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 _____	08/17/2021

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/15/21 through 8/17/21. 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 62 at the time of the survey. The survey sample consisted of 25 current resident reviews and 3 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. §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.	F 550		9/3/21

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

Electronically Signed | 09/03/2021

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 _____	08/17/2021

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 550	Continued From page 1 §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, and clinical record review, it was determined that the facility staff failed to provide care in a manner to promote dignity for one of 28 residents in the survey sample, Resident #26. During breakfast on 8/17/21, CNA [certified nursing assistant] #2 was observed standing over Resident #26 while she fed the resident breakfast. The findings include: Resident #26 was admitted to the facility on 11/7/19 with diagnoses including schizophrenia (1), epilepsy (2), and dementia (3). In June 2021, she was diagnosed with nasal cancer that has spread to the brain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/18/21, Resident #26 was coded as rarely/never understood by others for communication. She was coded as being severely impaired for both	F 550	F550 SS D Resident Rights 1. C.N.A # 2 has resigned from the facility. 2. Current residents requiring assistance with feeding are at risk. Current residents will be reviewed by DCS/ADCS/Nurse Manager to ensure dignity is provide while they are receiving assistance with meals by 9/22/2021. 3. Current licensed and certified staff will be educated on providing dignity while providing care to include when feeding residents by DCS/ADCS/Nurse Manager by 9/22/2021. 4. Don/Designee will observe staff at mealtimes 5 days a week for 4 weeks to reinforce and educate on ensuring dignity while providing care. The results of the quality monitoring data to be reviewed by 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
	495236	A. BUILDING _____ B. WING _____	08/17/2021

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 550	Continued From page 2	F 550	5. Date of Compliance 9-22-2021	

short term and long term memory. Resident #26 was coded as being completely dependent on staff for eating.

On 8/16/21 at 8:06 a.m., observation revealed Resident #26 sitting up in bed. The resident's bed was in the lowest position next to the floor. Further observation revealed CNA (certified nursing assistant) #2 standing to the resident's left, while feeding Resident #26. CNA #2 was bending over in order to reach the resident with the bed in the low position.

A review of Resident #26's care plan, dated 11/11/19 and updated 3/2/20, revealed, in part: "Resident requires ext-max (extensive to maximum) assist with meals."

On 8/16/21 at 12:06 p.m., CNA #1 was interviewed. When asked where she positions herself when she is feeding a resident, CNA #1 stated, "I sit in a chair beside them." When asked why she sits beside the resident instead of standing up next to them, she stated she can imagine it does not feel very good to the resident to have someone standing over them while they being fed. She stated the resident might feel rushed with someone standing up to feed them.

On 8/16/21 at 12:17 p.m., CNA #2 was interviewed. When asked where she positions herself when she is feeding a resident, CNA #2 stated, "I just stand. I have the table in front of me over their bed." When asked if she can think of how a resident might experience a staff member standing over them to feed them, CNA #2 stated, "They might feel uncomfortable." When asked if she was treating a resident with dignity when she stood beside the resident to feed them, she

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 _____	08/17/2021

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 550	Continued From page 3	F 550		

stated she was not. CNA #2 stated, "Maybe I could sit beside them instead."

On 8/16/21 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns. Policies related to treating residents with dignity were requested.

On 8/17/21 at 4:12 p.m., ASM #1 stated the facility does not have one particular policy regarding resident dignity. He stated the facility educates staff on resident rights, with treating residents with dignity being at the center of their care.

No further information was provided prior to exit.

REFERENCES
(1) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

(2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website

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 _____	08/17/2021

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 550	Continued From page 4 https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page. (3) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.	F 550		
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;	F 584		9/3/21

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 _____	08/17/2021

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 584	Continued From page 5 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §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, resident interview, staff interview, and clinical record review, it was determined the facility staff failed to provide a clean, comfortable, homelike environment for one of 28 residents in the survey sample, Resident #45. Observations on 8/15/21 and 8/16/21, revealed Resident #45 lying in bed covered with a blanket that had multiple black smudges along the top and side edges. The findings include: Resident #45 was admitted to the facility on 5/24/19 with diagnoses including COPD (chronic obstructive pulmonary disease) (1) and bipolar disorder (2). On the most recent MDS, a quarterly assessment with an ARD of 7/29/21, Resident #45 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS. On the following dates and times: 8/15/21 at 3:02	F 584	F584 SS D Safe/Clean/Comfortable/Homelike Environment 1. Patient blanket was changed upon notification by Nurse Manager on 8/16/2021. 2. Current residents have the potential to be affected. Current residents will be reviewed by the DCS/ADCS/Nurse Manager to ensure a clean home like environment with a focus on resident linen by 9/22/2021. 3. Current staff to be educated on a clean, safe, homelike environment to include ensuring that the residents have clean linen, that it is changed on shower days, and as need when soiled. 4. Daily rounds to be conducted by IDT team 5 days a week and tracked for 4 weeks. The results of the quality monitoring tool data to be reviewed by members of the quality assurance committee team meeting monthly for review, analysis and further	

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 _____	08/17/2021

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 584	Continued From page 6 p.m.; 8/16/21 at 8:46 a.m. and 12:16 p.m., Resident #45 was observed lying on his back in bed. At each observation, the blanket covering him had multiple black smudges along the top and side edges. On 8/15/21 at 12:16 p.m., Resident #45 was asked about the black smudges on the blanket. He stated he had not noticed that it was dirty. When asked if the black smudged blanket felt homelike, Resident #45 stated, No, at home, I would have gotten a clean one." On 8/16/21 at 12:17 p.m., CNA [certified nursing assistant] #1 was interviewed. When shown the black smudges on the blanket on Resident #45's bed, CNA #1 stated, "Oh no. That should not be like that." She stated that if she had been taking care of Resident #45 that day, she would have checked the blanket when she first got to the facility, and would have switched it out. When asked if the dirty blanket is something she would use at home, she stated it was not. On 8/16/21 at 12:18 p.m., CNA #2 was interviewed. When asked if she had noticed Resident #45's dirty blanket during her shift that day, she stated she had not. She stated she would get the resident a clean blanket. When asked if the dirty blanket is something she would use at home, she stated it was not. On 8/16/21 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and RN (registered nurse) #1, the assistant director of clinical services, were informed of the above concerns. Policies related to providing residents with a clean, comfortable, homelike environment	F 584	recommendations. 5. Date of Compliance 9-22-202	

