ENVOY
of Lawrenceville

December 5, 2019

Ms. Nicole Keeney, LTC Supervisor

Division of Long Term Care

Commonwealth of Virginia

Department of Health

Office of Licensure and Certification

9960 Maryland Dr.

Suite 401

Henrico, Va. 23233-1485

Dear Ms. Keeney,

Enclosed is our completed plan of correction for the annual survey that took place ending on November 21, 2019.

Our allegation of compliance will be December 12, 2019.

If you have any questions, please feel free to reach out to me. My cell number is 516 650 5201.

Thank you

Allen Sinowitz, Divisional Executive Director

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495192		11/21/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/19/19 through 11/21/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/19/19 through 11/21/19. Corrections are required for complaince with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this seventy-seven certified bed facility was 74 at the time of the survey. The survey sample consisted of eighteen current record reviews and three closed record reviews.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate MDS (minimum data set) for one of 21 residents in the survey sample, Resident #78. Resident #78 was discharged to home, not the hospital as indicated on the MDS. The findings include:	F 641	1. Root Cause Analysis conducted on 11/21/2019 by DON . AdHoc Quality Assurance Performance Improvement (QAPI) Committee meeting held by DON with the Interdisciplinary Team (IDT) on 11/22/2019. Resident #78's MDS was updated to accurately reflect the resident's correct discharge destination. 2. Quality Monitor conducted by the DON to include a 30day look back for MDS accuracy in Section A (discharge). Director of Nurses to validate the accuracy	

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

Divisional Executive Director 12/5/19

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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F 641	Continued From page 1 Resident #78 was admitted to the facility on 09/19/19 with diagnoses that included muscle weakness, repeated falls, gangrene, difficulty walking, and osteomyelitis. The admission MDS dated 9/26/19 assessed Resident #78 as moderately impaired for daily decision making with a score of 11 out of 15. The resident was not triggered for return to the community on this assessment. On 11/20/19, Resident #78's closed clinical record was reviewed. Observed in the clinical record was the "Discharge Plan and Instructions" form dated 10/7/19 with a timestamp of 11 a.m. The discharge plan and instructions form documented that Resident #78 discharged to home on 10/7/19 with her spouse. The form documented Resident #78 was provided with discharge, medication and treatment summaries for post discharge services. Resident #78's discharge MDS was reviewed and documented that the resident discharged on 10/7/19. The MDS documented the discharge was planned and the resident's return was not anticipated. The discharge MDS documented that the resident was discharged to an acute care hospital. On 11/20/19 at 3:45 p.m., the MDS Coordinator (LPN #2) was interviewed regarding Resident #78's discharge location. LPN #2 stated the resident discharged to home. LPN #2 was asked to review the MDS for accuracy of the resident's discharge location. LPN #2 reviewed the discharge MDS and stated it was coded in error, that Resident #78 did not discharge to the hospital, and the resident was a planned discharge to home.	F 641	of discharge destination prior to submission. 3. MDS Coordinator reeducated by the DON on MDS accuracy to include Section A. 4. DON/designee to conduct Quality Improvement monitoring on a weekly basis x 4 weeks, every other week x 2 weeks then monthly as needed utilizing the clinical meeting process to verify that Section A is coded correctly. 5. Date of completion: December 12, 2109.	

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F 641	Continued From page 2 This information was shared with the administrator, director of nursing and corporate consultant during a meeting on 11/20/19 at 5:15 p.m. No additional information was provided to the survey team prior to exit on 11/21/19 at 9:30 a.m.	F 641		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and resident interview, the facility staff failed to follow physician orders for the use of TED (thromboembolic deterrent) knee high compression stockings for one of 21 residents, Resident #63. The findings include: Resident #63 originally admitted to the facility on 09/30/19 and readmitted on 10/28/19 with diagnoses that included hypertension, intestinal obstruction, pulmonary embolism, chronic kidney disease - stage 3, and hyperglycemia. The most recent minimum data set (MDS) dated 11/1/19 was a 5-day assessment and assessed Resident #63 as moderately impaired for daily decision	F 684	1. Root cause analysis conducted by the DON on 11/21/19. AdHoc QAPI Committee meeting conducted by the DON with the IDT on 11/22/2019. TED hoses applied to Resident #63 as ordered by the physician on 11/21/19. 2. Quality monitoring review by the DON/designee for residents who have orders for specialty items. 3. Nurses reeducated by the DON on the process of obtaining specialty items from the Central Supply Clerk. The Clinical Team will review new orders during the next day's clinical meeting to ensure that new physician orders have been implemented. 4. DON/designee to conduct Quality Improvement monitoring on a weekly basis utilizing the morning meeting process to verify that new physician orders have been implemented. 5. Date of completion: December 12, 2109.	

