 61 to the hospital and/or provided to Resident # 61's responsible party, "If we provided the documentation it is in the nurse's notes." On 4/16/19 at 10:28 a.m., an interview was conducted with LPN (Licensed Practical Nurse)	F 625		

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F 625	Continued From page 86 #2. When asked about the process for what documents are sent with the resident who is transferred to the ER (emergency room) or hospital, LPN #2 stated, "We send the facesheet, the last progress notes, any relevant labs, the bed hold policy, a list of the care plan, physicians contact information, and any special instructions." When LPN #2 was asked about how the information 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 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 87 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 656	**F 656 Care plan development** **1.1) Resident #13 has her bed in low position as indicated in her plan of care.** **2) Resident # 52 is receiving her medications as prescribed by her physician as indicated in her plan of care.** **3) Resident # 70 is receiving treatment services as prescribed by her physician as indicated in her plan of care.** **4) Resident # 41 continues to receive oxygen therapy as ordered by the physician as indicated in her plan of care.** **5) Resident # 31 no longer has an order for Ambien and the comprehensive care plan has been updated.** **6) Resident # 73 implementation for call bell as indicated on care plan is appropriate for resident needs.** **2.Residents who reside in the facility have a comprehensive care plan developed according to the RAI manual. The implementation of interventions for residents care will be based on physician orders and interventions to assist residents to meet their highest psychosocial well being. Follow up will be based on findings.**	5-28-19

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F 656	Continued From page 88 document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for six of 41 residents in the survey sample, Residents #13, #52, #70, #41, #31 and #73. 1. The facility staff failed to have Resident #13's bed in the low position, while the resident was in the bed per the comprehensive care plan. 2. The facility staff failed to administer medications to Resident #52 per the physician order and the comprehensive care plan. 3. The facility staff failed to implement Resident #70's comprehensive care plan by not administering a physician ordered treatment. 4. The facility staff failed to implement the oxygen care plan for Resident #41 to provide oxygen per MD (medical doctor) orders. 5. The facility staff failed to develop a comprehensive care plan for Residents # 31's insomnia. 6. The facility staff failed to follow Residents # 73's comprehensive care plan for use of a call bell. The findings include: 1. Resident #13 was admitted to the facility on 10/08/18 with a recent readmission on 3/23/19, with diagnoses that included but were not limited to: high blood pressure, dementia, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 656	**3.The licensed nursing staff / MDS coordinator will update residents care plans when needed with interventions to address changes in care. The licensed nurse will be re educated by the DON or designee on updating the care plan and following interventions as outlined. Physician orders will be reviewed by the DON or designee daily, five times a week for eight weeks to ensure that care plan is updated in a timely manner. Quality review observations will be completed weekly for eight weeks by the DON or designee to ensure interventions are being implemented as written in the plan of care.** **4.The results of the quality monitoring will be reported to the quality assurance committee for review, analysis and further recommendations.tervention are implemented as written.**	

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F 656	Continued From page 89 assessment reference date of 2/8/19, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #13 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coded as requiring extensive assistance of two or more staff members for transfers and moving in the bed. The comprehensive care plan dated, 2/24/19, documented in part, "Focus: the resident is at risk for falls r/t (related to) nonambulatory/Hoyer lift for transfers, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, impaired hearing acuity." The "Interventions" documented in part, "Bed in low position." Observation was made of Resident #13 on 4/14/19 at 1:09 p.m. during the initial screening of residents. Resident #13 was observed in her bed. She was asleep. The bed was at the waist level of this surveyor, approximately 39 inches. A second observation was made of Resident #13 on 4/114/19 at 2:52 p.m. The resident was again noted in bed, asleep. The height of the bed was at the waist level of this surveyor, approximately 39 inches. An interview was conducted with CNA (certified nursing assistant) # 2 on 4/15/19 at 2:51 p.m. When asked if a resident's care plan documents, the resident should have their bed in the low position while in bed, should that be followed, CNA #2 stated, "Yes, you should make sure it's in	F 656		

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F 656	Continued From page 90 the low position if you leave the room." When asked the purpose of the care plan, CNA #2 stated, "It's how to properly care for the resident and meet the resident's needs. An interview was conducted with RN (registered nurse) #2, on 4/15/19 at 2:53 p.m. When asked about the purpose of the care plan, RN #2 stated, "It's how to take care of them (the residents). When asked if the care plan should be followed, RN #2 stated, "Absolutely, unless you need to implement further measures according to their needs." When asked if the care plan documents, to keep the bed in low position when the resident is in the bed, where should the bed be when the resident is in the bed, RN #2 stated, "In the low position." The facility policy, "Best Practice - Care Plans" documented in part, "Process: The resident's needs are addressed through patient centered interventions oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being." The facility policy, "Clinical Guidelines - Fall Management" documented in part, "3. Residents determined to be at risk for falls will have patient centered interventions developed and implemented to minimize the risk of falling and/or injury." 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.	F 656		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 656	Continued From page 91 No further information was provided prior to exit. 2. The facility staff failed to administer medications to Resident #52 per the physician order and the comprehensive care plan. Resident #52 was admitted to the facility on 9/17/18 with diagnoses that included but were not limited to lung cancer, COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic (1)], high blood pressure, anxiety, chronic pain and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/13/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired to make daily cognitive decisions. The resident was coded as having periods of disorganized thinking that comes and goes. Resident #52 was coded as having periods of hallucinations and delusions. The resident was coded as requiring limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antianxiety medication. The comprehensive care plan dated, 3/14/19, documented in part, Focus: The resident has acute/chronic pain r/t (related to) complaints of pain to right ankle with warmth/swelling/ CA (cancer)." The "Interventions" documented in part, "Administer analgesics as per orders." The comprehensive care plan dated, 3/26/19,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 92 documented in part, "Focus: The resident uses anti-anxiety medications r/t (related to) Anxiety disorder." The "Interventions" documented in part, "Administer ANT-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift)." The physician order dated, 12/31/18, documented, "Methadone* HCL (hydrochloride) 5 MG (milligram) Tablet; 3 tabs (tablets) by mouth three times daily at 0600 (6:00 a.m.) 1400 (2:00 p.m.), 2200 (10:00 p.m.) for pain." *Methadone is used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications (2). Review of the January 2019 MAR (medication administration record) documented the above physician order. On 1/14/19 at 2200 (10:00 p.m.), the nurse initialed the medication and circled their initials, indicating it wasn't given. There was no documentation on the reverse side of the MAR. Review of the nurse's notes failed to evidence nursing documentation on 1/14/19. The February 2019 MAR documented the above physician order. The Methadone was circled as not having been administered on 2/9/19 at 10:00 p.m., 2/10/19 at 10:00 p.m., 2/18/19 at 6:00 a.m., and 2/21/19 at 10:00 p.m. The reverse side of the MAR failed to evidence documentation of why the medication was not administered. Review of the nurse's notes for the above dates and times, failed to evidence the reason why the medication was not administered.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 93 The March 2019 MAR documented the above physician order. The Methadone was circles as not having been administered on 3/8/19 at 6:00 a.m. and 2:00 p.m., 3/12/19 at 2:00 p.m. and 3/13/19 at 2:00 p.m. There was nothing documented on the reverse side of the MAR. 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. Review of the nurse's notes for the above dates failed to evidence documentation of why the medication was not administered. 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 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. The physician order dated, 2/14/19, documented,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 94 "Reduce am (morning) dose of Ativan (used to treat anxiety) (3), to 0.5 mg (milligrams), cont (continue) pm (evening) dose of Ativan @ (at) 1 mg." The February MAR 2019 (medication administration record) documented the above medication orders. The Ativan scheduled for 2/15/19 at 9:00 a.m. had the nurse's initials with a circle around them. There was nothing documented on the reverse of the MAR. The MAR also documented the Ativan 1 mg to be administered at 5:00 p.m. to have the nurse's initials circled on 2/14/19, 2/15/19, 2/19/19, and 2/24/19. The reverse side of the MAR documented on 2/14/19 at 5:00 p.m. "Pending arrival from pharmacy." For 2/14/19 at 5:00 p.m., it documented, "Sleeping." There were no other notes on the reverse side of the MAR. Review of the nurse's notes for the above dates and times, failed to evidence documentation of why the medication was not administered. An interview was conducted with CNA (certified nursing assistant) # 2 on 4/15/19 at 2:51 p.m. When asked the purpose of the care plan, CNA #2 stated, "It's how to properly care for the resident and meet the resident's needs. An interview was conducted with RN (registered nurse) #2, on 4/15/19 at 2:53 p.m. When asked the purpose of the care plan, RN #2 stated, "It's how to take care of them (the residents). When asked if interventions on the care plan should be followed, RN #2 stated, "Absolutely, unless you need to implement further measures according to their needs."	F 656		

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	495236	A. BUILDING _____ 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

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F 656	Continued From page 95 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." When asked what a circle around the nurse's initials indicate, RN #1 stated it means that nurse did not give the medication. When asked if a nurse should document why a medication is not given, RN #1 stated, "Yes, they can either document it on the reverse side of the MAR or in a nurse's note." When asked if a medication is not given, refused or not available, should the physician be notified, RN #1 stated, "Absolutely and a note should be documented." When asked if the nurse does not give a medication and the care plan states to give the medications as ordered, is that following the care plan, RN #1 stated, "No, that's not." 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. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 96 Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682134.html (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html. 3. The facility staff failed to implement Resident #70's comprehensive care plan by not administering a physician ordered treatment. Resident #70 was admitted to the facility on 8/14/2018. Diagnoses included but were not limited to: spina bifida (1), pressure ulcer of the sacral region stage four (2) (3), muscle weakness and absence of the left leg. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/3/19 coded the resident as having a score of 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited assistance for most of her activities of daily living. In Section M - Skin Conditions, the resident was coded as having one unstageable pressure injury and two stage four pressure ulcers (3). The POS (physicians order summary) dated April 2019, documented, "2/12/19: Sacrum-cleanse with Dakin's Solution (4), cover with silver alginate then cover with foam dressing every day and as needed." In addition, the POS documented, "2/12/19: Ischium Wounds- Cleanse with Dakin's Solution, cover with foam dressing every day and as needed."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 97 The comprehensive care plan dated 3/14/19, documented, "The resident has a pressure injury to sacrum and left ischium, abd (abdominal) surgical related to history of ulcers and lack of mobility; Interventions: treatments as ordered." The TAR (treatment administration record) dated March 2019 documented, "2/12/19: Sacrum-cleanse with Dakin's Solution (5), cover with silver alginate then cover with foam dressing every day and as needed." the treatment was not documented as administered on: March 1st, 5th, 22nd, 23rd, and 26th 2019. The TAR (treatment administration record) dated March 2019 documented, "2/12/19: Ischium Wounds- Cleanse with Dakin's Solution, cover with foam dressing every day and as needed." the treatment was not documented as being administered on: "March 1st, 5th, 22nd, 23rd, and 26th 2019. On 04/17/19 at approximately 9:40 a.m., an interview was conducted with Resident #70. Resident #70 was asked if her wound care is administered daily. Resident #70 replied, "Mostly. The nurses change my dressings most days but sometimes they miss days." On 4/17/19 at approximately 9:47 a.m., an interview was conducted with ASM (administrative staff member) #2, the Interim Director of Clinical Services, after reviewing Resident #70's MAR and comprehensive care plan. ASM #2 was asked if the physician ordered wound treatment was administered on the days of March 1st, 5th, 22nd, 23rd, and 26th. ASM #2 replied, "If the nurse did not signed off the treatment I can't say it	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 98 was done." ASM #2 was asked if Resident #70's care plan was being followed. ASM #2 replied, "No." On 4/17/19 at approximately 10:30 a.m., ASM #1, the Executive Director, ASM (administrative staff member) #2, the Interim Director of Clinical Services and ASM #3, the Regional Director of Clinical Services were made aware of the findings. The facility policy titled, "Best Practice - Care Plan" dated 7/31/17, documented in part, "The resident's needs are addressed through patient centered interventions oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being." 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://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=	F 656		

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	495236	A. BUILDING _____ 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

