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:
	495203	A. BUILDING: _____ B. WING _____	1/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF ALEXANDRIA, LLC	900 VIRGINIA AVENUE ALEXANDRIA, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	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 it was determined that the facility staff failed to ensure an accurate discharge MDS assessment for one of 51 residents in the survey sample; Resident #98. The facility staff failed to code Resident #98's discharge MDS assessment with an ARD (assessment reference date) of 1/10/20 with the correct discharge status. The resident was coded as discharged to an acute hospital, when the clinical record documented the resident discharged to the community on 1/10/20. The findings include: Resident #98 was admitted to the facility on 1/25/18, and discharged on 1/10/20, with the diagnoses of but not limited to stroke, alcohol abuse, depression, bipolar disorder, high blood pressure, left and right leg below-the-knee amputation, phantom pain syndrome, and cellulitis. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/4/20 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for dressing; limited assistance for hygiene and transfers; supervision for bed mobility, eating and toileting; and was occasionally incontinent of bowel and bladder. A review of the clinical record was conducted as a closed record review. The discharge MDS assessment with an ARD of 1/10/20 documented in Section A2100 "Discharge Status" the discharge options were: "01. Community, 02. Another nursing home or swing bed, 03. Acute hospital, 04. Psychiatric hospital, 05. Inpatient rehabilitation facility, 06. ID/DD facility, 07. Hospice, 08. Deceased, 09. Long Term Care Hospital, 10. Other." The resident was coded as being discharged "03. Acute hospital." A review of the clinical record revealed a nurse's note dated 1/10/20 that documented, "...resident discharged to community at 12pm with all his meds [medications]. Writer explained all meds to resident and how to take them. Resident acknowledge the understanding of how to take them. Left the facility in a stable condition with his belongings..." On 1/30/20 at 11:24 AM, in an interview with RN #2, (Registered Nurse), the MDS nurse, RN #2 stated, "He went to the community. The MDS is coded wrong." When asked about policy for completing the MDS, she stated she uses the RAI Manual (Resident Assessment Instrument). On 1/30/20 at 1:50 PM, ASM #1 (the Administrator), ASM #2, ASM #3 (Senior Director of Operations) and ASM #4 (Regional Director of Clinical Services) were made aware of the findings. No further information was provided. Reference:

The above isolated deficiencies pose no actual harm to the residents

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F 641	Continued From Page 1

A review of the RAI Manual, Version 1.16, dated October 2018, documented on page 2-36 and 2-37:
OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.
09. Discharge Assessment-Return Not Anticipated (A0310F=10)
Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
Must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
Consists of demographic, administrative, and clinical items.
If the resident returns, the Entry tracking record will be coded A1700=1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident ' s stay will be covered by Medicare Part A, the PPS schedule starts with a Medicare-required 5-day scheduled assessment or combination of the Admission and 5- day PPS assessment.
Examples (Discharge-return not anticipated):
1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:
A0310F = 10
A2000 = 03-29-2011
A2100 = 01