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 _____	08/17/2021

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 584	Continued From page 7 were requested. On 8/17/21 at 4:12 p.m., ASM #1 stated the facility does not have a policy related to a clean, comfortable, homelike environment. No further information was provided prior to exit. REFERENCES (1) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd. (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 584		
F 622 SS=D	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;	F 622		9/3/21

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 _____	08/17/2021

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 622	Continued From page 8	F 622		

(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 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

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 _____	08/17/2021

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 622	Continued From page 9 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: (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	F 622	F 622 SS D Transfer and Discharge	

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 _____	08/17/2021

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 622	Continued From page 10 review, and clinical record review, it was determined that the facility staff failed to provide all required documentation to the receiving facility upon a hospital transfer for one of 28 residents in the survey sample, Resident #33. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility upon Resident #33's transfer to the hospital on 6/15/21. The findings include: Resident #33 was admitted to the facility on 4/5/17 and had the diagnoses of but not limited to cerebral vascular disease, diabetes, morbid obesity, stroke, acute respiratory failure, dysphagia, spinal stenosis, atrial fibrillation, heart failure, high blood pressure, and depression. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/12/21 coded Resident #33 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers, bathing, and toileting; extensive assistance for bed mobility, dressing and hygiene; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 6/15/21 that documented, "This nurse and nurse (name) went to assess resident as CNA (certified nursing assistant) noted resident not acting himself. Upon assessment resident unable to state his name, facial droop present, hand grips equal, and only able to move right leg. Per staff resident last normal around 1000am (10:00 AM). VS (vital signs) stable and BS (blood	F 622	Requirements 1. Resident #33 did not suffer harm when transferred to the hospital on 6/15/2021 with their comprehensive care plan goals. 2. Current residents that transfer out of the facility are at risk. Current Residents that transferred out to the hospital in the last 30 days will be audited by the DCS/ADS/Nurse Manager to ensure the care plans were correctly sent by 9/22/2021. 3. Licensed staff to be educated on providing the correct documentation for hospital transfers with an emphasis on Comprehensive Care Plans by the DCS/ADCS/Nurse Manager by 9/22/2021. 4. Resident transfers will be reviewed the following business day by DCS/Designee to ensure correct documentation is sent. Facility will track for 4 weeks. The results of the quality monitoring will be presented to the quality assurance committee monthly for review, analysis and further recommendations. 5. Date of Compliance 9-22-2021	

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 _____	08/17/2021

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 622	Continued From page 11	F 622		

sugar) 159. 911 (emergency medical services) called for transport. NP (nurse practitioner) (name) aware. RP (responsible party) (name) agrees to send to ER (emergency room) for evaluation. Med [medication] list, face sheet, bed hold policy, and copy of DNR (do not resuscitate) provided to squad. Report called to (hospital) by nurse (name). ED (Executive Director) and ADON (Assistant Director of Nursing) aware of situation."

A review of the "SNF/NH To Hospital Transfer Form" dated 6/15/21 failed to evidence that Resident #33's comprehensive care plan goals were sent to the receiving hospital upon transfer.

An undated, "Acute Care Transfer Document Checklist" completed for Resident #33 was reviewed. This documented contained a list of items that, when applicable, are to be sent to the receiving facility with the resident. Comprehensive care plan goals was not an item on the list that could be checked off. This form was noted to have been developed in 2014 (no specific date) and "Updated June 2018."

On 8/17/21 at 12:13 PM, an interview was conducted with RN #3 (Registered Nurse). When asked what documents are sent to the hospital when a resident is transferred to the hospital, RN #3 stated, "The transfer form, face sheet, order summary, DNR (do not resuscitate), bed hold policy, pertinent labs, etc." When asked if the comprehensive care plan goals are sent, RN #3 stated, "We do not send the comprehensive care plan goals. To my knowledge is not something we have ever done. Typically it is written in the notes what is sent. We have an envelope we send with the ambulance but it does not say care

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 _____	08/17/2021

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 622	Continued From page 12 plan on it." A review of the facility policy, "Transfer/Discharge Notification and Right to Appeal" dated 9/23/17 and revised on 3/26/18 documented, "Information provided to the receiving provider must include but is not limited to:....Comprehensive care plan goals...." On 8/17/21 at approximately 1:00 PM, ASM #1 (Administrative Staff Member) the Executive Director, was made aware of the findings. No further information was provided by the end of the survey.	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	F 623		9/3/21

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 _____	08/17/2021

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 623	Continued From page 13	F 623		

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 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

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 _____	08/17/2021

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 623	Continued From page 14 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 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 to provide written notification of a hospital transfer to the resident and/or resident representative for one of 28	F 623	F 623 SS D Notice Requirements Before Transfer/Discharge 1. Resident #33 did not suffer harm when transferred to the hospital on 6/15/2021 and their RP was not notified in writing.	

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 _____	08/17/2021

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 623	Continued From page 15 residents in the survey sample, Resident #33. The facility staff failed to evidence that a written notification was provided to the resident or the resident representative upon a hospital transfer on 6/15/21 for Resident #33 The findings include: Resident #33 was admitted to the facility on 4/5/17 and had the diagnoses of but not limited to cerebral vascular disease, diabetes, morbid obesity, stroke, acute respiratory failure, dysphagia, spinal stenosis, atrial fibrillation, heart failure, high blood pressure, and depression. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/12/21 coded Resident #33 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers, bathing, and toileting; extensive assistance for bed mobility, dressing and hygiene; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 6/15/21 that documented, "This nurse and nurse (name) went to assess resident as CNA (certified nursing assistant) noted resident not acting himself. Upon assessment resident unable to state his name, facial droop present, hand grips equal, and only able to move right leg. Per staff resident last normal around 1000am (10:00 AM). VS (vital signs) stable and BS (blood sugar) 159. 911 (emergency medical services) called for transport. NP (nurse practitioner) (name) aware. RP (responsible party) (name) agrees to send to ER (emergency room) for evaluation. Med [medication] list, face sheet, bed	F 623	2. Current residents that transfer out of the facility are at risk. Current Resident transfers audited for the last 30 days will be audited by the DCS/ADCS/Nurse manager and notification will be sent to Responsible Party by 9/22/2021. 3. Social Worker educated by ED on 9/1/21 on providing written documentation to responsible party for resident transfers to the hospital. 4. Resident transfers will be reviewed the following business day by DCS/Designee to ensure correct documentation is sent. Facility will track for 4 weeks. 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. Date of Compliance 9-22-2021	