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F 656	Continued From page 99 medlineplus-bundle&query=spina+bifida&_ga=2.165789432.755020280.1555684133-764922449.1555684133 2. Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin 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/000147.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 ulcer. 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. Unstageable 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. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. (See 'Debridement' below.) This information was obtained from the website: https://www.uptodate.com/contents/clinical-stagin	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 100 g-and-management-of-pressure-induced-skin-and-soft-tissue-injury?search=pressure%20ulcer%20staging&source=search_result&selectedTitle=1~4&usage_type=default&display_rank=1#H76128204 4. Dakin's solution (0.025% sodium hypochlorite) is widely used in a variety of difficult wound types and has been advocated by some for the management of burn wounds. It has broad-spectrum antimicrobial activity with efficacy in the clinical setting of MRSA, Vancomycin-resistant Enterococcus (VRE), and other antibiotic-resistant bacteria. This information was obtained from the website: https://www.uptodate.com/contents/topical-agents-and-dressings-for-local-burn-wound-care?search=dakins%20solution&sectionRank=1&usage_type=default&anchor=H10128208&source=machineLearning&selectedTitle=2~33&display_rank=1#H10128208 4. The facility staff failed to implement the oxygen care plan for Resident #41 to provide oxygen per MD (medical doctor) orders. Resident #41 was admitted to the facility on12/8/17 with the diagnoses including, but not limited to stroke, respiratory failure, high blood pressure, gastrostomy status (1) and dementia. The most recent MDS (Minimum Data Set), a quarterly review assessment with an ARD (Assessment Reference Date) of 2/28/19, documented that Resident #41 had moderate cognitive impairment for daily decision-making. On 4/14/19 at 2:00 p.m., on 4/15/19 at 8:55 a.m., and 12:15 p.m., Resident #41's oxygen flowrate on the oxygen concentrator was observed set at	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 101 2 ½ liters per minute during each observation. A review of the clinical record revealed a MAR (medication administration record) that was dated April 2019, which documented in part, "12/29/18: Oxygen 3L/Min (3 liters per minute) via nasal cannula ..." Further review of the clinical record revealed a physician's order, dated April 2019, that documented in part, "12/29/18: Oxygen 3L/Min via nasal cannula ..." Further review of the clinical record revealed a comprehensive care plan dated 2/21/19, that documented in part, "The resident has altered respiratory status/difficulty breathing related to chronic respiratory failure with hypoxia (5)." The comprehensive care plan "Interventions" documented in part, "Provide oxygen per MD (medical doctor) orders." On 4/16/19 at 12:24 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When LPN #2 was asked about the process for administering oxygen at the prescribed flowrate, LPN #2 stated, "You look at the order. Take the oxygen to the room and set it at the correct level." When LPN #2 was asked, how the nurse would determine if the flowrate is set at the correct level? LPN #2 stated, I look at the cylinder on the concentrator at eye level. I would put the black ball on the line, not above or below the line but at the center." When LPN #2 was asked the process for care planning and implementing oxygen therapy, LPN #2 stated, "The nurse checks it (physician's orders) and creates the care plan. It would be placed on the TAR (treatment administration record), that is	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 102 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 devices ...Procedure ...Physician's order for oxygen therapy shall include: Administration modality...liter flow ...continuous or PRN ... Review physician's order ...Start 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 physician ...To properly read the flowmeter B, locate 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 l/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	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 103 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. (1) Gastrostomy status: is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. This information was retrieved from the website: https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99/Z93-/Z93.1 5. The facility staff failed to develop a comprehensive care plan for Residents # 31's insomnia. Resident # 31 was admitted to the facility on 03/15/18 and a readmission of 03/16/19 with diagnoses that included but were not limited to insomnia (2), respiratory failure, (3), chronic obstructive pulmonary disease (4), and hypertension (5). Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/13/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 31 was coded as being independent for all activities of daily living. The physician's orders dated "April 2019" for Resident # 31 documented, "Zolpidem F/C (film coated) 5MG (milligram) Tablet (Ambien). 1 (one) tab (tablet) by mouth at bedtime as needed for sleep. 03/16/19." The MAR (medication administration record) dated March 2019 for Resident # 31 documented,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 656	Continued From page 104 "Zolpidem F/C (film coated) 5MG Tablet (Ambien). 1 tab by mouth at bedtime as needed for sleep. 03/16/19." Review of the MAR dated 03/16/19 through 03/31/19 revealed Resident # 31 received Zolpidem ten out of sixteen opportunities. Further review of the MAR dated "March 2019" failed to evidence documentation of non-pharmacological approaches being attempted prior to the administration of Zolpidem. The MAR (medication administration record) dated April 2019 for Resident # 31 documented, "Zolpidem F/C (film coated) 5MG Tablet (Ambien). 1 tab by mouth at bedtime as needed for sleep. 03/16/19." Review of the MAR dated 04/01/19 through 04/11/19 revealed Resident # 31 received Zolpidem seven of eleven opportunities. Further review of the MAR dated "April 2019" failed to evidence documentation of non-pharmacological approaches being attempted prior to the administration of Zolpidem. The comprehensive care plan for Resident # 31 dated 03/11/2019 documented failed to evidence documentation for insomnia and the use of Zolpidem. On 04/16/19 at 12:43 p.m., an interview was conducted with RN (registered nurse) # 6 temporary traveling MDS, coordinator. After reviewing the diagnosis of insomnia for Resident # 31 and the physician's order for the use of as needed Zolpidem (Ambien) and Resident # 31's care plan dated 03/11/2019, RN # 6 was asked if Resident # 31 should have a care plan to address insomnia. RN # 6 stated, "It should be, I don't see it on there." On 04/06/19 at approximately 3:43 p.m., ASM	F 656		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 656	Continued From page 105 (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) Comes as a tablet (Ambien) and an extended-release (long-acting) tablet (Ambien CR) to take by mouth. Zolpidem also comes as a sublingual tablet (Edluar, Intermezzo) to place under the tongue and an oral spray (Zolpimist), which is sprayed into the mouth over the tongue. If you are taking the tablets, extended-release tablets, sublingual tablets (Edluar), or oral spray, you will take the medication as needed, not more than one time a day, immediately before bedtime. If you are taking the sublingual tablets (Intermezzo), you will take the medication as needed, not more than one time during the night if you wake up and have difficulty returning to sleep. Zolpidem will work faster if it is not taken with a meal or immediately after a meal. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use zolpidem exactly as directed. You will probably become very sleepy soon after you take zolpidem and will remain sleepy for some time after you take the medication. Plan to go to bed right after you take zolpidem tablets, extended-release tablets, sublingual tablets (Edluar), and oral spray and to stay in bed for 7 to 8 hours. Take zolpidem sublingual tablets (Intermezzo) only when you are already in bed and can remain in bed for at least 4 more hours. Do not take zolpidem if you will be unable to remain asleep for the required number of hours after taking the medication. If you get up too soon after taking zolpidem, you may	F 656		

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	495236	A. BUILDING _____ 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

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F 656	Continued From page 106 experience drowsiness and problems with memory, alertness, or coordination. . This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693025.html. (2) A common sleep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both. As a result, you may get too little sleep or have poor-quality sleep. You may not feel refreshed when you wake up. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/insomnia.html. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 6. The facility staff failed to follow Residents # 73's comprehensive care plan for use of a call bell. Resident # 73 was admitted to the facility on 08/06/12 with a re-admission of 04/27/15 with diagnoses that included but were not limited to dementia (1), heart failure (2), atrial fibrillation (3)	F 656		

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	495236	A. BUILDING _____ 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

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F 656	Continued From page 107 and diabetes mellitus (4). Resident # 73's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/22/19, coded Resident # 73 as scoring an 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 73 was coded as requiring supervision with setup for all activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 73 as "No impairment" on both sides of her upper extremities (shoulder, elbow, wrist, hand). On 04/14/19 at 2:30 p.m., an observation of Resident # 73 revealed he was sitting on the edge of his bed. Observation of the call bell revealed it was lying on the floor underneath his bed. When asked if he could locate his call bell Resident # 73 stated, "It's over there" and pointed to a white cord under the privacy curtain toward the opposite side of the room. Further observation revealed Resident # 73 was unable to reach for the call bell under his bed. The comprehensive care plan for Resident # 73 dated 02/07/2019 documented, "Focus. (Resident # 73) is able to make his needs known, has clear speech, vision and hearing are adequate without devices. He does need assistance with ADLs due to impaired cognitive status. He is ambulatory and uses a wheeled walker [sic] with as eat on it. He sits on a chair by his bed when he is out of bed. He has 2 ¼ (two and a quarter) handrails on each side of the bed and he reports he uses them to help transfer and move around in the bed. Date Initiated:	F 656		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 656	Continued From page 108 02/07/2019." Under "Interventions" it documented, "Encourage the resident to use bell to call for assistance. Date Initiated: 02/07/2019." On 04/16/19 at 2:55 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan, LPN # 4 stated, "Monitor the progress of the resident and to maintain a healthy level of living." When asked if something is documented on the care plan to be followed or implemented and it is not followed could you say that the care plan was being implemented, LPN # 4 stated, "No." When asked about Resident # 73's call bell being observed on the floor under his bed and the care plan documenting the Resident # 73 should be encouraged to use his call bell, LPN # 4 stated, "The care plan is not being followed. He can't be encouraged to use the call bell if it is not within reach." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was	F 656		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 656	Continued From page 109 obtained from the website: https://medlineplus.gov/ency/article/000158.htm. (3) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	**F 657 Care plan timing and revision** **1.The care plan for resident # 31 has been updated to reflect the intervention of resident education to use brakes on rollator device.** **2.Residents who have experienced a fall within the past thirty days will be reviewed by the interdisciplinary team to ensure that interventions are in place and appropriate. Care plans will be updated or revised as needed.** **3.The licensed nurse will be re educated by the DON or designee on updating the care plan timely and following interventions as outlined. Physician orders will be reviewed by the DON or designee daily, five times weekly for eight weeks to ensure that care plan is updated in a timely manner. Quality review observations will be completed weekly for eight weeks by the DON or designee to ensure interventions are being implemented as written in the plan of care.**	5·28·19

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 657	Continued From page 110 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review/revise a comprehensive care plan for on of 41 residents in the survey sample, Resident # 31. The facility staff failed to review/revise Residents # 31's comprehensive care plan for following a fall on 04/09/19. The findings include: Resident # 31 was admitted to the facility on 03/15/18 and a readmission of 03/16/19 with diagnoses that included but were not limited to insomnia (2), respiratory failure, (3), chronic obstructive pulmonary disease (4), and hypertension (5). Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/13/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 31 was coded as being independent for all activities of daily living. The facility's "SBAR (Situation, Background, Appearance, Review and Notify) Communication Form" for Resident # 31 dated 04/09/19 documented, "Situation: Fall 04/09/19; Background: No changes observed; Appearance: Resident A&O (alert and oriented) v/s (vital signs) WNL (within normal limits) 0 (zero) c/o (complaint of) pain; Review and Notify: Primary Care Clinician Notified: (Name of Physician, Date:	F 657	**4.The results of the quality review data will be reported to the quality assurance committee monthly for review, analysis and further recommendations.**	

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F 657	Continued From page 111 4/9/19 Time: 2pm (2:00 p.m.). Name of Family/Health Care Agent Notified: (Name of Family Member). Date: 4/9/19 Time: 1500pm (3:00 p.m.)." The facility's "Fall Root Cause Investigative Report" for Resident # 31 dated 04/09/19 documented, "Resident slipped trying to sit in rollator (rolling walker)." Under "Resolution/Intervention for minimizing future occurrences" it documented, "Education on transferring to and from rollator. Education on rollator break use." The comprehensive care plan for Resident # 31 dated 03/11/2019 documented failed to evidence documentation of Resident # 31's fall on 04/09/19 and interventions related to the fall. On 04/16/19 at 12:43 p.m., an interview was conducted with RN (registered nurse) # 6 temporary traveling MDS, coordinator, regarding Resident # 31's fall on 4/9/19. After reviewing the comprehensive care plan for Resident # 31 dated 03/11/2019, RN # 6 agreed that the care plan was not updated with the new intervention. LPN # 6 stated, "It should be on the care plan." When asked to describe the procedure for updating a resident's care plan following a fall, RN # 6 stated, "It is review IDT (interdisciplinary team) meeting weekly and during the morning meeting, every morning. If there is any new fall, and new interventions are put in place, there would be documentation that the care plan that it was updated." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, director of clinical services,	F 657		

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F 657	Continued From page 112 were made aware of the above findings. No further information was provided prior to exit. References: (2) A common sleep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both. As a result, you may get too little sleep or have poor-quality sleep. You may not feel refreshed when you wake up. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/insomnia.html. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 684	Continued From page 113 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure one of 41 residents in the survey sample, received the care and services in accordance with professional standards of practice and the comprehensive care plan for Resident #52. The facility staff failed to administer medications per the physician orders for Resident #52. The findings include: Resident #52 was admitted to the facility on 9/17/18 with diagnoses that included but were not limited to lung cancer, COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic. (1)], high blood pressure, anxiety, chronic pain and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/13/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired to make daily	F 684	**F 684** **1.Resident # 52 is receiving Ativan as ordered by physician. The licensed nurse completed the MAR for administration of Ativan.** **2.Residents with physician orders for anti-anxiety medications will be reviewed by the DON or designee to ensure and medication is being administered as per physician order. Follow up based on findings.** **3.Licensed nursing staff will be re educated by DON/designee following physician orders and providing services in accordance with professional standard of practice for medication administration. Random medication administration reviews will be conducted weekly for eight weeks by the DON or designee to ensure medications are available and medication administration is completed as well as documented on the medication administration record in accordance with physician order.** **4.The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 684	Continued From page 114 cognitive decisions. The resident was coded as having periods of disorganized thinking that comes and goes. Resident #52 was coded as having periods of hallucinations and delusions. The resident was coded as requiring limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antianxiety medication. The physician order dated, 2/14/19, documented, "Reduce am (morning) dose of Ativan [used to treat anxiety (2)], to 0.5 mg (milligram), cont (continue) pm (evening) dose of Ativan @ (at) 1 mg." The February MAR 2019 (medication administration record) documented the above physician medication orders. The Ativan dose scheduled for 2/15/19 at 9:00 a.m. had the nurse's initials with a circle around them. There was nothing documented on the reverse side of the MAR. The MAR also documented the Ativan 1 mg dose to be administered at 5:00 p.m. with the nurse's initials circled on 2/14/19, 2/15/19, 2/19/19, and 2/24/19. The reverse side of the MAR documented on 2/14/19 at 5:00 p.m. "Pending arrival from pharmacy." On 2/14/19 at 5:00 p.m., the reverse side of the MAR documented, "Sleeping." There were no other notes on the reverse side of the MAR regarding the circled doses of Ativan listed above. The comprehensive care plan dated, 3/26/19, documented in part, "Focus: The resident uses anti-anxiety medications r/t (related to) Anxiety disorder." The "Interventions" documented in part, "Administer ANT-ANXIETY medications as ordered by physician. Monitor for side effects and	F 684		

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	495236	A. BUILDING _____ 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

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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" 6th edition, 2005; 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." Administrative staff member (ASM) #1, the	F 684		

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F 684	Continued From page 116 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.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services to promote the healing of a pressure injury for two of 41 residents in the	F 686		

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F 686	Continued From page 117 survey sample, Residents #30 and #70. 1. The facility staff failed to ensure weekly measurements and assessments were completed to assess and monitor the healing of Resident #30's left heel pressure injury from March 2018 through July 2018, and in October 2018. In addition, the staff failed to assess the stage of the pressure injury from March 2018 until January 2019. 2. The facility staff failed to ensure Resident #70 received the necessary treatment and services to promote the healing of a pressure injury. The findings include: 1. The facility staff failed to ensure weekly measurements and assessments were completed to assess and monitor the healing of Resident #30's left heel pressure injury from March 2018 through July 2018, and in October 2018. In addition, the staff failed to assess the stage of the pressure injury from March 2018 until January 2019. Resident #30 was admitted to the facility on 6/16/17. Resident #30's diagnoses included but were not limited to paralysis, peripheral vascular disease and obesity. Resident #30's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/1/19, coded the resident as being cognitively intact. Section G coded Resident #30 as requiring extensive assistance of two or more staff with bed mobility and as being totally dependent on two or more staff with transfers. Section M coded the resident as being at risk of developing pressure injuries and as have one	F 686	**F 686 Pressure ulcer** **1.Resident # 30 was seen by wound consultant physician on 4/23/2019 with documentation of left heel pressure injury as resolved. A weekly skin assessment by a licensed nurse on 5/7/2019 does not identify any new skin integrity concerns. Resident # 70 is being provided treatment and services to promote wound healing as prescribed by the physician.** **2.Residents identified as having pressure injury treatment orders have been reviewed for weekly measurements, assessments, and staging documentation in the medical record. Follow up to be conducted based on findings.** **3.The licensed nursing staff in the facility will be re educated by DON/ designee on documenting weekly pressure injury measurements, staging and assessments to monitor the healing process. Weekly pressure ulcer assessments will be completed by a licensed nurse and given to the DON. The interdisciplinary team will meet weekly to review residents with noted pressure injury to ensure all documentation and treatments are appropriate.** **4.The results of the quality monitoring will be reported to the quality assurance committee for review, analysis and further recommendations.**	5-28-19

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F 686	Continued From page 118 stage three pressure injury (1). Resident #30's comprehensive care plan dated 6/28/18 documented, "The resident has impaired skin integrity...Abdominal surgical site. Left Heel... Administer treatments as ordered and monitor for effectiveness. Weekly skin Checks..." Resident #30's most recent Braden scale for predicting pressure sore (injury) risk dated 3/6/19 documented the resident was at high risk for pressure injuries. Review of Resident #30's clinical record revealed a nurse's note dated 3/27/18 that documented the resident was readmitted to the facility with a blood fluid filled blister on the left heel and an order to apply skin prep to the area every shift was obtained. Resident #30 was discharged on 5/18/18. Further review of Resident #30's clinical record failed to reveal an assessment of the pressure injury on the left heel until 5/22/18 when a nurse's note documented Resident #30 was readmitted to the facility. The 5/22/18 note documented black necrotic tissue with a small amount of yellowish brown drainage to the left heel. The note documented the measurement of the area as approximately 12 cm (centimeters) (length) by 10 cm (width) by 0.1 cm (depth). Further review of Resident #30's clinical record failed to reveal another assessment of the left heel until 7/23/18. A nurse's note dated 7/23/18 documented the pressure injury on the left heel measured 6 cm by 6 cm by 1.2 cm. A wound physician consult note dated 7/24/18 documented the area on the left heel measured 6 cm by 5.5 cm by 1.2 cm. A nurse's note dated 8/13/18 documented the pressure injury on the left heel measured 4.5 cm by 4.5 cm by 0.5 cm. A nurse's note dated	F 686		