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F 684	Continued From page 3 making with a score of 12 out of 15. Resident # 63's clinical record was reviewed on 11/20/19. Observed on the physician order sheet was the following order: "TED knee high compression stockings daily, may remove at bed time, one time a day." The order date was 11/14/19 and the start date was 11/15/19. A review of Resident #63's treatment administration record (TAR) did not document the application of the stockings for the period of 11/15/19 through 11/18/19; the TAR was left blank for these days. On 11/19/19, the TAR documented the following code "9 = Other/See Nurse Notes)." A review of the nurses notes on 11/19/19 did not address the order for the stockings. On 11/20/19 at 8:55 a.m., Resident #63 was observed sitting beside her bed in her wheelchair talking on the telephone. Resident #63 was observed wearing light brown anti-slip socks with grippers on the bottom. On 11/20/19 at 1:45 p.m., Resident #63 was again observed sitting beside her bed in her wheelchair wearing the light brown anti-slip socks with grippers on the bottom. On 11/20/19 at 1:45 p.m., Resident #63 was interviewed regarding the use of the ted knee high compression stockings. Resident #63 stated "no I have not worn them yet. The lady doctor told me they were going to have to order a larger size for me. It's been almost a week and I haven't worn them yet. If my legs or feet swell, the girls will put my feet up or help me get in the bed."	F 684		

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F 684	Continued From page 4 On 11/20/19 at 2:00 p.m., the certified nursing assistant (CNA #1) who was providing care for Resident #63 was interviewed regarding the TED knee high compression stockings. CNA #1 stated "yes, I work with [Resident #63's name], but I didn't know she was suppose to have any TED hose on, otherwise I would have put them on her." On 11/20/19 at 2:01 p.m., the licensed practical nurse (LPN #1) was interviewed regarding the order for the TED knee high compression stockings. LPN #1 stated the CNA was responsible for applying the TED hose and then nursing would visually verify they were applied before signing off on the TAR. LPN #1 stated it could have been possible the TED hose were in the laundry. LPN #1 was asked to review Resident #63's orders and TAR and to speak with the resident as Resident #63 had stated she had not worn any TED hose since the physician wrote the order last week. LPN #1 reviewed the orders and TAR and stated she was not sure why Resident #63 had not been wearing the stockings. During this time, the central supply manager (OS #1) came to the nurses station and LPN #1 asked her if they had compression stockings in stock to fit Resident #63. OS #1 said "yes we have them here." OS #1 walked to the storage area and returned with an unopened pack of compression stockings for Resident #63. OS #1 stated "all someone had to do was let me know and [Resident #63's name] would have been wearing them." On 11/20/19 at 3 p.m., the director of nursing (DON) was interviewed regarding the order for the TED knee high compression stockings. The	F 684		

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F 684	Continued From page 5 DON reviewed the electronic medical record and stated the nurse practitioner wrote the order on 11/14/19 with a start date on 11/15/19. The nurse on duty did not apply the TED hose 11/15/19 - 11/19/19 because they were unable to locate a larger size for Resident #63. The DON continued and stated when the staff determined Resident #63 needed a larger size, they failed to communicate this information with the central supply manager (OS #1). The DON stated the central supply manager told her the items were in-stock; however, she was not notified by nursing that Resident #63 needed them until today (11/20/19). The DON stated "it all goes back to communication between staff, it's a work in progress." These findings were shared with the administrator, director of nursing and corporate consultant during a meeting on 11/20/19 at 5:15 p.m. No additional information was provided to the survey team prior to the exit on 11/21/19 at 9:30 a.m.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		

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F 756	Continued From page 6 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure a gradual dose reduction (GDR) for Ativan was attempted for one of 21 residents in the survey sample, Resident #43. Findings included: Resident #43 was admitted to the facility on 04/18/2012 and readmitted on 04/27/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Psychosis, Depression, and	F 756	1. Root cause analysis conducted by the DON on 11/21/2019. AdHoc QAPI conducted by the DON with the IDT on 11/22/2019. Resident #43 received a gradual dose reduction of Ativan on 11/21/2019. 2. Quality monitoring review by the DON/designee for residents who receive	