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 _____	08/17/2021

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 623	Continued From page 16 hold policy, and copy of DNR (do not resuscitate) provided to squad. Report called to (hospital) by nurse (name). ED (Executive Director) and ADON (Assistant Director of Nursing) aware of situation." A review of the "SNF/NH To Hospital Transfer Form" dated 6/15/21 failed to evidence that a written notification of the hospital transfer was provided to Resident #33 and/or his resident representative. On 8/17/21 at approximately 1:00 PM, a survey meeting was held to notify the administrative staff of any survey concerns and/or needs. This meeting was attended by ASM #1 (Administrative Staff Member) the Executive Director, ASM #2 the Director of Clinical Services, and ASM #3, the regional nurse consultant. When they were made aware that evidence of written notification to the resident or resident representative for Resident #33's hospital transfer on 6/15/21was needed, ASM #1 stated, "We don't do that. We document in nurses notes who we called and notified." A review of the facility policy, "Transfer/Discharge Notification and Right to Appeal" dated 9/23/17 and revised on 3/26/18 documented, "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.)" No further information was provided by the end of the survey.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/3/21

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 _____	08/17/2021

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 17 §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 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	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 _____	08/17/2021

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 18 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record reviews and facility document review it was determined that the facility staff failed to implement the comprehensive care plan for fall prevention interventions for two of 28 residents in the survey sample, Resident's #12 and #43. The facility staff failed to implement the comprehensive care plan interventions for Resident #12 and Resident #43 to have fall mats. The findings include: 1. Resident #12 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance (1), schizophrenia (2) and COPD (chronic obstructive pulmonary disease) (3). Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/2021, coded Resident #12 as scoring a 4 (four) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions. Section G coded Resident #12 requiring limited assistance from one staff member for bed mobility, transfers, walking in the room and totally dependent on one staff member for toilet use. Section J coded Resident #12 not having any falls since the prior assessment. On 8/15/2021 at approximately 3:00 p.m., an observation was made of Resident #12 in their room. Resident #12 was observed in bed asleep.	F 656	Revised F 656 S D Develop/Implement Comprehensive Care Plan 1. Resident Fall Mats for residents #12 and #43 implement per care plan upon notification by the nurse manager on 8.16.2021 2. Current residents are at risk for not having interventions implemented. DON/Designee will review the care plan of current residents to verify planned interventions are in place including fall interventions. 3. Education of all licensed staff by DON/Designee to reviewing the care plans interventions and ensuring interventions are in place as planned for the residents including fall interventions. The DCS/designee will verify residents' Kardex have been updated with current interventions. Licensed staff will be educated on ensuring interventions are in place and validated by TAR. Education of certified staff on Kardex and ensuring interventions are utilized. 4. Daily rounds to be conducted by DON/Designee to verify interventions are in place 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly x 3. The DCS will report findings of the rounds monthly x 3 months to Quality Assurance committee for review, analysis and further recommendations to ensure interventions are in place. 5. Date of compliance 9.22.2021	

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 _____	08/17/2021

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 19	F 656		

No fall mats were observed in place beside Resident #12's bed.

On 8/16/2021 at approximately 8:40 a.m., an additional observation was conducted of Resident #12. Resident #12 was observed lying in bed without fall mats on either side of the bed. At this time, an interview was conducted with Resident #12. Resident #12 stated that he had not fallen and had just finished breakfast. When asked about fall mats, Resident #12 did not respond appropriately to the question.

An additional observation of Resident #12 on 8/16/2021 at 2:35 p.m. revealed Resident #12 in bed asleep with bilateral fall mats in place on both sides of the bed.

The comprehensive care plan for Resident #12 dated 2/26/2021 documented in part, "[Resident #12] is at risk for falls r/t (related to) Gait/balance problems, incontinence, psychoactive drug use, hx (history) of falls. Date Initiated: 02/26/2021. Revision on: 04/02/2021." Under "Interventions" it documented in part, " ... Fall Mats at bedside. Date Initiated: 07/07/2021..."

The physician order's for Resident #12 documented in part, "Fall mats at bedside. Order Date: 07/08/2021."

The most recent "Fall Risk Evaluation" for Resident #12 dated 6/3/2021 documented in part, "...Category: Low Risk; Score: 50.0...Low Risk (Score 25-50)= Implement Standard Fall Prevention Interventions."

Resident #12's most recent "Post Fall Evaluation" dated 2/26/2021 documented in part,

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 _____	08/17/2021

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 20	F 656		

"...Category: High Risk; Score: 75.0...High Risk (Score >51)= Implement High Risk Fall Prevention Interventions...History of falling (Immediate or previous [within the last 6 months]? Yes..." The medical record also documented Post Fall Evaluations completed for Resident #12 on 12/17/2020, 12/26/2020, 2/2/2021 and 2/24/2021.

The progress notes for Resident #12 documented in part, "7/5/2021 12:33 (12:33 p.m.) ... Resident noncompliant with turning repositioning and positioning devices- he throws them in the floor. Air mattress deemed unsafe previously d/t (due to) behaviors of ending up in the floor..."

The nurse practitioner progress note for Resident #12 documented in part, "7/31/2021 5:44 p.m. ...Continue with safety and fall precautions and notify provider for any changes in condition..."