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F 686	Continued From page 119 8/27/18 (fourteen days after the previous measurement on 8/13/18) documented the pressure injury on the left heel measured 5.5 cm by 4.7 cm by 0.6 cm. A wound care physician consult dated 9/4/18 documented the pressure injury on the left heel measured 4.9 cm by 4.5 cm by 0.2 cm. A nurse's note dated 9/5/18 documented the pressure injury on the left heel measured 4.5 cm by 4.5 cm by 0.3 cm. A nurse's note dated 9/12/18 documented the pressure injury on the left heel measured 4.2 cm by 3.8 cm by 0.2 cm. A nurse's note dated 9/17/18 documented the pressure injury on the left heel measured 4.5 cm by 4.3 cm by 0.2 cm. A nurse's note dated 9/24/18 documented the pressure injury on the left heel measured 3.9 cm by 3.5 cm by 0.1 cm. A nurse's note dated 11/5/18 (42 days after the last measurement on 9/24/18) documented the pressure injury on the left heel measured 1.7 cm by 2.5 cm by 0.1 cm. A nurse's note dated 11/12/18 documented the pressure injury on the left heel measured 2.2 cm by 2.9 cm by 0.1 cm. A nurse's note dated 11/19/18 documented the pressure injury on the left heel measured 1.8 cm by 2.5 cm by 0.1 cm. A nurse's note dated 11/26/18 documented the pressure injury on the left heel measured 2.2 cm by 2.2 cm by 0.1 cm. A nurse's note dated 12/3/18 documented the pressure injury on the left heel measured 1.9 cm by 2.4 cm by 0.1 cm. A nurse's note dated 12/10/18 documented 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 pressure injury on the left heel measured 1.9 cm by 2.8 cm by 0.1 cm. A nurse's note dated 12/28/18 documented the pressure injury on the left heel measured 2.1 cm	F 686		

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F 686	Continued From page 120 by 2.5 cm by 0.2 cm. A nurse's note dated 1/7/19 documented the pressure injury on the left heel measured 2 cm by 2.8 cm by 0.1 cm. A nurse's note dated 1/14/19 documented the pressure injury on the left heel measured 1.7 cm by 2.8 cm by 0.1 cm. A nurse's note dated 1/21/19 documented the pressure injury on the left heel measured 1.6 cm by 2.5 cm by 0.1 cm. A nurse's note dated 1/28/19 documented the pressure injury on the left heel measured 1.5 cm by 2 cm by 0.1 cm. A nurse's note dated 2/4/19 documented the pressure injury on the left heel measured 1.4 cm by 1.2 cm by 0.1 cm. A nurse's note dated 2/25/19 (approximately 21 days after the 2/4/19 measurement) documented the pressure injury on the left heel measured 1.8 cm by 2.8 cm by 0.1 cm. None of the above assessments documented the stage of the pressure injury on the left heel. Further review of Resident #30's clinical record revealed a pressure ulcer (injury) record beginning on 3/4/19 that documented the following assessments of the pressure injury on the left heel: 3/4/19- stage 3- 2 cm by 2.2 cm by 0.1 cm. 3/11/19- stage 3- 2.5 cm by 1.6 cm by 0.1 cm. 3/18/19- stage 3- 1.3 cm by 2.8 cm by 0.1 cm. 3/25/19- stage 3- 0.7 cm by 1.3 cm by 0.1 cm. 4/1/19- stage 3- 0.3 cm by 0.3 cm by 0.1 cm. 4/9/19- stage 2 (1) - 1 cm by 1 cm by 0.1 cm. 4/15/19- "no open area, continue to assess and protect." Review of the physician's orders and TAR (treatment administration record) revealed multiple changes in treatment orders were made during the above period and that the treatments	F 686		

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F 686	Continued From page 121 were administered as ordered. On 4/16/19 at approximately 2:00 p.m., ASM (administrative staff member) #2 the interim director of nursing was asked for all measurements of Resident #30's wounds. The measurements above were all that was provided by ASM #2. On 4/17/19 at 9:55 a.m., an interview was conducted with RN (registered nurse) #5 (the wound care nurse, employed at the facility since June 2018). RN #5 stated she works at the facility every Monday and Wednesday. RN #5 stated she measures wounds on Mondays and completes wound care on Mondays and Wednesdays. RN #5 stated she used to document pressure injury assessments on a weekly form but now documents assessments on the pressure record. RN #5 was made aware there was a lack of assessments for Resident #30's left heel in the clinical record. RN #5 was made aware assessments were only observed in the nurses' notes until 3/4/19 when the assessments were documented on the pressure ulcer record. RN #5 stated she did not know what the facility staff did with the previous forms. On 4/17/19 at 10:17 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services). ASM #2 was asked to describe the information a pressure injury assessment should consist of. ASM #2 stated the assessment should contain the skin integrity, a description of the wound, what it looks like and measurements. When asked if the assessment should consist of the staging of the pressure injury, ASM #2 stated, "Yes but by a RN."	F 686		

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F 686	Continued From page 122 On 4/17/19 at 10:33 a.m., ASM #1 (the executive director), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility document titled, "Best Practices- Skin & Wound" documented, "Weekly skin evaluations completed by licensed nurses. Completion of non-pressure/pressure/wound tracking forms on identified wounds as indicated weekly until healed. Re-evaluate wound/skin treatment within two weeks of start date and every 2 weeks thereafter. Skin impairments documented on weekly wound report..." "It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission, and that factors that influenced its development, the potential for development of additional ulcers or for the deterioration of the pressure ulcer(s) be recognized, assessed and addressed (see discussion under Prevention regarding overall assessment and interventions). Any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers. When assessing the ulcer itself, it is important to: " Determine the ulcer's stage;" This information was obtained from the website: https://www.npuap.org/wp-content/uploads/2014/03/NPUAP-F-tag-final-March-2014.pdf The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue	F 686		

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F 686	Continued From page 123 type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)..." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014. No further information was presented prior to exit. (1) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color	F 686		

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F 686	Continued From page 124 changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. " This information was obtained from the website: https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 2. The facility staff failed to ensure wound care was administered to Resident #70 as ordered by	F 686		

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F 686	Continued From page 125 the physician on March 1st, 5th, 22nd, 23rd, and 26th 2019. Resident #70 was admitted to the facility on 8/14/2018. Diagnoses included but were not limited to: spina bifida (1), pressure ulcer of the sacral region stage four (2) (4), muscle weakness and absence of the left leg. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/3/19 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring limited assistance for most of her activities of daily living. In Section M - Skin Conditions, the resident was coded as having one unstageable pressure injury and two stage 4 pressure ulcers (3). The "Braden Scale for Predicting Pressure Sore Risk" documented, 18 indicating Resident #70 was at risk for the development of a pressure sore. The POS (physicians order summary) dated April 2019, documented, "2/12/19: Sacrum-cleanse with Dakin's Solution (4), cover with silver alginate then cover with foam dressing every day and as needed." In addition, the POS documented, "2/12/19: Ischium Wounds- Cleanse with Dakin's Solution, cover with foam dressing every day and as needed." The comprehensive care plan dated 3/14/19, documented, "The resident has a pressure injury to sacrum and left ischium, abd (abdominal) surgical related to history of ulcers and lack of	F 686		

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F 686	Continued From page 126 mobility; Interventions: treatments as ordered." The TAR (treatment administration record) dated March 2019 documented, "2/12/19: Sacrum-cleanse with Dakin's Solution (4) cover with silver alginate then cover with foam dressing every day and as needed." was not documented as being administered on: March 1st, 5th, 22nd, 23rd, and 26th 2019. The TAR (treatment administration record) dated March 2019 documented, "2/12/19: Ischium Wounds- Cleanse with Dakin's Solution, cover with foam dressing every day and as needed." Was not documented as being administered on: March 1st, 5th, 22nd, 23rd, and 26th 2019. Review of the "Pressure Ulcer Record" for the sacrum revealed in part the following: - 3/4/19 "Sacrum. Stage 4. Measurements (cm [centimeter]) length 0.5, width 1.5, depth 1.3. Wound Bed: red wound with granulation tissue. Wound Edges: firm with no redness." - 3/13/19 "Sacrum. Stage 4. Measurements (cm): length 0.5, width 1.5, depth 1.5. Wound Bed: pink with granulation tissue. Wound Edges: firm with no redness." - 3/18/19 "Sacrum. Stage 4. Measurements (cm): length 0.5, width 1.5, depth 1.5. Wound Bed: pink with granulation tissue. Wound Edges: firm with no redness." - 3/25/19 "Sacrum. Stage 4. Measurements (cm) length 0.5, width 1.5, depth 1.5. Wound Bed: pink with granulation tissue. Wound Edges: firm with no redness." Review of "Pressure Ulcer Record" for the left ischium revealed in part the following: - 3/4/19 "Left Ischium. Stage 4. Measurements	F 686		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 686	Continued From page 127 (cm) length 3, width 3, depth 3.2. Wound Bed: red with granulation tissue. Wound Edges: firm with no redness." - 3/13/19, documented in part, "Left Ischium. Stage 4. Measurements (cm) length 2.8, width 2.3, depth 3.2. Wound Bed: red with granulation tissue. Wound Edges: firm with no redness." - 3/18/19, documented in part, "Left Ischium. Stage 4. Measurements (cm) length 2.5, width 2.8, depth 3.2. Wound Bed: red with granulation tissue. Wound Edges: firm with no redness." - 3/25/19, documented in part, "Left Ischium. Stage 4. Measurements (cm) length 2.5, width 2.8, depth 3.2. Wound Bed: red with granulation tissue. Wound Edges: firm with no redness." The wound care nurses note dated 3/18/19 at 2:00 p.m., documented, "Wound care- Sacrum 0.5 (cm- centimeters) x 1.5 (cm) x 1.5 (cm) granulating tissue, no odor. L (left) Ischium 2.5 (cm) x 2.8 (cm) x 3.2 (cm) granulating tissue no odor. L back fold 0.5 (cm) x 0.1 (cm) x0.1 (cm), pink wound bed. R (right back fold improved 0.2 (cm) x0.5 (cm) x 0.1(cm) pink wound bed. L post thigh wound bed yellow 4.5(cm) x3 (cm) x 0.2 (cm) Santyl being used. Abdomen 2.8x1.3x2.3 small amount yellow slough in base of wound, no odor. Continue POC (plan of care). Observation was made of Resident #70's wounds, on 4/15/19, at 10:47 a.m., with RN (registered nurse) #5, wound care nurse. The resident was observed laying on her right side. The resident's foot was observed with multiple deformities in bone structure. RN #5 measured the wound to Resident #70's sacrum as follows: width 1 cm, length 3 cm, depth 1.2 cm. The wound bed was pink with granulation tissue. The wound edges were rolled. The wound to Resident	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

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F 686	Continued From page 128 #70's left ischium was measured as follows: width 2.5cm, length 2.7 cm, depth 2.4 cm. The wound bed was red with granulation tissue. The wound edges were rolled. RN #5 was asked what stages the wounds were. RN #5 replied, "They are both stage four. She came here with both of the wounds, so far we have not been able to heal them but have gotten better." On 04/17/19 at approximately 9:40 a.m., an interview was conducted with Resident #70. Resident #70 was asked if her wound care is administered daily. Resident #70 replied, "Mostly. The nurses change my dressings most days but sometimes they miss days." On 4/17/19 at approximately 9:47 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Clinical Services, after reviewing Resident #70's MAR and comprehensive care plan. ASM #2 was asked if the physician ordered wound treatment was administered on the days of March 1st, 5th, 22nd, 23rd, and 26th. ASM #2 replied, "If the nurse did not signed off the treatment I can't say it was done. Normally after doing wound care, you would initial the MAR. If for some reason you could not do it then the nurse would circle that date on the MAR and enter a nurse's note stating why the treatment could not be administered." March 2019 nurse's notes were reviewed and did not document why wound care was not administered on the dates of: March 1st, 5th, 22nd, 23rd, and 26th 2019. The facility document titled, "Best Practices- Skin & Wound" documented, "Weekly skin evaluations completed by licensed nurses. Completion of	F 686		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 686	Continued From page 129 non-pressure/pressure/wound tracking forms on identified wounds as indicated weekly until healed. Re-evaluate wound/skin treatment within two weeks of start date and every 2 weeks thereafter. 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://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=spina+bifida&_ga=2.165789432.755020280.1555684133-764922449.1555684133 2. Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin	F 686		

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	495236	A. BUILDING _____ 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

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F 686	Continued From page 130 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/000147.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 ulcer. 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. Unstageable 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. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. (See 'Debridement' below.) This information was obtained from the website: https://www.uptodate.com/contents/clinical-staging-and-management-of-pressure-induced-skin-and-soft-tissue-injury?search=pressure%20ulcer%20staging&source=search_result&selectedTitle=1~4&usage_type=default&display_rank=1#H76128204	F 686		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 686	Continued From page 131 4. Dakin's solution (0.025% sodium hypochlorite) is widely used in a variety of difficult wound types and has been advocated by some for the management of burn wounds. It has broad-spectrum antimicrobial activity with efficacy in the clinical setting of MRSA, Vancomycin-resistant Enterococcus (VRE), and other antibiotic-resistant bacteria. This information was obtained from the website: https://www.uptodate.com/contents/topical-agents-and-dressings-for-local-burn-wound-care?search=dakins%20solution&sectionRank=1&usage_type=default&anchor=H10128208&source=machineLearning&selectedTitle=2~33&display_rank=1#H10128208	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to implement fall interventions for one of 41 residents in the survey sample, Resident # 13. The facility staff failed to have Resident #13's bed in the low position when the resident was in bed to prevent falls per the comprehensive care plan.	F 689		

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	495236	A. BUILDING _____ 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

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F 689	Continued From page 132 The findings include: Resident #13 was admitted to the facility on 10/08/18 with a recent readmission on 3/23/19, with diagnoses that included but were not limited to: high blood pressure, dementia, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/8/19, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #13 was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living. The resident was coed as requiring extensive assistance of two or more staff members for transfers and moving in the bed. Observation was made of Resident #13 on 4/14/19 at 1:09 p.m. during the initial screening of residents. Resident #13 was observed in her bed. She was asleep. The bed was at the waist level of this surveyor, approximately 39 inches. A second observation was made of Resident #13 on 4/14/19 at 2:52 p.m. The resident was again noted in bed, asleep. The height of the bed was at the waist level of this surveyor, approximately 39 inches. The comprehensive care plan dated, 2/24/19, documented in part, "Focus: the resident is at risk for falls r/t (related to) nonambulatory/Hoyer lift for transfers, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, impaired hearing	F 689	**689 Free of Accident and Hazards** **1.The bed for resident # 13 is maintained in the lowest position when nursing staff is not at bedside as indicated on care plan.** **2.Fall risk evaluation tool will be used to identify residents with high risk injury related to fall. The residents identified as high risk care plans will be reviewed by the interdisciplinary team to develop resident centered interventions. Follow up to be based on findings.** **3. Nursing staff will be re educated on implementing fall interventions as identified on the care plan of care by DON/ designee. The interdisciplinary team will meet weekly to discuss residents with falls to ensure interventions are in place. Members of the quality assurance committee team will conduct rounds five times weekly ensure fall intervention for resident are in place, weekly for eight weeks.** **4.The results of quality review data will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