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F 756	Continued From page 7 Anxiety. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/22/2019. Resident #43 was assessed as severely impaired in her cognitive status with a total cognitive score of three (03) out of 15. Resident #43's clinical record was reviewed on 11/20/2019 at 2:00 p.m. A Behavioral Health Progress Note dated 6-14-19 included, "...Plan: ...Ativan 0.5mg [milligrams] TiD [three times daily], consider dose reduction in Ativan..." A monthly Consultation Report from the facility pharmacist dated 07/09/2019 included, "...Comment: [Name] Resident #43 takes risperidone 0.5mg QHS [at bedtime], lorazepam 0.5mg TID [three times daily], and trazodone 25mg QHS. Recommendation: ...please attempt a gradual dose reduction (GDR) of one or more of these agents...Physicians's Response: I accept the recommendation(s) above, please implement as written. I accept the recommendation(s) above WITH THE FOLLOWING MODIFICATION(S): D/C Trazadone..." Both options were checked by the physician, although no dose reduction recommendations had been suggested by the pharmacy. The physician signed off on this pharmacy consult on 7/10/19. Review of past medication regimen reviews dated November 2018 through October 2019 did not include any recommendations for GDR attempts for Ativan or Trazodone during this time frame. Risperidone was not started until 06/17/2019.	F 756	psychotropic medications. 3. The IDT will review residents receiving psychotropic medications on a quarterly basis and discuss with the physician if a GDR is appropriate. 4. IDT team will meet weekly to review residents whose Quarterly assessment is due. If the resident receives psychotropic medications the IDT will discuss a GDR with the physician. 5. Date of completion 12/12/2019.	

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F 756	Continued From page 8 The November MAR 2019 included, "Ativan Tablet 0.5MG (Lorazepam). Give 0.5 mg via PEG-Tube three times a day related to Anxiety Disorder...-Start Date- 07/17/2018..." Resident #43 was currently taking this medication three times daily. No dosage reductions had been attempted since the Ativan was started July 2018. The DON (director of nursing) was interviewed on 11/20/2019 at 3:00 p.m. When asked about the Behavior Health Progress Note and the physician's recommendations, the DON stated, "[Name] Medical Director looks at these." Regarding the pharmacy consult report, the DON stated, "I took the notations above to mean a gradual dose reduction of one or more and he dc'd the Trazodone." On 11/21/2019 at 8:40 a.m., the pharmacist, Other #2, was interviewed via phone regarding Resident #43's pharmacy reviews. Other #2 stated, "Going by memory, there may have been a contraindication. I believe going forward I will just write a note for each medicine and nothing will get lost in translation in the computer. That seems the best thing to do." Resident #43's physician, the Medical Director, was interviewed on 11/21/2019 at 8:50 a.m. via phone regarding no attempts at a GDR for Ativan. Medical Director stated, "She had been in the hospital prior to coming to long term care and had been on the Ativan for quite some time. I spoke with her daughter and she was very reluctant to make any medication changes. It is unusual for me to have someone on a benzo [benzodiazepine] three times a day. I believe I wrote to decrease it on the November recommendation. I didn't change her	F 756		

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F 756	Continued From page 9 Risperidone because she was having hallucinations and I thought the Risperidone would help her rest better." The Administrator was informed of the above findings during a meeting with the survey team on 11/21/2019 at approximately 9:00 a.m. No further information was received prior to the exit conference.	F 756		
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 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;	F 758	1. Root cause analysis conducted by the DON on 11/21/2019. AdHoc QAPI conducted by the DON with the IDT on 11/22/2019. Resident #43 received a gradual dose reduction of Ativan on 11/21/2019. 2. Quality monitoring review by the DON/ designee for residents who receive pharmacy recommendations. 3. DON/designee will implement recommendations when received as written per physician's order on the date that the order is given. 4. The IDT will review recommendations given by the Pharmacist weekly to ensure that recommendations have been implemented. 5. Date of completion 12/12/2019.	