On 8/16/2021 at approximately 2:37 p.m., an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 stated that all residents were assessed for falls on admission, after a fall and quarterly. RN #3 stated that fall mats were an interventions put into place to protect the resident from injury in the case of a fall. RN #3 stated that the care plan was an individualized picture of the resident and the care to be provided to the resident. RN #3 stated that the care plan was interdisciplinary and followed by the nursing staff, dietary, social services, therapy and activities. RN #3 stated that all interventions on the care plan should be implemented as documented. RN #3 stated that the care plan was revised as needed and reviewed at least quarterly with removal of anything that did not apply any longer. RN #3

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 _____	08/17/2021

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 21	F 656		

stated that if fall mats were documented as an intervention on the care plan they should be implemented. RN #3 was made aware of the observations of Resident #12 in bed on 8/15/2021 at 3:00 p.m. and 8/16/2021 at 8:40 a.m. without the fall mats in place. RN #3 stated that Resident #12 was supposed to have fall mats down when in bed and was unsure when they had been put down but they should have been down at all times when Resident #12 was in the bed.

On 8/17/2021 at approximately 1:15 p.m., a request was made to ASM (administrative staff member) #1, the executive director for the facility policy on implementing the care plan.

The facility policy, "Plans of Care" dated 9/25/2017 documented in part, "...Develop and implement an Individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team that includes but is not limited to- the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident and,, to the extent practicable, the participation of the resident and the resident's representative(s) within seven (7) days after completion of the comprehensive assessment (MDS)..."

On 8/16/2021 at approximately 4:40 p.m., ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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 _____	08/17/2021

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 22	F 656		

References:

1. Dementia: 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. Schizophrenia: "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

3. Chronic obstructive pulmonary disease (COPD): 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.

2. Resident #43 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1), hemiplegia (2) and diabetes (3).

Resident #43's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/21/2021, coded Resident #43 as scoring a 5 (five) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 5- being severely impaired for making daily decisions. Section G coded Resident #43

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 _____	08/17/2021

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 23	F 656		

being totally dependent on two or more staff for bed mobility and transfers. Section J coded Resident #43 having two or more falls without injury since the prior assessment.

On 8/15/2021 at approximately 3:10 p.m., an observation was made of Resident #43 in their room. Resident #43 was observed in bed. No fall mats were observed in place on either side of Resident #43's bed. At this time, an interview was attempted with Resident #43. Resident #43 did not respond appropriately and requested juice.

Additional observations of Resident #43 were made on 8/16/2021 at approximately 8:19 a.m., 9:22 a.m. and 2:35 p.m. Resident #43 was observed in bed without a fall mat on either side of the bed.

The comprehensive care plan for Resident #43 dated 6/9/2021 documented in part, "... [Resident #43] chooses to stay in bed in a patient gown. [Resident #43] chooses to lay flat in her bed, refuses to turn for pressure relief and/or brief change, yells out and doesn't know why, will place self onto fall mats [Resident #43] yells out/screams during wound care... Date Initiated: 06/09/2021..." The care plan further documented, "[Resident #43] is at risk for falls and has had a fall/roll out of bed no injuries r/t (related to) Deconditioning, Incontinence, hx (history) of CVA (cerebrovascular accident), hx of falls. Date Initiated: 07/22/2021." Under "Interventions" it documented in part, "...fall mat to rsd's (residents) right side while she is in bed. Date Initiated: 06/10/2021..."

The physician order's for Resident #43

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 _____	08/17/2021

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 24	F 656		

documented in part, "Fall mat to rsd's (residents) right side while rsd in bed. Order Date: 06/10/2021."

The most recent "Fall Risk Evaluation" for Resident #43 dated 7/22/2021 documented in part, "...Category: High Risk; Score: 60.0...High Risk (Score >51)= Implement High Risk Fall Prevention Interventions..."

Resident #43's most recent "Post Fall Evaluation" dated 7/22/2021 documented in part, "... History of falling (Immediate or previous [within the last 6 months]? Yes..." The medical record also documented Post Fall Evaluations completed for Resident #43 on 5/6/2021, 5/31/2021, 6/9/2021, 6/17/2021 and 6/27/2021.

The progress notes for Resident #43 documented in part,

- "6/11/2021 13:58 (1:58 p.m.) Note Text: Rsd (resident) observed by writer attempting to push self over the right side of the bed, while stating," I'm gonna fall". Writer assisted Rsd back to center of the bed and educated her on the risk and benefit of staying in bed and utilizing call bell if in need of positioning assistance..."
- "6/17/2021 13:30 (1:30 p.m.) Note Text: 1300 (1:00 p.m.): Writer walked in room and observed Rsd rolling self off of bed. Rsd did not hit head. Denies any pain, no injuries noted..."
- "6/18/2021 14:01 (2:01 p.m.) Note Text: IDT (interdisciplinary team) met to review safety interventions from recent fall. In attendance: [Names of staff members present]. Interventions found to be appropriate and to continue through next review."
- "6/29/2021 13:49 (1:49 p.m.) Note Text: Rsd observed by writer attempting to propel self out of

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 _____	08/17/2021

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 25	F 656		

bed by turning self to stomach and forcing her left leg over side of bed, attempt unsuccessful..."

- "7/1/2021 14:11 (2:11 p.m.) Note Text: IDT met to review recent roll out of bed (6/27) in attendance; [Name of staff members present]. Safety interventions reviewed and still appropriate. Safety plan to continue through next review. Rp (responsible party) father aware of ongoing decompensation..."

- "7/23/2021 15:35 (3:35 p.m.) Late Entry: Note Text: IDT met to review recent ROOB (roll out of bed) - In attendance; [Names of staff members present]. Interventions for safety reviewed. Intervention placed was assist with getting up she will allow. Interventions found to be appriopate [sic] and to continue through next review."

The nurse practitioner progress note for Resident #43 documented in part, "8/12/2021 12:07 p.m. ...Continue with safety and fall precautions..."