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F 689	Continued From page 133 acuity." The "Interventions" documented in part, "Bed in low position." An interview was conducted with CNA (certified nursing assistant) #2, on 4/15/19 at 2:51 p.m. When asked how the CNAs find which safety devices or instructions are required for a resident, CNA #2 stated, "You look in the care plan or the nurse's tell you." When asked if a resident is a fall risk, should their bed be elevated to approximately waist high when no one is in the room providing care, CNA #2 stated, "No, Ma'am." When asked if the care plan documents, the resident's bed is to be in the low position, should that be done, CNA #2 stated, "Yes, we have to make sure it's in the low position when we leave a resident in bed." An interview was conducted with RN (registered nurse) #2 on 4/15/19 at 2:53 p.m. When asked if a resident is a fall risk and has interventions documented on the care plan, should those interventions be in place, RN #2 stated, "Absolutely." The above observation was shared with RN #2. The facility policy, "Clinical Guidelines - Fall Management" documented in part, "3. Residents determined to be at risk for falls will have patient centered interventions developed and implemented to minimize the risk of falling and/or injury." 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.	F 689		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 689	Continued From page 134 No further information was provided prior to exit.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for six of 41 residents in the survey sample, Residents #60, #41, #69, #27, #20 and #53. 1.a. The facility staff failed to obtain a physician's order for Resident #60's use of an incentive spirometer. 1.b. The facility staff failed to store Resident #60's incentive spirometer mouthpiece in a clean and sanitary manner. 2. The facility staff failed to administer Resident #41's oxygen according to the physician's orders. 3. The facility staff failed to ensure that Resident #69 observed receiving oxygen therapy had a	F 695	**F 695 respiratory** **1. Resident # 60 was assessed by nurse practitioner for use of an incentive spirometer and he does not require the device, it has been removed from the room as of 5/6/2019.** **Resident # 69 currently does not receive oxygen therapy and no oxygen equipment is in his room.** **Resident #41 physician's order for oxygen reviewed and oxygen is being administered per order.** **Resident # 27 oxygen tubing is properly stored in a sanitary manner at the bedside.** **Resident #20 CPAP mask is stored in a sanitary manner with the mask covered when not in use.** **Resident # 53 oxygen nasal cannula when not in use is stored in sanitary manner.** **2. Residents in the facility with physician orders for oxygen administration and oxygen device: rooms have been assessed for sanitary storage of equipment when not in use as of by the licensed nursing staff. Resident s room rounds have been conducted by licensed nursing staff and no oxygen found to be in use without physician orders as of 5/6/2019.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 695	Continued From page 135 physician's order for oxygen. 4. The facility staff failed to change Resident #27's, oxygen tubing according to the physician's orders. 5. The facility staff failed to store Resident #70's CPAP (1) (continuous positive airway pressure) mask in a sanitary manner. Resident #70's CPAP mask was observed uncovered during multiple observations. 6. The facility staff failed to store Resident # 53's nasal cannula oxygen device in a sanitary manner. The nasal cannula, a two-pronged tube that is placed in the nose for delivering oxygen from the oxygen system, was left uncovered on the resident's bed. The findings include: 1.a. The facility staff failed to obtain a physician's order for Resident #60's use of an incentive spirometer (1). Resident #60 was admitted to the facility on 2/22/19. Resident #60's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), heart failure and pain. Resident #60's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 3/22/19, coded the resident as being cognitively intact. Section G coded the resident as requiring extensive assistance of one staff with bed mobility, dressing, toilet use and personal hygiene. Review of the physician's order sheet for Resident #60, signed by the physician on 4/15/19	F 695	**3. Licensed nurses will be re educated by DON/designee on providing respiratory care and services consistent with professional standard of practice to include administering treatment with physicians order as well as in a sanitary manner to prevent infection. Quality monitoring will be completed by the DON or designee to ensure that oxygen administration and devices are handled and stored in a sanitary manner in accordance with the physician order. This will be completed weekly for eight weeks.** **4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	

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F 695	Continued From page 136 failed to reveal an order 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 incentive spirometer was sitting on a table in the resident's room. 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. When asked how nurses know what should be done if a resident has an incentive spirometer, RN #1 stated the nurses should follow the facility policy and procedure. When asked if residents should have a physician's order for the use of an incentive spirometer, RN #1 stated, "Yes." When asked why, RN #1 stated an incentive spirometer could be a nursing intervention but she also always calls the physician for an order so she knows how often the incentive spirometer should be used. On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (interim director of clinical services) were made aware of the above concern. The facility policy titled, "Incentive Spirometer" documented, "Procedure: Review chart..."	F 695		

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	495236	A. BUILDING _____ 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 137 No further information was presented prior to exit. (1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. How to use an Incentive Spirometer Many people feel weak and sore after surgery and taking big breaths can be uncomfortable. A device called an incentive spirometer can help you take deep breaths correctly. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm (2) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.106270788.695687771.1555589628-1667741437.1550160688	F 695		

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	495236	A. BUILDING _____ 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

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F 695	Continued From page 138 1.b. The facility staff failed to store Resident #60's incentive spirometer (1) mouthpiece in a clean and sanitary manner. Resident #60 was admitted to the facility on 2/22/19. Resident #60's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), heart failure and pain. Resident #60's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 3/22/19, coded the resident as being cognitively intact. Section G coded the resident as requiring extensive assistance of one staff with bed mobility, dressing, toilet use and personal hygiene. Review of the physician's order sheet for Resident #60, signed by the physician on 4/15/19 failed to reveal an order 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'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	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 139 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 ASM #2 (interim director of clinical services) were made aware of the above concern. The facility policy titled, "Incentive Spirometer" failed to document information regarding incentive spirometer storage. No further information was presented prior to exit. (1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. How to use an Incentive Spirometer Many people feel weak and sore after surgery and taking big breaths can be uncomfortable. A device called an incentive spirometer can help you take deep breaths correctly. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy." This information was obtained from the website:	F 695		

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F 695	Continued From page 140 https://medlineplus.gov/ency/patientinstructions/000451.htm (2) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.106270788.695687771.1555589628-1667741437.1550160688 2. The facility staff failed to administer Resident #41's oxygen according to the physician's orders. Resident #41 was admitted to the facility on 12/8/17 with the diagnoses of but not limited to stroke, respiratory failure, high blood pressure, gastrostomy status (1), respiratory failure, and dementia. The most recent MDS (Minimum Data Set), a quarterly review assessment with an ARD (Assessment Reference Date) of 2/28/19, documented that Resident #41 had moderate cognitive impairment for daily decision-making. On 4/14/19 at 2:00 p.m., on 4/15/19 at 8:55 a.m., and 12:15 p.m., Resident #41's oxygen flowrate on the oxygen concentrator was observed set at	F 695		

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F 695	Continued From page 141 2 ½ liters per minute, during each observation. A review of the clinical record revealed a MAR (medication administration record) that was dated April 2019, which documented in part, "12/29/18: Oxygen 3L/Min (3 liters per minute) via nasal cannula ..." Further review of the clinical record revealed a physician's order, dated April 2019, that documented in part, "12/29/18: Oxygen 3L/Min via nasal cannula ..." Further review of the clinical record revealed a comprehensive care plan dated 2/21/19, that documented in part, "The resident has altered respiratory status/difficulty breathing related to chronic respiratory failure with hypoxia (5)." The comprehensive care plan documented in part, "Interventions" "Provide oxygen per MD (medical doctor) orders." On 4/16/19 at 12:24 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When LPN #2 was asked about the process for administering oxygen at the prescribed flowrate, LPN #2 stated, "You look at the order. Take the oxygen to the room and set it at the correct level." When LPN #2 was asked, how the nurse would determine if the flowrate is set at the correct level, LPN #2 stated, "I look at the cylinder on the concentrator at eye level. I would put the black ball on the line, not above or below the line but at the center." When LPN #2 was asked the process for care planning and implementing oxygen, LPN #2 stated, "The nurse checks it (physician's orders) and creates the care plan. It would be placed on the TAR (treatment administration record), that is how you follow the	F 695		

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F 695	Continued From page 142 order." A review of the facility's policy "Oxygen Therapy" with a revision date of 8/28/17, that documented in part, "Oxygen therapy is the administration of a FiO2 (Fraction of Inspired Oxygen) greater than 21% by means of various administration devices ...Procedure ...Physician's order for oxygen therapy shall include: Administration modality...liter flow ...continuous or PRN ... Review physician's order ...Start 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 physician ...To properly read the flowmeter B, locate 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 l/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 PM, ASM (Administrative Staff Member) #1 (Executive Director), AMS #3 (Regional Director of Clinical Services), and ASM	F 695		

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F 695	Continued From page 143 #2 (Interim Director of Clinical Services) were made aware of the findings. No further information was provided by the end of the survey. (1) Gastrostomy status: is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. This information was retrieved from the website: https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99/Z93-/Z93.1 (2) G-tube: A gastrostomy tube (G-tube) is a tube placed in a surgically created opening into the stomach through the abdominal wall per Barron's Medical Guide: Dictionary of Medical Terms for the Non Medical Reader, Mikel A. Rothenberg, M.D. and Charles F. Chapman, page 243. (3) Ostomy: An ostomy is surgery to create an opening (stoma) from an area inside the body to the outside. It treats certain diseases of the digestive systems. This information was retrieved from the website: https://medlineplus.gov/ostomy.html (4) PEG: Percutaneous endoscopic gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term nutrition. This information was retrieved from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/ (5) Hypoxia: Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp	F 695		

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	495236	A. BUILDING _____ 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

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F 695	Continued From page 144 oxia. 3. The facility staff failed to ensure that Resident #69 who was observed receiving oxygen therapy had a physician's order for oxygen. Resident #69 was admitted to the facility on 3/28/19 with the diagnoses of but not limited to obstructive and reflux uropathy (2), benign prostatic hyperplasia (BPH) (3) with lower urinary tract symptoms, acute kidney failure, and retention of urine. The most recent MDS (Minimum Data Set), a five day Medicare assessment, with an ARD (Assessment reference date) of 4/4/19, coded the resident as scoring a 9 on the BIMS (Brief interview for mental status) score, indicating the Resident has moderate cognitive impairment for daily decision making. On 4/14/19 at 1:15 p.m., Resident #69 was observed in his room lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered at a flow rate of 2 liters per minute. On 4/15/19 at 9:14 a.m., and at 12:15 p.m., Resident #69 was observed in his room lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator revealed oxygen was being delivered at a flow rate of 1 ½ liters per minute. A review of the clinical record revealed a physician's telephone order that was dated 2/28/19, which documented in part, "O2 (oxygen) at 3 liters per minute PRN (as needed) to keep sats (oxygen saturation in the blood) above 92%."	F 695		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 695	Continued From page 145 On 4/16/19 at 12:24 p.m., a copy of the physician's order for Resident #69's oxygen therapy was requested from RN (registered nurse) #3. On 4/16/19 at 12:45, RN (Registered nurse) #3 stated, "Resident #69 does not have an order for oxygen." When reviewing Resident #69's physician orders with RN #3, she stated, "The order for oxygen written on 2/28/19 is not a valid order due to he (Resident #69) has been readmitted since then." Further review of the clinical record revealed a POS (physician's order sheet) that was dated April 2019, which revealed no documentation of an oxygen order. A review of the clinical record revealed a MAR (medication administration record) that was dated April 2019, that documented in part, "Check O2 sats q (every) shift. Notify MD (medical doctor) if < 90%." Continued review of the clinical record revealed a MAR that was dated April 2019, which revealed no documentation of an oxygen therapy order. Further review of the clinical record revealed a comprehensive care plan that was dated 4/8/19, that documented in part, "The resident has shortness of breath (SOB) related to hypoxia (3)." The comprehensive care plan documented "Interventions" that documented in part, "O2 sats (saturation) as ordered and O2 via NC (nasal cannula) as ordered." On 4/16/19 at 12:24 p.m., an interview was conducted with LPN (Licensed Practical Nurse)	F 695		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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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 administered without an order. The nursing staff should have called the physician for a new oxygen order." When 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, "Procedure ...Physician's order for oxygen therapy shall include: Administration modality...liter flow ...continuous or PRN ...PRN orders must include specific guidelines as to when the resident is to use oxygen ...Review 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 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."	F 695		

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F 695	Continued From page 147 On 4/16/19 at 3:15 PM, ASM (Administrative Staff Member) #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) Obstructive and reflux uropathy: Obstructive uropathy is structural or functional hindrance of normal urine flow, sometimes leading to renal dysfunction (obstructive nephropathy). The information was obtained from the website: https://www.merckmanuals.com/professional/genitourinary-disorders/obstructive-uropathy/obstructive-uropathy (2) Benign prostatic hyperplasia: is a condition in men in which the prostate gland is enlarged and not cancerous. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostate-enlargement-benign-prostatic-hyperplasia (3) Hypoxia: Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. 4. The facility staff failed to change Resident #27's, oxygen tubing according to the physician's orders. Resident # 27 was admitted to the facility on 08/24/14 and a readmitted on 10/19/18 with	F 695		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 695	Continued From page 148 diagnoses that included but were not limited to: respiratory arrest (1), history of traumatic brain injury (2), and quadriplegia (3). Resident # 27's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 02/22/19 coded the resident as scoring a zero indicating that Resident # 27 was unable to complete the brief interview for mental status (BIMS) and Section C0600 the "Staff Assessment for Mental Status" being completed. Section C1000 "Cognitive Skills for daily Decision Making" coded Resident # 27 a 2 (two), "Moderately impaired-decisions poor, cues/supervision required." Resident # 27 was coded as being dependent of one staff member for all activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 27 for "Oxygen therapy." On 04/15/19 at 9:52 a.m., an observation of Resident # 27's oxygen tubing connected the oxygen concentrator and delivering oxygen through Resident # 27's tracheostomy revealed a label on the oxygen tubing dated 04/08/19. On 04/15/19 at 4:22 a.m., an observation of Resident # 27's oxygen tubing connected the oxygen concentrator and delivering oxygen through Resident # 27's tracheostomy revealed a label on the oxygen tubing dated 04/08/19. The POS (physician's order sheet) dated "April 2019" for Resident # 27 documented, "10/20/18 Change oxygen tubing; humidifying tubing; and jetneb tubing every week on Sunday 7P-7A shift." 04/15/19 at approximately 4:34 p. m., an interview	F 695		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 695	Continued From page 149 and observation of Resident # 27's oxygen tubing was conducted with ASM (administrative staff member) # 2, interim director of clinical services. After observing Resident # 27's oxygen tubing with the label dated 04/08/19, ASM # 2 stated, "The tubing should have been changed." When asked why it was important to change the oxygen tubing according to the physician's orders, ASM # 2 stated, "It is changed to keep it clean." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) The cessation of breathing, and it may occur for a variety of reasons. ... When a patient goes into respiratory arrest, they are not getting oxygen to their vital organs and may suffer brain damage or cardiac arrest within minutes if not promptly treated. This information was obtained from the website: https://acls.com/free-resources/...base/respiratory-arrest.../managing-respiratory-arrest. (2) Happens when a bump, blow, jolt, or other head injury causes damage to the brain. Symptoms of a TBI may not appear until days or weeks following the injury. A concussion is the mildest type. It can cause a headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness. People with a moderate or severe TBI may have those, plus other symptoms: A headache that gets worse or does not go away, Repeated vomiting or nausea, Convulsions or seizures, Inability to awaken from sleep, Slurred	F 695		

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	495236	A. BUILDING _____ 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

