STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 03/03/2020 through 03/05/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 130 certified bed facility was 114 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		4/1/20

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

Electronically Signed | 03/24/2020

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F 842	Continued From page 1	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 2 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain an accurate clinical record for 2 residents (Resident #1 and Resident #3), in a sample size of 4 residents. The Findings included: 1. For Resident #1, there was incomplete documentation in the clinical record for a fall on 02/19/2020. On 03/03/2020, during the course of a closed record review for Resident #1, outside records provided by a local hospital for an Emergency Room visit on 02/25/2020, revealed a history of a previous Emergency Room visit to the same local hospital on 02/19/2020. Hospital records from 02/19/2020 were obtained and revealed Resident #1 was turning in bed at approximately 4:30 AM and rolled out onto the floor, landing on his knees. The facility sent Resident #1 to the Emergency department for evaluation. The Emergency room physician determined that Resident #1 bruised his left knee and Resident #1 was sent back to the facility at approximately 8:00 AM the same morning. On 03/04/2020, a comprehensive review of Resident #1's clinical record was performed with particular attention given to Progress Notes and Care Plan. The Care Plan had been updated with new fall interventions initiated on 02/20/2020 to include "check range of motion daily" and	F 842	Disclaimer Notice: Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of alleged deficiencies but instead is prepared for the sole purpose of compliance with State and Federal Regulations. F842 1. Resident #1 and #3 no longer reside at the facility. 2. Current residents have the potential to be affected. 3. All licensed nursing staff will be educated by the DON/designee by 03/30/2020 on documentation of a fall in the medical record to provide an accurate clinical record. 4.The DON/designee will monitor clinical records of residents experiencing a fall weekly for 4 weeks then monthly for 3 months to ensure proper documentation of the fall within the clinical record. The DON/designee will report results monthly to the QAPI Committee for on-going compliance and/or revision. 5. 4/01/2020	

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F 842	Continued From page 3	F 842		

"monitor/document/report PRN [report as needed] x 72h [hours] to MD for s/sx [signs/symptoms]: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation".

The Progress Notes revealed no documentation of the actual fall event on 02/19/2020, no documentation of clinical assessments by facility staff, and no documentation of monitoring for 72 hours as per Care Plan and facility policy.

Review of the facility policy and procedure entitled, "Fall Management", revised 07/29/2019, subheading "Post Fall Strategies", item #6 read, "Initiate post fall documentation every shift for 72 hours". An interview was conducted with the Division Executive Director (Employee C) and the Director of Nursing (DON, Employee B). Both employees verified and agreed there was no documentation of the resident's fall at the time of occurrence and no documentation of follow up care. Both Employee B and C stated that it is their expectation for the actual fall event and follow up care to be documented in the Progress Notes to enable the healthcare team to make accurate treatment plans for the resident. No further information was provided.

2. For Resident #3, there was incomplete documentation in the clinical record for a fall on 02/19/2020.

On 03/04/2020, in the course of a complaint investigation, a request was made for the facility staff to provide a list of all residents who experienced a fall on 02/19/2020. Resident #3

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F 842	Continued From page 4 was on that list. However, a review of the clinical record for Resident #3 revealed no documentation of the actual fall event on 02/19/2020 in the Progress Notes. Employee C and Employee B were informed of these findings and verified the lack of documentation with regard to the fall experienced by Resident #3 on 02/19/2020. Employee C stated it is her expectation for falls to be documented in the clinical record to provide accurate detail for the healthcare team. No further information was provided.	F 842		