On 8/16/2021 at approximately 2:37 p.m., an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 stated that all residents were assessed for falls on admission, after a fall and quarterly. RN #3 stated that fall mats were an interventions put into place to protect the resident from injury in the case of a fall. RN #3 stated that the care plan was an individualized picture of the resident and the care to be provided to the resident. RN #3 stated that the care plan was interdisciplinary and followed by the nursing staff, dietary, social services, therapy and activities. RN #3 stated that all interventions on the care plan should be implemented as documented. RN #3 stated that the care plan was revised as needed and reviewed at least quarterly with removal of

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 _____	08/17/2021

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 26	F 656		

anything that did not apply any longer. RN #3 stated that if fall mats were documented as an intervention on the care plan they should be implemented. RN #3 was made aware of the observations of Resident #43 in bed on 8/15/2021 at 3:10 p.m. and 8/16/2021 at 8:19 a.m., 9:22 a.m. and 2:35 p.m. without the fall mats in place. RN #3 observed Resident #43 in bed without a fall mat to the right side of the bed at approximately 2:40 p.m. and stated that they would review the care plan and orders and ensure the fall mat was placed as ordered.

On 8/16/2021 at approximately 4:40 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

2. Hemiplegia: Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is 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

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 _____	08/17/2021

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 27 occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Diabetes mellitus: 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 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	F 657		9/3/21

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 _____	08/17/2021

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 657	Continued From page 28 comprehensive and quarterly review assessments. 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 that the facility staff failed to review and revise the comprehensive care plan for three of 28 residents in the survey sample; Residents #25, #45, and #12. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan for the use of side rails for Resident #25. Resident #25 was admitted to the facility on 12/9/15 and had the diagnoses of but not limited to paraplegia, morbid obesity, heart failure, depression, chronic pain, insomnia, peripheral vascular disease, contractures, and anxiety. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 7/2/21 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, and bed mobility; extensive assistance for toileting and dressing; limited assistance for transfers, supervision for eating; and was occasionally incontinent of bowel and bladder. On 8/16/21 at 8:52 AM, an observation was made of Resident #25 in bed, with upper half side rails up bilaterally.	F 657	Revised F 657 SS D Care Plan Timing and Revision 1. Resident #25 was assessed for side rail use and care plan was revised upon notification by MDS Nurse on 8.17.2021 Residents #45 and #12 were victims of resident to resident altercations and received psychosocial assessment completed by the facility's social worker and their care plan was updated as needed on 8.16.2021. Residents #45 and #12 did not recall or exhibit any latent negative feelings about the resident to resident alterations. 2. Maintenance Director utilized updated list/tool provided to DON/ADCS and removed all side rails from resident's beds that have not been assessed and care planned for their use. Current residents involved in a resident to resident altercations within the last 45 days were assessed and care plan updated as needed by Social Worker. Licensed staff will be educated by DON/Designee ensuring care plans are updated/revised in a timely manner by 9.22.2021. IDT staff will be educated by ED in a resident to resident altercation to include that victims will have psychosocial assessment completed and their care plans reviewed/revised as needed by 9.22.2021 3. DON/designee will audit care plans of	

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 _____	08/17/2021

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 657	Continued From page 29 On 8/17/21 at 9:28 AM, a second observation was made of Resident #25 in bed, with upper half side rails up bilaterally. At this time an interview was conducted with Resident #25. He stated that he has to have them, that he cannot move in bed without them. He stated that risks and benefits were explained to him. A review of the clinical record failed to reveal evidence that the use of the side rails were on the current active comprehensive care plan. On 8/17/21 at approximately 10:00 AM, ASM #2 (Administrative Staff Member) the Director of Clinical Services, was asked about the side rails not being on the care plan. She stated that they should be, and that she thought that they were. On 8/17/21 at approximately 11:00 AM, in a follow up interview with ASM #2, she stated that after review, the side rails had previously been on the care plan, but that at some unknown point, for some unknown reason, it was removed from the care plan. She stated that should not have happened and that the side rails should still be on the care plan. On 8/17/21 at 11:14 AM, an interview was conducted with RN #2 (Registered Nurse) the MDS nurse. She stated that the purpose of the care plan was "to show individualized care we are doing for a resident." When asked why that was important, she stated, "to show an up-to-date picture of the resident." When asked who updates the care plan, she stated, "We all do - the IDT (interdisciplinary) team. me, the DON (Director of Nursing), ADON (Assistant Director of Nursing), the unit manager, the social worker, the dietician, and activities."]	F 657	current residents to validate residents have interventions meet current care needs, including assistive devices, changes of condition and orders. The IDT will review residents with changes in condition and new orders will be reviewed in clinical morning meeting 5 times/week and in weekly SOC meetings to verify updates and/or update care plans. Maintenance director/designee to conduct weekly side rail audit x 4 weeks then monthly. 4. Maintenance Director and DCS results reported to Quality Assurance Performance Improvement meetings for review, analysis, and further review/recommendations. 5. Date of compliance 9.22.2021	

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 _____	08/17/2021

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 657	Continued From page 30	F 657		

On 8/17/21 at 11:17 AM an interview was conducted with RN #3, the unit manager. When asked what was the purpose of the care plan, she stated, "It creates an individual picture of the resident while we provide care." When asked who updates the care plan, she stated, "The nurses, MDS, I can do it - anyone who takes care of the resident." At this time, RN #2 stated, "The first person who learns about it (a new resident issue or concern) should update it - whoever initiates the intervention should update the care plan."

On 8/17/21 at approximately 1:00 PM, a survey meeting was held to notify the administrative staff of any survey concerns and/or needs. This meeting was attended by ASM #1 (Administrative Staff Member) the Executive Director, ASM #2 the Director of Clinical Services, and ASM #3, the regional nurse consultant. They were made aware the concern that the care plan for Resident #25 did not currently reflect the use of side rails that the resident was observed with, and that the resident stated that he has to have them.

A review of the facility policy, "Plans of Care" dated 11/30/14 and revised on 9/25/17 documented, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements....Review, updated and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions....as needed. The interdisciplinary team shall ensure the plan of care addresses any

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 _____	08/17/2021

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 657	Continued From page 31	F 657		

resident needs...."

No further information was provided by the end of the survey.

2. The facility failed to update the care plan for Resident #12 after a resident-to-resident incident between him and Resident #155 on 3/4/20.