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F 695	Continued From page 150 speech, Weakness or numbness in the arms and legs, Dilated eye pupils. This information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html (3) The loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 5. The facility staff failed to store Resident #70's CPAP (1) (continuous positive airway pressure) mask in a sanitary manner. Resident #70's CPAP mask was observed uncovered during multiple observations. Resident #70 was admitted to the facility on 8/14/2018. Diagnoses included but were not limited to: spina bifida (2), pressure ulcer of the sacral region stage 4 (3), muscle weakness and absence of the left leg. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/3/19 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Section O-Special Treatment, coded Resident #70 as receiving oxygen therapy. The physician order dated April 2019, documented "CPAP at 14 (centimeters of water	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 151 pressure) with 3L (liters) of oxygen at bedtime and off every morning." Reviewed of Resident #70's MAR (medication administration record) dated April 2019, documented "CPAP at 14 (centimeters of water pressure) with 3L (liters) of oxygen at bedtime and off every morning." (4) The MAR documented this as being given. On 4/14/19 at approximately 3:40 p.m., an observation was made of Resident #70. Resident #70's CPAP mask was observed on her bedside table, without any cover and not in use by the resident. On 4/15/19 at approximately 11:45 a.m., a second observation was made of Resident #70. Resident #70's CPAP mask was observed on her bedside table, without any cover and not in use by the resident. On 4/15/19 at approximately 11:56 a.m., a third observation was made of Resident #70 with CNA (certified nursing assistant) #6. Resident #70's CPAP mask was observed on her bedside table, without any cover and not in use by the resident. On 4/15/19 at approximately 11:57 a.m., an interview was conducted with CNA (certified nursing assistant) #6. When asked how Resident #70's CPAP mask should be stored when not in use, CNA #6 replied, "They are supposed to be in a bag." CNA #6 was asked why a CPAP mask should be covered when not in use. CNA #6 replied, "To keep germs from getting on it." According to facility, policy titled "Oxygen Therapy" with a revision date 8/28/2017,	F 695		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 152 documented "Follow infection control procedures, as appropriate." On 4/16/19 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. Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm 2. 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://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-	F 695		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 695	Continued From page 153 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=spina+bifida&_ga=2.165789432.755020280.1555684133-764922449.1555684133 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 ulcer. 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. Unstageable 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. If slough or eschar is removed, a stage 3 or stage 4 pressure injury will be revealed. (See 'Debridement' below.) This information was obtained from the website: https://www.uptodate.com/contents/clinical-staging-and-management-of-pressure-induced-skin-and-soft-tissue-injury?search=pressure%20ulcer%20staging&source=search_result&selectedTitle=1~4&usage_type=default&display_rank=1#H76128204 6. The facility staff failed to store Resident # 53's nasal cannula oxygen device in a sanitary manner. The nasal cannula, a two-pronged tube that is placed in the nose for delivering oxygen from the oxygen system, was left uncovered on	F 695		

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F 695	Continued From page 154 the resident's bed. Resident # 53's most recent facility admission was 12/26/18 with diagnoses that included but were not limited to: chronic respiratory failure (1) with hypoxia (2), peripheral vascular disease (3), and chronic obstructive pulmonary disease (4). Resident # 53's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 01/02/18, coded Resident # 53 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 indicating the resident has moderate cognitive impairment for daily decision making. Under section O, Resident # 53 was coded "C. Oxygen therapy." Resident # 53 was also coded as requiring extensive assistance of one staff member for activities of daily living but only supervision for eating. On 04/15/19 at 1:33 p.m., an observation of Resident # 53's room revealed a nasal cannula laying on top of the Resident's bed uncovered. The nasal cannula was connected to an oxygen concentrator with the flow meter set at two liters per minute. A POS (physician order sheet) dated 01/07/19 documented, "oxygen at 2 (two liters) via (by) nasal cannula as needed for shortness of breath." The comprehensive care plan documented under focus area, "The resident has ineffective breathing pattern r/t (related to) COPD (chronic obstructive pulmonary disease)." Under interventions, it was documented, "Give oxygen as ordered."	F 695		

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F 695	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 equipment 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 policies 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/medlineplus/respiratoryfa	F 695		

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F 695	Continued From page 156 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/hypoxia. 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 called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 4. Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		

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F 727	Continued From page 157 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure the services of a RN (registered nurse) for eight consecutive hours a day, seven days a week. The facility staff failed to ensure RN coverage for eight consecutive hours on 3/14/19, 3/30/19 and 4/14/19. The findings include: Review of facility nurse staffing schedules and employee time cards revealed no RN was present in the facility on 3/14/19 and 3/30/19. Further review of nurse staffing schedules and employee time cards revealed a RN was present in the facility for only four hours on 4/14/19. On 4/15/19 at 10:20 a.m., an interview was conducted with OSM (other staff member) #2 (the staffing coordinator). OSM #2 was asked the facility process for ensuring RN coverage. OSM #2 stated, "The policy is that I have to have a RN at least eight hours in every 24 hours. If I don't have one scheduled currently, I reach out to agency to see if they have one as well and reach out to the RNs we have to see if I can get them to pick up extra shifts. If I'm still at zero, I let the DON (director of nursing) know immediately if I don't have one then I keep her updated, then I have to follow direction from her as to what the next step may be. Sometimes using our MDS (minimum data set) nurse."	F 727	**F 727** **1.The facility currently has eight hours of RN scheduled daily.** **2.The staffing coordinator reviews the daily nursing schedule to ensure eight consecutive hours of RN coverage is scheduled. Follow up based on findings.** **3.Executive Director, Director of Nursing DON and staff coordinator have been re educated on monitoring RN coverage in the facility daily by Regional Director of Nursing as of 5/9/2019. The nursing staff coordinator and director of nursing will meet daily to review RN staffing coverage to ensure there is at least eight hours of coverage.** **4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

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F 727	Continued From page 158 On 4/15/19 at 11:13 a.m., OSM #2 confirmed the facility did not have a RN present in the building on 3/14/19 and 3/30/19, and only had a RN in the building for four hours on 4/14/19. On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. On 4/17/19 at 10:32 a.m., ASM #3 (the regional director of clinical services) stated the facility did not have a policy regarding RN coverage and the federal regulations should be followed. No further information was presented prior to exit.	F 727		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete annual CNA (certified nursing assistant) performance reviews for four of ten CNA records reviewed, CNAs #7, #9, #10 and #11 The annual performance reviews for CNA #7 (hired on 1/11/17), CNA #9 (hired on 10/13/97), CNA #10 (hired on 2/7/18), and CNA #11 (hired	F 730		

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F 730	Continued From page 159 on 5/3/04) were not completed. The findings include: On 4/15/19 at 10:20 a.m., a list of CNAs who were employed at the facility for more than one year was provided by OSM (other staff member) #4 (the regional director of human resources), per this surveyor's request. A sample of ten CNAs was selected from the list and on 4/15/19 at 10:36 a.m., ASM (administrative staff member) #3 (the regional director of clinical services) was asked to provide the annual performance reviews for the ten selected CNAs. Review of the annual performance reviews failed to reveal reviews for CNA #7 (hired on 1/11/17), CNA #9 (hired on 10/13/97), CNA #10 (hired on 2/7/18), and CNA #11 (hired on 5/3/04). On 4/15/19 at 1:06 p.m., ASM #3 was made aware of the above concern and was asked to provide the annual performance reviews for: CNA #7, CNA #9, CNA #10 and CNA #11. ASM #3 confirmed performance reviews for some CNAs could not be located. On 4/16/19 at 8:46 a.m., an interview was conducted with ASM #1 (the executive director) and ASM #2 (the interim director of clinical services) (both responsible for ensuring annual performance reviews are completed). ASM #1 and ASM #2 were asked the facility process for ensuring annual performance reviews are completed. ASM #2 stated the facility staff has a schedule that coincides with employees' hire dates and ensures annual performance reviews	F 730	**F 730** **1.Employee CNA#7 has a completed annual performance review as of 5/9/2019.** **Employee CNA#9 has a completed annual performance review as of 5/9/2019.** **Employee CNA#10 has a completed annual performance review as of 5/9/2019** **Employee CNA#11 has a completed annual performance review as of 5/9/2019.** **2.Human Resource Manager or Designee will review all actively employed nurse aides to ensure that an annual performance review was conducted within the last year and in-service education was provided based on the outcome. Follow ups will be done based on findings.** **3.Human Resources Manager will be educated on ensuring that the facility completes a performance review of every nurse aide once every 12 months and provide regular in-service education based on the outcomes by Executive Director or Designee. Human Resource Manager or Designee to review all nurse aides to ensure performance review was completed on an annual basis and in-service education provided monthly x 3 Months.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

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F 730	Continued From page 160 are completed. ASM #1 and ASM #2 were made aware of the above concern. The facility policy titled, "Employee j= 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 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a 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	F 732	**F 732** **1.The facility nursing staff information is being posted daily with accurate information.** **2.No residents were affected.** **3.The nursing staff coordinator and DON have been re educated on maintaining and posting accurate nursing information and RN coverage by the Regional Director of Clinical Services as of 5/6/2019. The DON or designee will ensure that staff posting correctly reflects the staff in the facility per shift.** **4.The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations**	5-28-19

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F 732	Continued From page 161 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure complete and accurate nurse staff postings. 1. The facility staff failed to ensure the 4/14/19 daily nursing staffing form (nurse staff posting) accurately documented RN (registered nurse) staff on the day shift. 2. The facility staff failed to ensure the evening census was documented on the daily nursing staffing form on 3/28/19 and 3/29/19 and failed to ensure the total number and actual hours of RN staff on the day shift was documented on the daily nursing staffing form on 3/30/19 and 3/31/19. The findings include: 1. The facility staff failed to ensure the 4/14/19 daily nursing staffing form (nurse staff posting) accurately documented RN (registered nurse) staff on the day shift.	F 732		

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F 732	Continued From page 162 On 4/14/19 at 12:55 p.m., observation of the facility daily nursing staffing form, posted in the lobby, revealed documentation that one RN was in the building for eight hours on day shift. On 4/14/19 at 1:00 p.m., observation of the facility nurses was conducted. Two LPNs (licensed practical nurses) were observed in the facility. On 4/14/19 at 1:15 p.m., LPN #5 confirmed he and another LPN were the only two nurses in the facility. On 4/14/19 at 2:23 p.m., an interview was conducted with OSM (other staff member) #2 (the employee responsible for completing the nursing staffing form). OSM #2 was made aware of the above observations and was asked the facility process for ensuring the accuracy of the daily nursing staffing form. OSM #2 stated she fills out the form, based on the scheduled staff, on Friday when she will not be in the facility on Saturday or Sunday, or fills out the form, based on the scheduled staff, on Saturday if she will not be in the facility on Sunday, and the receptionist is responsible for posting the form. OSM #2 stated she filled out the 4/14/19 form on the previous day based on the staff that was scheduled for this day but the RN who was scheduled called out. OSM #2 stated she should have called the receptionist and asked her to change the form when the RN called out. On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.	F 732		

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F 732	Continued From page 163 On 4/17/19 at 10:32 p.m., ASM #3 (the regional director of clinical services) stated the facility did not have a policy regarding nurse staff postings. No further information was presented prior to exit. 2. The facility staff failed to ensure the evening census was documented on the daily nursing staffing form on 3/28/19 and 3/29/19 and failed to ensure the total number and actual hours of RN staff on the day shift was documented on the daily nursing staffing form on 3/30/19 and 3/31/19. Review of daily nursing staffing forms (nurse staff postings) revealed the following: - The 3/28/19 and 3/29/19 forms failed to reveal documentation of the facility census. -The 3/30/19 and 3/31/19 forms failed to reveal documentation of the total number and actual hours of RN staff on the day shift. On 4/15/19 at 10:20 a.m., an interview was conducted with OSM (other staff member) #2 (the employee responsible for completing the nurse staffing forms). OSM #2 was asked what information should be documented on the nurse staffing forms. OSM #2 stated, "The nurses that are scheduled or in-house daily, how many hours they have worked, the number of CNAs (certified nursing assistants) and their hours, the date and the name of the facility and the census." When asked the facility process for ensuring nurse staffing forms are complete and accurate, OSM #2 stated, "It's left up to me to maintain it." OSM #2 was made aware of the above concerns. On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and	F 732		

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F 732	Continued From page 164 ASM #2 (the director of clinical services) were made aware of the above concern. On 4/17/19 at 10:32 p.m., ASM #3 (the regional director of clinical services) stated the facility did not have a policy regarding nurse staff postings. No further information was presented prior to exit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	**F 755** **1.The physician was notified of the medication omission on 4/15/2019 for resident #52. Resident # 52 currently has adequate supply of Methadone in the facility and it is being administered as ordered by the physician.** **2. No other residents in the facility are prescribed Methadone.** **3. Licensed nursing staff will be re educated by DON/designee on obtaining medication from pharmacy, utilizing the facility stat box when appropriate and notifying the physician if medication has not been received from pharmacy. Random medication administration reviews will be conducted weekly for eight weeks by the DON or designee to ensure medications are available and medication administration is completed in accordance with physician order.** **4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 755	Continued From page 165 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure medications were available for administration for one of 41 residents in the survey sample, Resident #52. The facility staff failed to ensure Resident #52's physician prescribed medication Methadone was available for administration. The findings include: Resident #52 was admitted to the facility on 9/17/18 with diagnoses that included but were not limited to lung cancer, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic) (1), high blood pressure, anxiety, chronic pain and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/13/19, coded the resident as scoring a "1" on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired to make daily cognitive decisions. The resident was coded as having periods of disorganized thinking that comes and goes. Resident #52 was coded as having periods of hallucinations and delusions. The resident was coded as requiring limited	F 755		

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F 755	Continued From page 166 assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antianxiety medication. A family interview was conducted on 4/14/19 at 3:02 p.m. The family member expressed concerns that the facility didn't order her mother's medication timely, so she missed doses of it. The physician order dated, 12/31/18, documented, "Methadone* HCL (hydrochloride) 5 MG (milligram) Tablet; 3 tabs (tablets) by mouth three times daily at 0600 (6:00 a.m.) 1400 (2:00 p.m.), 2200 (10:00 p.m.) for pain." *Methadone is used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications (2). Review of the January 2019 MAR (medication administration record) documented the above physician order. On 1/14/19 at 2200 (10:00 p.m.) the nurse initialed the medication and circled their initials, indicating it wasn't given. There was no documentation on the reverse side of the MAR regarding the missed dose of Methadone. Review of the nurse's notes failed to evidence nursing documentation on 1/14/19. The February 2019 MAR documented the above physician order. The Methadone was circled as not administered on 2/9/19 at 10:00 p.m., 2/10/19 at 10:00 p.m., 2/18/19 at 6:00 a.m., and 2/21/19 at 10:00 p.m. The reverse side of the MAR failed to evidence documentation regarding why the medication was not administered as ordered by the physician.	F 755		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 755	Continued From page 167 Review of the nurse's notes for the above dates and times, failed to evidence the reason why the medication was not administered. The March 2019 MAR documented the above physician order. The Methadone was circled as not administered on 3/8/19 at 6:00 a.m. and 2:00 p.m., 3/12/19 at 2:00 p.m. and 3/13/19 at 2:00 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. 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.),	F 755		