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F 758	Continued From page 10 §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 and clinical record review, facility staff failed to ensure two of 21 residents in the survey were free from unnecessary medications, Resident #43 and Resident #36. Findings included: Resident #43 was admitted to the facility on 04/18/2012 and readmitted on 04/27/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Psychosis, Depression, and Anxiety. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/22/2019. Resident #43 was	F 758		

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F 758	Continued From page 11 assessed as severely impaired in her cognitive status with a total cognitive score of three (03) out of 15. Resident #43's clinical record was reviewed on 11/20/2019 at 2:00 p.m. A monthly Consultation Report from the facility pharmacist dated 07/09/2019 included, "...Comment: [Name] Resident #43 takes risperidone 0.5mg QHS [at bedtime], lorazepam 0.5mg TID [three times daily], and trazodone 25mg QHS. Recommendation: ...please attempt a gradual dose reduction (GDR) of one or more of these agents...Physicians's Response: I accept the recommendation(s) above, please implement as written. I accept the recommendation(s) above WITH THE FOLLOWING MODIFICATION(S): D/C Trazadone..." Both options were checked by the physician, although no dose reduction recommendations had been suggested by the pharmacy. The physician signed off on this pharmacy consult on 7/10/19. The DON (director of nursing) signed off on the pharmacy consult on 8/21/19. The July and August MARs (medication administration sheet) 2019 included, "Trazodone HCl Tablet 50 MG [milligrams]. Give 25 mg via PEG-Tube at bedtime for dementia. -Start Date-04/27/2018...-D/C [discontinue] Date-08/21/2019..." Resident #43 received this medication through 08/20/2019 according to documentation on the MARs. The DON (director of nursing) was interviewed on 11/20/2019 at 3:00 p.m. regarding why the physician had signed off to discontinue the Trazodone on 7/10/19, but Resident #43 continued to receive Trazodone through	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495192		11/21/2019

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F 758	Continued From page 12 8/20/2019. The DON stated, "We put these [pharmacy review reports] in [Name], Medical Director's book, usually the next day. He comes in on Wednesday and looks at them and signs off. He leaves them in his book. Someone from nursing, usually me, gets them and records the orders. I was out with pneumonia during this time [7/10/19-8/20/19] and didn't sign them off until my return. No one looked at them while I was out. My ADON [assistant director of nursing] will look at them in my absence now." The Administrator was informed of the above findings during a meeting with the survey team on 11/21/2019 at approximately 9:00 a.m. No further information was received prior to the exit conference. 2. Resident 36 with diagnoses including, but not limited to: dementia, osteoporosis, macular degeneration, high blood pressure, schizoaffective disorder and depressive disorder (single episode). The resident's most current MDS (minimum data set) was an annual assessment dated 10/18/19. The resident was assessed as a "3" cognitively, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as having dementia, depression and schizophrenia. The resident was assessed as receiving antipsychotic, anti-anxiety and antidepressant medications in the previous 7 day look back period. In section N0450 of this MDS, the resident was assessed as receiving antipsychotic medications on a routine basis and that a GDR had not been attempted. It was also documented that the physician had documented that a GDR was contraindicated. The GDR contraindication was for the medication Seroquel,	F 758		

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F 758	Continued From page 13 which occurred in December of 2018. A review of Resident #36's current medications documented that the resident was receiving Buspar 5 mg (milligram) every night, Seroquel 25 mg every night, and Prozac 10 mg every day. The resident's pharmacy MMR (monthly medication reviews) documented on 06/21/18 that the pharmacist made a recommendation for a GDR for the medication Buspar. The pharmacy recommendation documented, "[Name of Resident #36] is on Buspar 5 mg every night at bedtime" recommendation to consider a GDR, trial discontinuation or documenting that a dose reduction is clinically contraindicated. The physician response section documented, "Accept the recommendation (s) above, please implement as written." The physician signed and dated the recommendation on 06/21/18. The resident's clinical records were further reviewed and did not evidence that a GDR had actually been completed for the medication Buspar. Resident #36's current CCP (comprehensive care plan) documented, "...psychoactive medication...anti-anxiety and antipsychotic...administer medication as ordered...dose reduction attempts per evaluation if clinically indicated...non drug interventions..." On 11/20/19 at 1:44 PM, the DON (director of nursing) was asked if a GDR had been completed for Resident #36, as the clinical record did not indicate that a GDR had occurred. The DON stated that it had not and that she was not the DON when that happened.	F 758		

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F 758	Continued From page 14 No further information and/or documentation was presented prior to the exit conference on 11/21/19 to evidence that a GDR was completed as recommended and ordered for Resident #36.	F 758		