Resident #12 was admitted to the facility on 9/16/16 with diagnoses including COPD (chronic obstructive pulmonary disease) (1), dementia (2) with behaviors, and schizophrenia (3). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/21, Resident #12 was coded as being severely cognitively impaired for making daily decisions, having scored four out of 15 on the BIMS (brief interview for mental status). He was coded as demonstrating no behaviors during the look back period, and as requiring the limited assistance of one person for walking.

Resident #155 was admitted to the facility on 1/31/20, and was discharged on 2/11/21. He was admitted with diagnoses including history of a stroke and atrial fibrillation (4). On the most recent MDS, a quarterly assessment with an ARD of 1/22/21, he was coded as being moderately impaired for making daily decisions, having scored ten out of 15 on the BIMS. He was coded as demonstrating no behaviors during the look back period, and as being independent for walking.

A review of facility FRIs (facility reported incidents) revealed an incident dated 3/4/20 and reported to the SA (state agency) on 3/5/20. A review of the FRI for this incident revealed, in

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 _____	08/17/2021

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 657	Continued From page 32	F 657		

part: "On the evening of 3/4/20, [Resident #12] struck [Resident #155] with an upper extremity reacher. The residents were separated and the police were called. Both residents were sent out to the hospital and have returned... [Resident #12] is on 1:1 (one to one) supervision for safety."

A review of Resident #12's clinical record revealed 1:1 supervision logs from 3/5/20 through 3/24/20. These logs evidenced the 1:1 supervision was provided for Resident #12.

A review of Resident #12's comprehensive care plan, dated 12/28/18 and most recently updated 4/12/21, revealed no evidence that Resident #12's care plan was updated to include the 1:1 supervision from 3/5/20 through 3/24/20.

On 8/16/21 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

On 8/17/21 at 8:32 a.m., ASM #2 stated there is nothing on either Resident #12's care plan reflecting the incident on 3/4/20. When asked if the care plan should reflect this incident and interventions put in place afterward, she said, "Yes they should."

On 8/17/21 at 11:14 a.m., RN (registered nurse) #2, the MDS Coordinator, and RN #3, a unit manager were interviewed. When asked the purpose of a care plan, RN #2 stated the care plan shows individualized care that is happening for a resident. When asked why it is important for the care plan to be accurate, she stated: "To

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 _____	08/17/2021

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 657	Continued From page 33	F 657		

show the up to date picture." When asked who is responsible for updating the care plan, she stated the interdisciplinary team and anyone who is providing care for the resident can update the care plan. She stated the interdisciplinary team consists of her, ASM #2, RN #1, the unit manager, the social worker, the dietician, and the activities staff. RN #3 stated the care plan creates an individual picture of the care for each resident. She stated whoever initiates an intervention should update the care plan.

REFERENCES
(1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

(2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

(3) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

(4) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to

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 _____	08/17/2021

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 657	Continued From page 34	F 657		

beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.

3. a. The facility staff failed to update Resident #12's and Resident #45's care plans after a resident-to-resident incident on 4/1/20.

Resident #12 was admitted to the facility on 9/16/16 with diagnoses including COPD (chronic obstructive pulmonary disease) (1), dementia (2) with behaviors, and schizophrenia (3). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/21, Resident #12 was coded as being severely cognitively impaired for making daily decisions, having scored four out of 15 on the BIMS (brief interview for mental status). He was coded as demonstrating no behaviors during the look back period, and as requiring the limited assistance of one person for walking.

Resident #45 was admitted to the facility on 5/24/19 with diagnoses including COPD and bipolar disorder (6). On the most recent MDS, a

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 _____	08/17/2021

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 657	Continued From page 35	F 657		

quarterly assessment with an ARD of 7/29/21, Resident #45 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS. He was coded as demonstrating no behaviors during the look back period. He was coded as requiring extensive assistance of one staff member for bed mobility and transfers, and as not walking during the look back period.

Further review of facility FRIs revealed an incident dated 4/1/20 and reported to the SA on 4/1/20. A review of the FRI for this incident revealed, in part: "On 4/1/20, prior to morning smoke break, [Resident #45] proceeded towards the day room. While waiting in the threshold to enter he observed another resident attempting to leave, so he proceeded to back up into the hallway to make room for the individual to pass. [Resident #45] in his efforts to back up to let the other resident through, backed into [Resident #12]. [Resident #12] responded by hitting [Resident #45] in the back of the head... [Resident #12] continues to be on 1:1 supervision for safety. He had a room change to [new room number] to further distance him from [Resident #45]."

A review of Resident #12's clinical record revealed 1:1 supervision logs from 4/1/20 through 4/19/20. These logs evidenced the 1:1 supervision was provided for Resident #12.

A review of Resident #12's comprehensive care plan, dated 12/28/18, and most recently updated 4/12/21, revealed no evidence that Resident #12's care plan was updated to include the 1:1 supervision from 4/1/20 through 4/19/20.

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 _____	08/17/2021

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 657	Continued From page 36	F 657		

A review of Resident #45's comprehensive care plan, dated 6/4/19 and most recently updated 12/23/20, revealed no evidence that the care plan was updated to include the incident between him and Resident #12 on 4/1/20.

On 8/16/21 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns.

On 8/17/21 at 8:32 a.m., ASM #2 stated there is nothing on either Resident #12's or Resident #45's care plan reflecting the incident on 4/1/20. When asked if the care plan should reflect this incident and interventions put in place afterward, she said, "Yes they should."

REFERENCES
(6) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

b. The facility staff failed to update Resident #45's care plan for the use of side rails.