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F 755	Continued From page 168 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. The comprehensive care plan dated, 3/14/19, documented in part, Focus: The resident has acute/chronic pain r/t (related to) complaints of pain to right ankle with warmth/swelling/ CA (cancer)." The "Interventions" documented in part, "Administer analgesics as per orders." 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." When asked what a circle around the nurse's initials indicate, RN #1 stated it means that nurse did not give the medication. When asked if a nurse should document why a medication is not given, RN #1 stated, "Yes, they can either document it on the reverse side of the MAR or in a nurse's note." The box of emergency medications stored in the medication room was observed on 4/15/19 at 4:16 p.m. accompanied by RN (registered nurse)	F 755		

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F 755	Continued From page 169 #2. The narcotics emergency box failed to document the storage of Methadone. 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. 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/a682134.html	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		

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F 758	Continued From page 170 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure one of 41 residents was free of unnecessary medications, Residents # 31. The facility staff failed to implement non-pharmacological interventions prior the	F 758	**F 758** **1.Resident # 31 was assessed by psychiatric nurse practitioner on 4-23-2019 and zolpidem (Ambien) medication was discontinued.** **2. No other residents in facility are prescribed as needed psychotropic hypnotic medications.** **3.Licensed nursing staff will be re educated on implementing non pharmacological interventions prior to administering prn medications by the director of nursing. The interdisciplinary team will meet weekly to review residents with prescribed psychotropic medication to validate continued usage to prevent unnecessary medication. This will continue weekly for eight weeks.** **4.The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 758	Continued From page 171 administration of prn (as needed) Zolpidem [Ambien] (1) to Resident #31. The findings include: Resident # 31 was admitted to the facility on 03/15/18 and a readmitted of 03/16/19 with diagnoses that included but were not limited to insomnia (2), respiratory failure, (3), chronic obstructive pulmonary disease (4), and hypertension (5). Resident # 31's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/13/19, coded Resident # 31 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 31 was coded as being independent for all activities of daily living. The physician's orders dated "April 2019" for Resident # 31 documented, "Zolpidem F/C (film coated) 5MG (milligram) Tablet (Ambien). 1 (one) tab (tablet) by mouth at bedtime as needed for sleep. 03/16/19." The MAR (medication administration record) dated March 2019 for Resident # 31 documented the above physician order. Review of the MAR dated 03/16/19 through 03/31/19 revealed Resident # 31 received Zolpidem ten out of sixteen opportunities. Further review of the MAR dated "March 2019" failed to evidence documentation of non-pharmacological approaches being attempted prior to the administration of Zolpidem. The MAR (medication administration record)	F 758		

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F 758	Continued From page 172 dated April 2019 for Resident # 31 documented the above physician order for Zolpidem F/C 5MG Tablet (Ambien). Review of the MAR dated 04/01/19 through 04/11/19 revealed Resident # 31 received Zolpidem seven out of eleven opportunities. Further review of the MAR dated "April 2019" failed to evidence documentation of non-pharmacological approaches being attempted prior to the administration of Zolpidem. The facility's "Interdisciplinary Progress Notes" dated 03/16/19 through 04/11/19 failed to evidence documentation of non-pharmacological approaches being attempted prior to the administration of Zolpidem. The comprehensive care plan for Resident # 31 dated 03/11/2019 documented failed to evidence documentation for insomnia and the use of Zolpidem. On 04/16/19 at 10:44 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked to describe the use for the medication Ambien, LPN # 2 stated, "It's for insomnia, help them sleep." When asked to describe the procedure for administering Ambien prn (as needed), LPN # 2 stated, "I would try a different approach...make sure the room is comfortable, turn off the television and lights, make sure they are not having pain that might be keeping them awake." When asked how often she would attempt other non-pharmacological interventions, before administering the medication, LPN # 2 stated, "I would attempt it every time they ask for it." When asked where the attempted non-pharmacological interventions are documented, LPN # 2 stated, "It should be documented in nurse's notes, if it is not	F 758		

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F 758	Continued From page 173 documented can't say it is being attempted." LPN # 2 was then asked to review Resident # 31's MAR dated March 2019 and April 2019 and the "Interdisciplinary Progress Notes" dated 03/16/19 through 04/11/19. LPN # 2 stated, "I don't see where other approaches were attempted at the times it (Ambien) was administered." The facility's policy "Medication Management-Psychotropic Medications" it documented, "Procedure: 5. Resident centered non-pharmacological interventions should be initiated as indicated." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, interim director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) Comes as a tablet (Ambien) and an extended-release (long-acting) tablet (Ambien CR) to take by mouth. Zolpidem also comes as a sublingual tablet (Edluar, Intermezzo) to place under the tongue and an oral spray (Zolpimist), which is sprayed into the mouth over the tongue. If you are taking the tablets, extended-release tablets, sublingual tablets (Edluar), or oral spray, you will take the medication as needed, not more than one time a day, immediately before bedtime. If you are taking the sublingual tablets (Intermezzo), you will take the medication as needed, not more than one time during the night if you wake up and have difficulty returning to sleep. Zolpidem will work faster if it is not taken with a meal or immediately after a meal. Follow the directions on your prescription label carefully,	F 758		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 758	Continued From page 174 and ask your doctor or pharmacist to explain any part you do not understand. Use zolpidem exactly as directed. You will probably become very sleepy soon after you take zolpidem and will remain sleepy for some time after you take the medication. Plan to go to bed right after you take zolpidem tablets, extended-release tablets, sublingual tablets (Edluar), and oral spray and to stay in bed for 7 to 8 hours. Take zolpidem sublingual tablets (Intermezzo) only when you are already in bed and can remain in bed for at least 4 more hours. Do not take zolpidem if you will be unable to remain asleep for the required number of hours after taking the medication. If you get up too soon after taking zolpidem, you may experience drowsiness and problems with memory, alertness, or coordination. . This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693025.html. (2) A common sleep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both. As a result, you may get too little sleep or have poor-quality sleep. You may not feel refreshed when you wake up. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/insomnia.html. (3) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (4) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website:	F 758		

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F 758	Continued From page 175 https://www.nlm.nih.gov/medlineplus/copd.html. (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on the medication administration observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a medication error rate of less than five percent. There were 29 opportunities made during the medication administration observation, with three errors, which equals a medication error rate of 12.9 percent. 1. The facility staff administered the incorrect dose of Vitamin D 2 to Resident # 26. 2. The facility staff failed to administer the correct dose of calcium with vitamin D and failed to administer Tamsulosin per the physician order to Resident # 59. The findings include: 1. The facility staff administered the incorrect dose of Vitamin D 2 (1) to Resident # 26.	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 759	Continued From page 176 Resident #26 was admitted to the facility on 4/3/15 with diagnoses that included but were not limited to: muscular dystrophy [any of a group of hereditary disease of the muscular system characterized by weakness and wasting of groups of skeletal muscles, leading to increasing disability (2)], depression, diabetes and vitamin D deficiency. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/21/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Observation was made of RN (registered nurse) #2, on 4/15/19 at 7:41 a.m. administering medications to Resident #26. RN #2 prepared the following medications: Breo Ellipta 100-25 inhalation - one inhalation (used to treat asthma and COPD) (3) Allopurinol 300 mg (milligrams) - one tablet (used to treat gout) (4) Baclofen 10 mg - 1/2 tablet (used to relieve pain and improve muscle movement) (5) Buspirone HCL (hydrochloride) 10 mg - one tablet (used to treat anxiety disorders) (6) Carvedilol 6.25 mg - one tablet (used to treat heart failure) (7) Duloxetine HCL 30 mg capsule - (Used to treat depression and anxiety disorders) (8) Eliquis 5 mg - one tablet - (used to prevent strokes and blood clots) (9) Fexofenadine HCL 180 mg - one tablet (Used to treat allergies) (10) Gabapentin 400 mg - one capsule (used to treat	F 759	**F 759** **1.A) The physician was notified of the medication error as on 4/15/2019 and no new orders were received. Resident # 26 is currently receiving vitamin D2 as ordered by physician.** **B) Resident # 59 physicians have reviewed vitamin D medication dosage and wrote a new prescription on 4-15-19 for calcium with vitamin D 500mg/400u. The medication administration time for Tamulosin has been reviewed by physician on 4-15-19 and desires given at 1600.** **2.Resident's with physician orders for Vitamin D, Calcium with vitamin D and Tamulosin has been reviewed by the director of nursing to ensure medications are available and being administered in accordance with the physician order as of 5/9/2019. Follow up based on findings.** **3.Licensed nurse will be re educated by DON/ designee on following physician orders by utilizing the six rights of medication administration for consistency. Random medication administration reviews will be conducted weekly for eight weeks by the DON or designee to ensure medications are available and medication administration is completed in accordance with physician order.** **4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 759	Continued From page 177 seizures and pain) (11) Metformin HCL 500 mg - one tablet (used to treat diabetes) (12) Oxycodone 10 mg - one tablet (used to treat moderate to severe pain) (13) Pravastatin Sodium 40 mg - one tablet (used to treat elevated cholesterol) (14) Rexulti 0.5 mg - one tablet (used to treat symptoms of schizophrenia) (15) Thera Tab - one tablet (multivitamin supplement) (16) Topiramate 50 mg - one tablet (used to help prevent migraine headaches) (17) Vitamin D 3 5,000 IU (international units) - one capsule Review of the physician orders dated 9/16/17 and renewed on 3/26/19, documented, "Vitamin D 2 capsule 50,000 Unit capsule (Gen [generic] - ergocalciferol). 1 cap (capsule) by mouth every Monday and Friday for deficiency." The April 2019 MAR (medication administration record) documented the above order for Vitamin D2. An interview was conducted with RN (registered nurse) #2 on 4/15/19 at 10:07 a.m. RN#2 verified which bottle of Vitamin D she used to obtain the medication that she had administered to Resident #26. RN #2 verified her initials on 4/15/19 MAR (medication administration record) for the ordered dose of Vitamin D2. RN #2 was asked to read the physician order documented on the MAR. Once read, RN #2 was asked if she gave the medication per the physician's order, RN #2 stated, "No, but I don't have that dose (Vitamin D 2 capsule 50,000 Unit) on my med (medication) cart."	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 759	Continued From page 178 On 4/15/19 at 10:30 a.m., the medication room was observed with RN #2. There was no bottle of Vitamin D 2 50,000 units. At this time, RN #2 informed the surveyor that she had found a medication card on her medication cart with the correct medication. None of the capsules had been removed from the card. RN #2 stated, "It's my error." The facility policy, "Medications - Oral Administration Of" documented in part, "Procedure: Take Medication Administration Record (MAR) and Medication Cart to hallway outside resident's room....Compare unit/dose medication on Medication Administration Record (MAR). Read label on the container THREE (3) TIMES; BEFORE REMOVING the drug from the container or card, before returning the drug to the med (medication) cart or disposing of the container; and BEFORE HANDING the drug to the resident. Refrain from touching powders, capsules or pills with hands." According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg. 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 759	Continued From page 179 right client, 4. The right route, 5. The right time, and 6. The right documentation." 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. No further information was provided prior to exit. (1) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=ergocalciferol (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 381 (3) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=breo+ellipta. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682673.html (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682530.html. (6) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a688005.html (7) This information was obtained from the following webiste:	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 759	Continued From page 180 https://medlineplus.gov/druginfo/meds/a697042.html (8) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a604030.html (9) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html (10) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697035.html (11) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html (12) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a696005.html (13) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html (14) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a692025.html (15) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a615046.html (16) This information was obtained from the following website: https://www.heart.org/en/healthy-living/healthy-eating/eat-smart/nutrition-basics/vitamin-supplements-hype-or-help-for-healthy-eating	F 759		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 759	Continued From page 181 (17) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697012.html. 2. The facility staff failed to administer the correct dose of calcium with vitamin D and failed to administer Tamsulosin per the physician order to Resident # 59. Resident #59 was admitted to the facility on 3/8/19, with diagnoses that included but were not limited to: high blood pressure, diabetes, dementia, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/5/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. Observation was made of LPN (licensed practical nurse) #1 on 4/15/19 at 8:11 a.m. administering medications to Resident #59. LPN #1 prepared the following medications: Duloxetine 60 mg (milligrams) - one capsule (used to treat depression and anxiety disorders) (1) Fish Oil 500 mg - two capsules (is an omega - 3 supplement) (2) Glimepiride 4 mg - tablet (used to treat diabetes) (3) Oyster Shell Calcium 500 mg - one tablet (used as a supplement for bone loss) (4) Tamsulosin HCL (hydrochloride) 0.4 mg (used to treat enlarged prostate and frequent urination) (5) Memantine HCL 5 mg - one tablet (used to treat symptoms of dementia) (6)	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 759	Continued From page 182 The physician orders dated, 3/8/19, documented in part, "Calcium (a C with a line over it indicating 'with') D (vitamin D) 500/200 (500 mg of calcium and 200 mg of Vitamin D) one PO (by mouth) QD (every day). Tamsulosin 0.4 mg one cap (capsule) PO @ (at) 1600 (4:00 p.m.)." The review of the March 2019 Medication Administration Record (MAR) documented the above orders. On the March MAR the Tamsulosin was scheduled for 1600 (4:00 p.m.). The review of the April 2019 MAR documented the above orders. On the April MAR the Tamsulosin was printed for 1600 (4:00 p.m.) but someone had handwritten 0900 (9:00 a.m.) across the 1600 (4:00 p.m.) time. An interview was conducted with LPN #1 on 4/15/19 at 10:13 a.m. LPN #1 was asked to verify which calcium supplement she administered to Resident #59 the Oyster Shell Calcium 500 mg was confirmed. The above order for calcium with vitamin D was reviewed with LPN #1. When asked if she followed the physician's order, LPN #1 stated she did not. The medication cart was reviewed with LPN #1 and there was no bottle of calcium with vitamin D 500/200 on the medication cart. The order for the Tamsulosin was reviewed with LPN #2. When asked if a nurse can just change a physician's order for a medication-scheduled time, LPN #2 stated, "No, you would need a physician order to change the time." The clinical record was reviewed and there was no physician order to change the administration time of the Tamsulosin from 1600 (4:00 p.m.) to 0900 (9:00 a.m.). An interview was conducted with administrative	F 759		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 759	Continued From page 183 staff member (ASM) #3, the regional director of clinical services, on 4/15/19 at 10:43 a.m. When asked if the physician order documents to administer a medication at 1600 can a nurse change the administration time, ASM #3 stated, "Only after she has spoken to the doctor. Unless the resident requested it at a certain time, but they still need a physician order to change the time." 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. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a604030.html (2) This information was obtained from the following website: https://nccih.nih.gov/health/omega3/introduction.htm (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a696016.html (4) This information was obtained from the following website: https://medlineplus.gov/ency/article/007477.htm (5) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698012.html (6) This information was obtained from the following website:	F 759		

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F 759	Continued From page 184 https://medlineplus.gov/druginfo/meds/a604006.html.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label and store medications according to professional standards in one of three medications carts, the wing 200 medication cart; and failed to ensure expired biological's	F 761	**F 761** **1.A) The insulin unlabeled and the unopened insulin in medication cart 200 was discarded during survey. Insulin that is in usage is stored properly.** **2a) The nutritional supplements were immediately checked in the nourishment room for expiration date and appropriately discarded during survey.** **2b) The MED PASS a nutritional supplement in the facility nutritional refrigerator with open date 4/8/19 was immediately discarded.** **2. Medication carts in the facility have been checked by a licensed nurse and any insulin not labelled according to the manufacturer recommendation has been discarded. The nutritional room has been checked to ensure nutritional supplements have appropriate dates and discarded when necessary. Follow up based on findings.**	5.28.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 761	Continued From page 185 were not available for use in the facility nutritional room and nutritional refrigerator, located on the 100 hallway. 1. The facility staff failed to label opened insulin and failed to store unopened insulin in the refrigerator. 2a. The facility staff failed to ensure expired nutritional supplements were not available for Resident use in the facility nourishment room. 2b. The facility staff failed to ensure that a MED PASS (1) nutritional supplement observed in the facility nourishment refrigerator with a documented open date of 04/08/19 was stored at the proper temperature and discarded according to the manufacturer recommended date of 04/12/19. The findings include: 1. On 4/15/19 at 3:49 p.m., observation of the wing 200 medication cart was conducted. The following opened insulin's were observed without a labeled open date: - One vial of Novolog (1) - Three Novolog flex pens. The pens were labeled with a sticker that documented, "Discard 28 days after opening." - Two Lantus solostar pens (2). The pens were labeled with a sticker that documented, "Discard 28 days after opening." - One Basaglar kwikpen (3). The pen was labeled with a sticker that documented, "Discard 28 days after opening." -Two Levemir flextouch pens (4). The pens were labeled with a sticker that documented, "Discard	F 761	**3. Licensed nurses will be reeducated by DON/designee on following manufacturing guidelines for insulin storage and nutritional supplements as well as discarded when expired. The dietary manager will complete quality review of the kitchenette area on the unit weekly to ensure proper storage of supplements. Random medication administration reviews will be conducted weekly for eight weeks by the DON or designee to ensure insulin is available, properly stored and administration is completed in accordance with physician order. The director of nursing will complete and monitor tool will be completed weekly for eight weeks.** **4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. .**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 761	Continued From page 186 42 days after opening." The medication cart also contained a Basaglar kwikpen and a Lantus solostar pen that was unopened (as evidenced by a sticker wrapped around the opening). Both pens contained a sticker that documented, "Refrigerate until opened." The Novolog manufacturer's website documented, "Throw away open vials and pens 28 days after first use, even if there is insulin left inside." This information was obtained from the website: https://www.rapidactinginsulin.com/novolog/using-novolog/storage-and-handling.html The Lantus solostar manufacturer's website documented, "The LANTUS vials you are using should be thrown away after 28 days, even if it still has insulin left in it." The Lantus solostar manufacturer's instructions further documented, "Unopened Lantus vials, cartridge systems and SoloStar device should be stored in a refrigerator..." This information was obtained from the website: http://products.sanofi.us/lantus/lantus.html#section-16.2 The Basaglar manufacturer's website documented, "Store unused Pens in the refrigerator at 36°F to 46°F (2°C to 8°C). Throw away the Pen you are using after 28 days, even if it still has insulin left in it." This information was obtained from the website: http://uspl.lilly.com/basaglar/basaglar.html#ug The Levemir manufacturer's website documented, "Dispose after 42 days, even if	F 761		

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F 761	Continued From page 187 there is insulin left in it." This information was obtained from the website: https://www.levemir.com/levemir-flextouch-and-vial.html On 4/15/19 at 4:12 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked about the facility process for labeling insulin vials and pens. RN #1 stated, "You label them when you open them with the date opened." When asked why, RN #1 stated, "Because they expire." RN #1 was asked how a nurse would know if an insulin with a modified expiration date after being opened was expired if it was not labeled with an open date. RN #1 stated, "Then you should throw it away and get a new one because you don't know when it was opened." When asked if there were any types of insulin's that should be refrigerated until opened, RN #1 stated she knew there were some but could not describe which insulin's or the reason why they should be refrigerated until opened. RN #1 was made aware of and confirmed, all the above concerns. RN #1 stated she would discard and reorder the insulin's. When asked the facility process for checking insulin's for proper labeling and storage, RN #1 stated she thought each nurse should check the insulin's each shift but the unit manager completes medication cart checks once a month. When asked who the unit manager was, RN #1 stated she thought there was no unit manager at this time. On 4/16/19 at 8:51 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the interim director of clinical services) were made aware of the above concern. The facility/pharmacy policy titled, "5.3 Storage	F 761		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 761	Continued From page 188 and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according the United States Pharmacopeia guidelines for temperature ranges..." No further information was presented prior to exit. (1) Novolog is insulin used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605013.html (2) Lantus is insulin used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html (3) Basaglar is insulin used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html (4) Levemir is insulin used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a606012.html 2a. The facility staff failed to ensure expired nutritional supplements were not available for Resident use in the facility nourishment room.	F 761		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 761	Continued From page 189 On 4/16/19 at 11:22 a.m., an observation of the facility nourishment room revealed the following: -Two cans of Glucerna (3)-1.2 calories were observed on the top left shelf stored at room temperature with an expiration date 04/01/19 -Two one-quart cartons of "Thick and Easy" (4) nutritional supplement located in the nourishment room on the right corner of the second shelf at room temperature with an expiration date 3/7/19. On 4/16/19 at 11:51 a.m., an interview was conducted with OSM (other staff member) # 5, dietary manager. When asked who responsible for stocking the nourishment supply room, OSM # 5 stated, "I'm not sure but the kitchen is only responsible for the juices and the apple sauces." When asked if the expired items should be on the shelf available for use, OSM # 5 stated, "No it should not.' On 4/16/19 at 11:58 a.m., an interview conducted in the nourishment room with OSM # 8, medical logistic staff. When asked who was responsible for stocking the nourishment room. OSM # 8 stated she was. OSM # 8 stated, when the nourishment supplies arrive she rotates the old supplies and marks the supplies with the date the items were placed on the shelf. When asked if the above-expired items on the shelf should be available for use, OSM # 8 stated, "No they should not." 2b. The facility staff failed to ensure that a MED PASS (1) nutritional supplement observed in the facility nourishment refrigerator with a documented open date of 04/08/19 was stored at the proper temperature and discarded according	F 761		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 761	Continued From page 190 to the manufacturer recommended date of 04/12/19. On 4/16/19 at approximately 11:22 a.m., an observation of the nourishment refrigerator revealed a one-quart nutritional supplement of "MED PASS" located on the bottom shelf of the refrigerator door. The MED PASS supplement container was observed a quarter full. Further observation of the MED PASS box revealed the manufacturer expiration date of 01/24/20, storage date 3/25 and open date of 4/8/19. The instructions on the box documented, "Discard 4 (four) days after the open date." Observation of the thermometer for the nourishment refrigerator revealed the temperature was registered at 50 degrees Fahrenheit. On 4/16/19, an interview was conducted with RN (registered nurse) # 1 regarding the above observation. When asked if the [MED PASS] nutritional supplement was available for resident's use, RN # 1 stated, "Yes, but only if they (residents) have order for it." RN #1 was asked what the open date was and how long it is good for once opened. After looking at the container, RN # 1 stated, "No, based on the instructions on the box it should be thrown away." When asked why it should be thrown away, RN # 1 stated, "It could be spoiled or it could be growing bacteria." Review of the manufacturer's instructions documented, "5. MED PASS® 2.0/MED PASS® NSA needs to be kept at refrigerated temperature (34-40 degrees F) once opened. If kept at this temperature range, product is good for 4 days from the time opened. If product is opened and not refrigerated, product should be discarded after 4 hours." This information was obtained	F 761		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 761	Continued From page 191 from the website: http://www.hormelhealthlabs.com/product-support/product-protocols/med-pass On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) # 1, the executive director, ASM # 2, interim director of clinical services, and ASM # 3, regional director of clinical services, were made aware of the findings. No further information was obtained prior to exit. Reference: 1. A therapeutic nutrition specifically designed to help meet the nutritional needs of people on dialysis. This information was obtained from the website: https://www.amazon.com/Nutrition-Homemade-Vanilla-8-Ounce-Containers/dp/B000ARPKAS/ref=sr_1_4?hvadid=153739360550&hvdev=c&hvlocphy=9008455&hvnetw=g&hvpos=1t1&hvqmt=e&hvrand=10350154094813125827&hvtargid=kwd-13281102931&keywords=nepro+shakes&qid=1555802932&s=gateway&sr=8-4 2. A delicious meal or snack replacement shake that helps manage blood sugar. This information was obtained from the website: https://glucerna.com/nutrition-products/glucerna-shakes-rich-chocolate 3. Complete nutrition that tastes great when your body requires extra protein and calories. A balance of good for you nutrients formulated to help gain or maintain an optimal weight and for use during surgical recovery. Healthcare facilities can meet a host of resident	F 761		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 761	Continued From page 192 needs with fortified nutritional shake. The nectar consistency makes it suitable for a variety of diets. This information was obtained from the website: https://www.walgreens.com/store/c/hormel-med-pass-2.0-fortified-nutritional-shake/ID=prod6106110-product?ext=gooKBM_PLA_-_Home_Medical&pla&adtype=pla&kpid=sku6094120&sst=_k_EAIaIQobChMI8Zimnurf4QIVhYWzCh0TPAZIEAQYASABEgJA3PD_BwE_k_&gclid=EAIaIQobChMI8Zimnurf4QIVhYWzCh0TPAZIEAQYASABEgJA3PD_BwE 4. Instant Food & Beverage Thickeners are easy to use and safe for those with swallowing difficulties. Thicken up all varieties of hot and cold foods and liquids to be enjoyed without affecting the taste. This information was obtained from the website: http://www.hormelhealthlabs.com/t-e-inst-food-thknr-100-4-5g	F 761		
F 803 SS=B	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803	**F 803 Menu Meet Resident Needs/Prep in Advance/Followed** **1.Food Service Director updated published menu to accurately reflect what was being served for the lunch and dinner meal.** **2.Food Service Director will round the whole facility to include the dinning room and bulletin board across the nurse's station to ensure all menus are accurate in reflecting what is being served for lunch and dinner. Follow-ups done based on findings.** **3.Food Service Director will be educated by Healthcare Services District Manager on Daily manager rounds and closing rounds. Food service director will sign off on daily audit sheet 5 times a week for 5 weeks.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5.28.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 803	Continued From page 193 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure meals were served according to the published menu. The food served for diner on 4/15/19 did not reflect the foods listed on the published lunch menu. The findings include: On 4/14/19 at 1:04 p.m., an observation of the Kitchen through the dining room with OSM (other staff member) # 7, cook supervisor revealed the bulletin board in the dining room was missing the food menu. When asked where the menus are posted, OSM # 7 stated, "The menus are posted on the bulletin board in the dining room and on the wall across from the nursing station. A copy of the menu posted across from the nursing station was obtained from OSM # 7. The menu was typed on a letter size piece of paper with black and white letters with a character size of approximately 14 to 16 font. On the bottom of the page it was hand written, "All menus are subject	F 803		

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F 803	Continued From page 194 to change- Dietary." On 4/14/19 at approximately 4:30 p.m., observation of the steam table in the kitchen during the food temperature check revealed the following foods were prepared for dinner: green beans, corn bread stuffing, hamburger paddies, mashed potatoes, peas, and steamed carrots. The dinner menu for Sunday presented by OSM # 7 documented, "Country fried chicken with cream gravy, mashed potatoes, and snickerdoodle cookie." On 04/15/19 at approximately 2:07 p.m., a group interview was conducted with six alert and oriented residents. When asked about the dining experience at the facility, Resident # 28 stated, "You see those things, [pointing to the menus on the table], they are not right. They only change them like once a week, sometime they are right but most times they are wrong." All other residents around the table nodded in agreement with that statement. On 04/16/19 7:44 a.m., an interview was conducted with OSM # 5, dietary manager. When asked to describe the process of posting the menu, OSM # 5 stated, "I post lunch and dinner menus before lunch time. A copy is placed in the dining room, on the tables, and at the nursing station." When asked if the current menu was posted, OSM # 5 stated, "No my cook forgot to post the menu on Sunday, but I am on it. I arrived on Monday and I posted it." When asked if the published menu was followed, OSM # 5 stated, "Yes, but we forgot to change it to the right week, I agree that the menu was not correct." When asked to describe the process of notifying the residents when the menu changes, OSM # 5	F 803		

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F 803	Continued From page 195 stated, "The menu is printed, posted, and we inform the residents through the resident council. I also go room to room to inform the residents." When asked why it is important for the residents to have the menu in advance, OSM # 5 stated, "So the residents know what food to expect." On 04/16/19 at approximately 10:05 a.m., a phone interview was conducted with OSM # 6, dietitian. When asked to describe the process of posting the menu, OSM # 6 stated, "The menu is posted on the bulletin board in the dining room, at the nursing station and we put a ticket on the resident's tray listing the food items being served." When asked how residents are kept informed when the menu changes, OSM # 6 stated, "We let them know during resident council meetings. Changes are approved by a committee including the dietary manager, her supervisor, and myself." When asked if the menu should be followed and how to ensure the menu is being followed, OSM # 6 stated, "Yes, the menu should have been followed and I was not aware of the fact that the correct menu was not posted." OSM # 6 added that going forward she will ensure better communication between herself and the dietary manager regarding the menu. When asked if it was important that the residents receive nutritionally balanced food at all times, OSM # 6 stated, "If the nutrition schedule is not followed, it's not a good practice." The facility policy provided, "Food: Preparation" did not address the menu process. On 04/16/18 at approximately 3:45 p.m., ASM (administrative staff member) # 1, the executive director, ASM # 2, director of clinical services, and ASM # 3, regional director of clinical services,	F 803		

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 803	Continued From page 196 were made aware of the findings. No further information was provided.	F 803	**4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store, prepare and serve food in a sanitary manner. 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. 2. The facility staff failed to maintain the food	F 812	**F 812** **1.Food Service Director ensured that all stored items were wrapped individually and stored in a sanitary manner.** **Food service director made sure that all kitchen equipment that was cleaned after use was allowed to fully dry before storing.** **2.Food Service Director rounded whole facility to ensure that food was individually wrapped and that food processing equipment was dry prior to storing. Follow-ups done based on findings.** **3.Food Service Director will be educated by Healthcare Services District Manager on the importance of storing food items individually to optimize sanitary conditions. Food Service Director will be educated by Healthcare Services District Manager on the importance of storing food preparation equipment after it has been allowed to fully dry after being washed. Executive Director will complete random kitchen inspection weekly for eight weeks. Food service director will sign off on daily audit sheet 5 times a week for 5 weeks.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

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F 812	Continued From page 197 blender in a sanitary manner in the kitchen. 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. On 04/14/19 at 1:00 p.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 7, the cook. Observation of the walk-in refrigerator revealed a three shelf cart with a sheet pan on each shelf. Observation of the sheet pans revealed twelve dessert plates with a slice of frosted cake on each sheet pan for a total of 36 slices of cake on the cart. Further observation of the sheet pans containing the cake revealed a sheet of wax paper covering the top of the cakes, but exposing the sides of the cake. During the observation of the rest of the items in the walk-in refrigerator, the refrigeration fan would be activated blowing toward the cart containing the slices of cake. Observation of the covering over the cake revealed that when the refrigeration fan was activated or the walk-in refrigerator door was opened the coverings over the sheet pans of cake would be lifted and moved further exposing the cakes to the contaminates from the environment. When asked who prepared and covered the desserts OSM # 7 stated, (OSM 11)." On 4/14/19, at approximately 1:30 p.m., an interview was conducted with OSM # 11. When asked about the sheet pans containing the slices of cake on the cart in the walk-in refrigerator OSM # 11 stated she had prepared and covered them. After observing the sheet pans containing	F 812		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 812	Continued From page 198 the slices of cake on the cart in the walk-in refrigerator OSM # 11 stated, "They're not fully covered. They should be wrapped separately." 3. The facility staff failed to maintain the food blender in a sanitary manner in the kitchen. On 04/14/19 at 1:15 p.m., an observation a food blender sitting on a food preparation table was conducted. When asked if it was cleaned and ready for use OSM # 7, cook stated yes. Observation of the food blender revealed the inside of the pitcher was wet. When asked to describe the procedure for storing the pitcher for the blender OSM # 7 stated, "It should be dry before putting it back together." On 04/16/19 at 8:03 a.m., an interview was conducted with OSM # 5, dietary manager. After OSM #5 was informed of the observation of the trays of cake slices on the cart in the walk-in refrigerator OSM # 5 stated, "The cakes should have been individually wrapped." When asked to describe the procedure for storing the food blender OSM # 5 stated, "It is put it on the drying rack until it is dry and then reassemble it." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814		