On the following dates and times, Resident #45 was observed lying on his back in bed. At each observation, two side rails were observed to be within the resident's reach at the head of his bed: 8/15/21 at 3:02 p.m.; 8/16/21 at 8:46 a.m. and

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 _____	08/17/2021

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 657	Continued From page 37 12:16 p.m.; and 8/17/21 at 8:35 a.m. On 8/17/21 at 8:35 a.m., Resident #45 was asked if he uses the rails for positioning. He stated he does. A review of Resident #45's clinical record revealed a Side Rail Evaluation dated 9/28/20. The evaluation documented Resident #45's having been assessed for safety for the use of side rails, and of his need for the side rails for positioning. Further review of Resident #45's clinical record revealed a Consent for Side Rails dated 3/9/20. The consent was signed verbally by the resident's RR (resident representative). A review of Resident #45's comprehensive care plan, dated 6/4/19 and most recently updated 12/23/20, revealed no evidence of the resident's use of side rails for positioning. On 8/17/21 at 11:14 a.m., RN #1 stated side rails should be on the resident's care plan. No further information was provided prior to exit.	F 657		
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.	F 689		9/3/21

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 _____	08/17/2021

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 689	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record reviews and facility document review it was determined that the facility staff failed to implement assistive devices to ensure an environment free of accident and hazards for two of 28 residents in the survey sample, Resident's #12 and #43. The facility staff failed to implement the fall safety intervention of falls mats per the comprehensive care plan and physician orders to prevent accidents for Resident #12 and Resident #43. The findings include: 1. Resident #12 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance (1), schizophrenia (2) and COPD (chronic obstructive pulmonary disease) (3). Resident #12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/2021, coded Resident #12 as scoring a 4 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions. Section G coded Resident #12 requiring limited assistance from one staff member for bed mobility, transfers, walking in the room and totally dependent on one staff member for toilet use. Section J coded Resident #12 not having any falls since the prior assessment. On 8/15/2021 at approximately 3:00 p.m., an observation was made of Resident #12 in their room. Resident #12 was observed in bed asleep.	F 689	Revised F 689 SS D Free of Accident Hazards/Supervision/Devices 1. Resident Fall Mats for residents #12 and #43 implemented per care plan upon notification by the nurse manager on 8.16.2021. 2. Current residents with care planned assistive devices to include fall mats are at risk. 3.Current staff to be educated on reviewing care plans and Kardex ensuring interventions are in place and proper placement of assistive devices to include fall mats to prevent accidents by DON/designee. DON/Designee will review and update care plans and Kardex with fall interventions including assistive devices such as falls mats to prevent accidents during morning meetings. 4.Daily rounds by DON/designee to verify residents' planned interventions are in place to prevent accidents including fall interventions 5 days a week x 4 weeks then weekly x 4 weeks, then monthly x 3. The DCS will present results will to the Quality Assurance committee monthly x 3 months or until resolved for review, analysis and further recommendations. 5.Date of compliance 9.22.2021	

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 _____	08/17/2021

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 689	Continued From page 39	F 689		

No fall mats were observed in place beside Resident #12's bed.

On 8/16/2021 at approximately 8:40 a.m., an additional observation was conducted of Resident #12. Resident #12 was observed lying in bed without fall mats on either side of the bed. At this time, an interview was conducted with Resident #12. Resident #12 stated that he had not fallen and had just finished breakfast. When asked about fall mats, Resident #12 did not respond appropriately to the question.

An additional observation of Resident #12 on 8/16/2021 at 2:35 p.m. revealed Resident #12 in bed asleep with bilateral fall mats in place on both sides of the bed.

The physician order's for Resident #12 documented in part, "Fall mats at bedside. Order Date: 07/08/2021."

The comprehensive care plan for Resident #12 dated 2/26/2021 documented in part, "[Resident #12] is at risk for falls r/t (related to) Gait/balance problems, incontinence, psychoactive drug use, hx (history) of falls. Date Initiated: 02/26/2021. Revision on: 04/02/2021." Under "Interventions" it documented in part, " ... Fall Mats at bedside. Date Initiated: 07/07/2021..."

The most recent "Fall Risk Evaluation" for Resident #12 dated 6/3/2021 documented in part, "...Category: Low Risk; Score: 50.0...Low Risk (Score 25-50)= Implement Standard Fall Prevention Interventions."

Resident #12's most recent "Post Fall Evaluation" dated 2/26/2021 documented in part,

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 _____	08/17/2021

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 689	Continued From page 40	F 689		

"...Category: High Risk; Score: 75.0...High Risk (Score >51)= Implement High Risk Fall Prevention Interventions...History of falling (Immediate or previous [within the last 6 months]? Yes..." The medical record also documented Post Fall Evaluations completed for Resident #12 on 12/17/2020, 12/26/2020, 2/2/2021 and 2/24/2021.

The progress notes for Resident #12 documented in part, "7/5/2021 12:33 (12:33 p.m.) ... Resident noncompliant with turning repositioning and positioning devices- he throws them in the floor. Air mattress deemed unsafe previously d/t (due to) behaviors of ending up in the floor..."

The nurse practitioner progress note for Resident #12 documented in part, "7/31/2021 5:44 p.m. ...Continue with safety and fall precautions and notify provider for any changes in condition..."

On 8/16/2021 at approximately 2:37 p.m., an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 stated that all residents were assessed for falls on admission, after a fall and quarterly. RN #3 stated that fall mats were an interventions put into place to protect the resident from injury in the case of a fall. RN #3 was made aware of the observations of Resident #12 in bed on 8/15/2021 at 3:00 p.m. and 8/16/2021 at 8:40 a.m. without the fall mats in place. RN #3 stated that Resident #12 was supposed to have fall mats down when in bed and was unsure when they had been put down but they should have been down at all times when Resident #12 was in the bed.

On 8/17/2021 at approximately 1:15 p.m., a request was made to ASM (administrative staff

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 _____	08/17/2021

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 689	Continued From page 41	F 689		

member) #1, the executive director for the facility policy on falls.

The facility policy, "Fall Management" dated 11/30/2014 documented in part, "...Purpose: Is to identify residents at risk for falls and establish/modify interventions to decrease the risk of a future fall(s) and minimize the potential for a resulting injury..."

On 8/16/2021 at approximately 4:40 p.m., ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

1. Dementia: 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. Schizophrenia: "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html

3. Chronic obstructive pulmonary disease (COPD): Disease that makes it difficult to breath that can lead to shortness of breath. This

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 _____	08/17/2021

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 689	Continued From page 42	F 689		

information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Resident #43 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1), hemiplegia (2) and diabetes (3).