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	495236	A. BUILDING _____ 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

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F 814	Continued From page 199 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a sanitary manner. The facility staff failed to close the sliding doors on the facility's two dumpsters and maintain the area around the dumpsters free of trash. The findings include: On 04/14/19 at approximately 1:40 p.m., an observation of the facility's dumpsters was conducted with OSM (other staff member) # 7, the cook. Observation revealed the facility had two trash dumpsters and one cardboard recycling dumpster located behind the facility. Observations of the area around the trash dumpsters revealed three pairs of used plastic gloves, a piece of plastic bubble wrap and a used plastic bag lying on the ground next to and behind the trash dumpsters. Further review of the two trash dumpsters revealed the sliding door on each dumpster was open. When asked about the debris lying on the ground around the dumpsters OSM stated, it should be picked up." When asked about the dumpster doors being left open OSM stated, "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	F 814	**F 814** **1.Food Service Director closed all dumpster lids and picked all debris to include gloves in the surrounding area.** **2.Food Service Director conducted a comprehensive sweep of the dumpster area to ensure that there was not any trash or debris on the ground and that the dumpsters were tightly closed. Follow-ups done based on findings.** **3.Food Service Director will be educated by Healthcare Services District Manager on Daily manager rounds and closing rounds with a focus on ensuring that the dumpster area is free of debris and that the dumpster lids are closed. Executive Director will complete dumpster inspections weekly to ensure no food or debris is noted outside the dumpster. Food service director will sign off on daily audit sheet 5 times a week for 5 weeks.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ENVOY AT THE MEADOWS	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

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F 814	Continued From page 200 dumpster area. When you take the trash out to the dumpster, if there is stuff on the ground the staff should be picking it and putting it in the dumpster and the doors should be kept closed at all times." On 04/06/19 at approximately 3:43 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit.	F 814		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure the QAPI (quality assurance and performance improvement) committee met at	F 868	Past noncompliance: no plan of correction required.	

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 868	Continued From page 201 least quarterly. The facility staff failed to evidence the QAPI committee met at least quarterly from April 2018 through April 2019. The findings include: On 4/17/19 at 10:33 a.m., an interview regarding QAPI was conducted with ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of clinical services) and ASM #3 (the regional director of clinical services). ASM #1 was asked to explain the facility QAPI process. ASM #1 stated the QAPI committee meets monthly and consists of himself, the medical director, the director of clinical services, nursing staff and department heads. ASM #1 stated the committee discusses old business, looks at any new areas of opportunity for improvement, reviews any outstanding plans of corrections, develops new plans of correction, reviews systematic data and engages in any actions that are needed to be done as a result. At this time, ASM #1 confirmed he could not provide evidence that the QAPI committee met at least quarterly from April 2018 through April 2019. On 4/17/19 at 10:40 a.m., ASM #3 provided a QAPI sign-in sheet dated 4/10/18 and stated she could not provide any further evidence of QAPI meetings until January 2019 when the facility staff identified an issue with the quarterly QAPI meetings and developed a plan of correction. The plan of correction dated 1/11/19 documented, "1. Facility leadership will be educated having monthly QAPI meetings by the RDCS (regional director of clinical services).	F 868		

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	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 868	Continued From page 202 2. Residents that reside in the facility have the potential to be affected. 3. The facility will have monthly meetings and document minutes and signature sheets. 4. QAPI minutes will be reviewed by the RDCS monthly." This plan of correction was reviewed, verified and approved by the survey team. The facility was found to be in compliance during the survey. The facility QAPI plan documented, "QAPI Committee meetings will be conducted monthly..." No further information was presented prior to exit. PAST NON-COMPLIANCE.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

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F 880	Continued From page 203 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880	**F 880 Infection Control** **1.The incentive spirometer device for resident # 60 was removed from resident room due to no physician order. Resident's meals are served with proper technique that includes not touching the edge of the plate while serving food.** **2.Resident's rooms with physician orders for respiratory equipment have been assessed for proper infection control practices as of 5/9/2019 by the licensed nursing staff. Staff observations of meal time have been conducted for proper hand hygiene etiquette to prevent infection. Follow up to be conducted based on findings.** **3.Licensed nurse will be re educated on ensuring residents have physician's order for respiratory devices in use by the Director of Nursing or designee. The certified nursing staff will be re-educated of proper meal delivery in accordance with good infection control practices by the DON or designee. A quality review of resident's room will be conducted to ensure respiratory equipment is maintained in a sanitary condition by the DON or designee weekly for eight weeks. A quality review of meal delivery will be completed weekly for eight weeks by the DON or designee to ensure infection control practices are being followed.**	5-28-19

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F 880	Continued From page 204 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to implement infection control practices for one of 41 residents in the survey sample, Resident #60, and in the facility dining room during. 1. The facility staff failed to store Resident #60's incentive spirometer (1) mouthpiece in a clean and sanitary manner to prevent infection. 2. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of resident's plate, while serving food in the dining room. The findings include: 1. Resident #60 was admitted to the facility on 2/22/19. Resident #60's diagnoses included but were not limited to chronic obstructive pulmonary disease (2), heart failure and pain. Resident #60's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 3/22/19, coded the resident as being cognitively intact. Section G coded the resident as requiring extensive assistance of one staff with bed mobility, dressing, toilet use and personal hygiene.	F 880	**4.The results of the quality monitoring will be reported to the quality assurance committee for review, analysis and further recommendations.**	

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F 880	Continued From page 205 Review of physician's order sheet for Resident #60 signed by the physician on 4/15/19 failed to reveal an order 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'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 ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, "Incentive Spirometer" failed to document information regarding	F 880		

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F 880	Continued From page 206 incentive spirometer storage. No further information was presented prior to exit. (1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. How to use an Incentive Spirometer Many people feel weak and sore after surgery and taking big breaths can be uncomfortable. A device called an incentive spirometer can help you take deep breaths correctly. By using the incentive spirometer every 1 to 2 hours, or as instructed by your nurse or doctor, you can take an active role in your recovery and keep your lungs healthy." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm (2) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=copd&_ga=2.106270788.695687771.1555589628-1667741437.1550160688	F 880		

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F 880	Continued From page 207 2. The facility staff failed to wash or sanitize their hands after touching the food service cart, and then touched the edge of resident's plate, while serving food in the dining hall. On 4/15/19 between 7:30 a.m. and 8:04 a.m., an observation was made of the dining room for the breakfast meal. The following was observed: CNA (Certified nurse assistant) #1 was observed opening the kitchen door, pushing a serving tray from table to table, and without washing or sanitizing her hands, she served residents their drinks. CNA #2, #3, #4, and OSM (Other staff member) #3 were observed serving residents plates with bare hands with their thumbs on the rim of the plate food contact surface as they moved the plate from the food service cart to the table, placing the plates in front of the residents. CNA #2, #3, #4, and OSM #3 were not observed washing or sanitizing their hands during the breakfast service. On 4/16/19 at 8:26 a.m., an interview was conducted with CNA #3. When asked about the process for serving resident meals, she stated, "You set the resident at the seat that they want and place the dining proctor on. You place the silverware, drinks, and cereal in front of the resident. When there are two CNA's in there, one passes the breakfast plates while the other finishes passing out the cereal and drinks. We try to make sure we have clean hands when we do." When CNA #3 was asked about the need to wash her hands after pushing the serving cart, CNA#3stated, "Yes. If you don't wash your hands after pushing the serving cart and then serving the plates, it would be a problem with cross contamination. You would need to wash your	F 880		

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F 880	Continued From page 208 hands before or you would need to toss the plate and get a new one. You don't ever touch the top of the plate or the rim of the plate." When CNA #3 was asked to demonstrate how to hold a resident's plate, she demonstrated holding a plastic plate underneath the plastic plate. When CNA #3 was asked if a server's bare thumbs were on the top rim of the place, would that be a problem, she stated, "Yes, your thumbs should not be where the food is." On 4/16/19 at 12:02 p.m., a request for the facility's policy for dining and serving meals was made. A review of the facility's policy for "Hand Hygiene" with a revision date of 8/29/17 that documented in part, "Overview: The CDC (Center for Disease Control) defines hand hygiene as cleaning your hands by using either handwashing ..., antiseptic hand rubs ...Purpose: to reduce the spread of germs in the healthcare setting ...Process: Hand hygiene should be performed: After contact with inanimate objects...in the immediate patient vicinity..." On 4/17/19 at 10:32 AM, ASM (Administrative Staff Member) #3 stated, "There is no policy for dining and serving meals." In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care, the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene.	F 880		

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F 880	Continued From page 209 Contaminated hands of health care workers are a primary source of infection transmission in health care settings." 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.	F 880		
F 925 SS=C	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined the facility staff failed to ensure an effective pest control program so that the facility is free of pests, A black spider, a quarter round in size, on the floor on the 100 hallway across the hall from the nourishment room on 4/15/19. The findings include: During the initial pool of resident interviews, two alert and oriented residents stated that there was a "spider problem" at the facility. On 4/15/19 at 2:07 p.m., a group interview was conducted with six alert and oriented residents. The residents voiced concern of spider sightings. One resident stated, "I've been here for four years and they sprayed once, 2 years ago, and that was not effective."	F 925		

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F 925	Continued From page 210 Observation was made on 4/15/19 at 2:22 p.m., of a black spider, a quarter round in size, on the floor on the 100 hallway across the hall from the nourishment room. An interview was conducted with CNA (certified nursing assistant) #1 on 4/15/19 at 2:23 p.m. When asked about the facility process staff follows if they see a bug/spider, CNA #1 stated, "I would get a paper towel, squish it to ensure it's dead and tell housekeeping." When asked if they document any bug sightings anywhere, CNA #1 stated, "Not that I'm aware of." Observation was made on 4/15/19 at 2:25 p.m. of the same black spider moving down the hallway approximately four tile lengths or four feet from the original sighting. An interview was conducted with LPN (licensed practical nurse) #1, on 4/15/19 at 2:27 p.m. When asked staff are supposed to do if they see a bug or spider, LPN #1 stated, "I get a tissue and squish it. I tell maintenance or housekeeping." When asked if they write anything down for maintenance or housekeeping anywhere, LPN #1 stated, "I honestly don't know." Observation was made of the same black spider on 4/15/19 at 2:29 p.m., moving again down the hall approximately eight tiles or eight feet, from the original tile. At 2:30 p.m., a staff member went and disposed of the spider. An interview was conducted with other staff member (OSM) #1, the director of maintenance, on 4/15/19 at 2:34 p.m. When asked how the staff lets him know of any bug/spider sightings,	F 925	**F 925** **1.Professional exterminator treated facility for spiders on 4/29/2019.** **2.Maintenance Director or Designee will conduct facility rounds to include residents' rooms and external points of entry to identify any other signs of pest and treat as needed.** **3.Residents will be asked in the monthly resident counsel meeting to report any sightings of pest for 3 months.** **Staff will be educated on appropriately communicating any pest sightings to the Maintenance Director or Executive Director.** **Maintenance Director will maintain a relationship with professional exterminator service and have them treat the facility on a regular periodic cycle based on their recommendations and findings.** **4.The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	5-28-19

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F 925	Continued From page 211 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.	F 925		

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F 925	Continued From page 212 No further information was provided prior to exit.	F 925	**F 947 Required In-service training for nurse aides**	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to provide the required annual in-service trainings for ten of ten CNA (certified nursing assistant) record reviews. The facility staff failed to provide the required annual 12 hours and/or dementia management trainings for CNAs #2, #7, #8, #9, #10, #11, #12, #13, #14 and #15. The findings include:	F 947	**1.Employee CNA#2 will complete the 12 hours of annual training by May 20, 2019.** **Employee CNA#7 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#8 will complete the 12 hours of annual training to include Dementia training by May 20,2019.** **Employee CNA#9 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#10 will complete the 12 hours of annual training by May 20, 2019.** **Employee CNA#11 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#12 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#13 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#14 will complete the 12 hours of annual training to include Dementia training by May 20, 2019.** **Employee CNA#15 will complete the 12 hours of annual training to include Dementia Training by May 20, 2019.**	5-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 213 On 4/15/19 at 10:20 a.m., a list of CNAs who were employed at the facility for more than one year was provided by OSM (other staff member) #4 (the regional director of human resources), per this surveyor's request. A sample of ten CNAs was selected from the list and on 4/15/19 at 10:36 a.m., ASM (administrative staff member) #3 (the regional director of clinical services) was asked to provide the annual 12 hours of required training and annual dementia management training for the ten CNAs. Review of trainings for the CNAs failed to reveal 12 hours of annual required training for all ten CNAs: CNA #2 (hired on 3/21/18) CNA #7 (hired on 1/11/17) CNA #8 (hired on 12/29/14) CNA #9 (hired on 10/13/97) CNA #10 (hired on 2/7/18) CNA #11 (hired on 5/3/04) CNA #12 (hired on 8/14/00) CNA #13 (hired on 3/27/14) CNA #14 (hired on 1/3/18) CNA #15 (hired on 9/21/16) Review of trainings failed to reveal annual dementia management training was provided for: CNA#7 CNA #8 CNA #9 CNA #11 CNA #12 CNA #13 CNA #14 CNA #15	F 947	**2.Human Resource Manager or Designee will review all actively employed nurse aides to ensure that 12 hours of in-service education to include dementia management training was conducted in the last 12 months. Follow ups will be done based on findings.** **3.Human Resources Manager will be educated on ensuring that every actively employed nurse aide has 12 hours of in-service training to include dementia management within the last 12 months by Executive Director or Designee. Human Resource Manager will ensure that moving forward nurse aides have 12 hours of in-service training to include dementia management yearly. Monthly anniversary 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 to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	04/17/2019

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F 947	Continued From page 214 On 4/15/19 at 1:06 p.m., ASM #3 was made aware of the above concern and asked to provide evidence that the trainings were completed. ASM #3 confirmed trainings for some CNAs could not be located. On 4/16/19 at 8:46 a.m., an interview was conducted with ASM #1 (the executive director) and ASM #2 (the interim director of clinical services) (both responsible for ensuring employee trainings are completed). ASM #1 and ASM #2 was asked the facility process for ensuring annual CNA trainings are completed. ASM #2 stated the facility staff has a schedule that coincides with employees' hire dates and ensures trainings are completed. ASM #1 and ASM #2 were made aware of the above concern. The facility policy titled, "In-Service Training-General" documented, "Employees will be provided in-service trainings on required topics on an annual basis...2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, and may include Company required in-service education topics. Each Care Center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly..." No further information was presented prior to exit.	F 947		