Resident #43's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/21/2021, coded Resident #43 as scoring a 5 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 5- being severely impaired for making daily decisions. Section G coded Resident #43 being totally dependent on two or more staff for bed mobility and transfers. Section J coded Resident #43 having two or more falls without injury since the prior assessment.

On 8/15/2021 at approximately 3:10 p.m., an observation was made of Resident #43 in their room. Resident #43 was observed in bed. No fall mats were observed in place on either side of Resident #43's bed. At this time, an interview was attempted with Resident #43. Resident #43 did not respond appropriately and requested juice.

Additional observations of Resident #43 were made on 8/16/2021 at approximately 8:19 a.m., 9:22 a.m. and 2:35 p.m. Resident #43 was observed in bed without a fall mat on either side of the bed.

The physician order's for Resident #43 documented in part, "Fall mat to rsd's (residents) right side while rsd in bed. Order Date:

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 _____	08/17/2021

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 689	Continued From page 43	F 689		

06/10/2021."

The comprehensive care plan for Resident #43 dated 6/9/2021 documented in part, "... [Resident #43] chooses to stay in bed in a patient gown. [Resident #43] chooses to lay flat in her bed, refuses to turn for pressure relief and/or brief change, yells out and doesn't know why, will place self onto fall mats [Resident #43] yells out/screams during wound care... Date Initiated: 06/09/2021..." The care plan further documented, "[Resident #43] is at risk for falls and has had a fall/roll out of bed no injuries r/t (related to) Deconditioning, Incontinence, hx (history) of CVA (cerebrovascular accident), hx of falls. Date Initiated: 07/22/2021." Under "Interventions" it documented in part, "...fall mat to rsd's (residents) right side while she is in bed. Date Initiated: 06/10/2021..."

The most recent "Fall Risk Evaluation" for Resident #43 dated 7/22/2021 documented in part, "...Category: High Risk; Score: 60.0...High Risk (Score >51)= Implement High Risk Fall Prevention Interventions..."

Resident #43's most recent "Post Fall Evaluation" dated 7/22/2021 documented in part, "... History of falling (Immediate or previous [within the last 6 months]? Yes..." The medical record also documented Post Fall Evaluations completed for Resident #43 on 5/6/2021, 5/31/2021, 6/9/2021, 6/17/2021 and 6/27/2021.

The progress notes for Resident #43 documented in part,
- "6/11/2021 13:58 (1:58 p.m.) Note Text: Rsd (resident) observed by writer attempting to push self over the right side of the bed, while stating,"

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 _____	08/17/2021

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 689	Continued From page 44	F 689		

I'm gonna fall". Writer assisted Rsd back to center of the bed and educated her on the risk and benefit of staying in bed and utilizing call bell if in need of positioning assistance..."
- "6/17/2021 13:30 (1:30 p.m.) Note Text: 1300 (1:00 p.m.): Writer walked in room and observed Rsd rolling self off of bed. Rsd did not hit head. Denies any pain, no injuries noted..."
- "6/18/2021 14:01 (2:01 p.m.) Note Text: IDT (interdisciplinary team) met to review safety interventions from recent fall. In attendance: [Names of staff members present]. Interventions found to be appropriate and to continue through next review."
- "6/29/2021 13:49 (1:49 p.m.) Note Text: Rsd observed by writer attempting to propel self out of bed by turning self to stomach and forcing her left leg over side of bed, attempt unsuccessful..."
- "7/1/2021 14:11 (2:11 p.m.) Note Text: IDT met to review recent roll out of bed (6/27) in attendance; [Name of staff members present]. Safety interventions reviewed and still appropriate. Safety plan to continue through next review. Rp (responsible party) father aware of ongoing decompensation..."
- "7/23/2021 15:35 (3:35 p.m.) Late Entry: Note Text: IDT met to review recent ROOB (roll out of bed) - In attendance; [Names of staff members present]. Interventions for safety reviewed. Intervention placed was assist with getting up she will allow. Interventions found to be appriopate [sic] and to continue through next review."

The nurse practitioner progress note for Resident #43 documented in part, "8/12/2021 12:07 p.m. ...Continue with safety and fall precautions..."

On 8/16/2021 at approximately 2:37 p.m., an interview was conducted with RN (registered

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 _____	08/17/2021

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 689	Continued From page 45	F 689		

nurse) #3, the unit manager. RN #3 stated that all residents were assessed for falls on admission, after a fall and quarterly. RN #3 stated that fall mats were an interventions put into place to protect the resident from injury in the case of a fall. RN #3 was made aware of the observations of Resident #43 in bed on 8/15/2021 at 3:10 p.m. and 8/16/2021 at 8:19 a.m., 9:22 a.m. and 2:35 p.m. without the fall mat in place to the right side of the bed. RN #3 observed Resident #43 in bed at 2:40 p.m. without a fall mat to the right side of the bed and stated that they would confirm the orders and care plan for Resident #43 and ensure that the fall mat was put into place.

On 8/16/2021 at approximately 4:40 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

2. Hemiplegia: Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way

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 _____	08/17/2021

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 689	Continued From page 46 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. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Diabetes mellitus: 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 689		
F 727 SS=C	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 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 observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure 8 consecutive hours of RN (Registered Nurse) coverage on 7/31/21 and 8/1/21.	F 727	F 727 SS C RN 8 Hrs/7 days/Wk 1. R.N. Staffing corrected upon notification by staffing coordinator on 8/15/2021. Residents did not suffer harm due to lack of 8 consecutive R.N hours on 7/31/2021 and 8/1/2021.	9/3/21

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 _____	08/17/2021

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 727	Continued From page 47 The findings include: A review of the as-worked schedule and daily staff posting for the last 30 days (7/15/21 to 8/15/21) was conducted. The following was identified: On Sunday, 7/25/21 the daily posting documented 1 RN (Registered Nurse) for 8 hours of RN coverage. The as-worked schedule did not have any RN's identified as being on shift. On Saturday, 7/31/21, the daily posting documented 1 RN for 8 hours of RN coverage. The as-worked schedule did not have any RN's identified as being on shift. On Sunday 8/1/21, the daily posting documented 1 RN for 8 hours of coverage. The as-worked schedule did not have any RN's identified as being on the shift. In addition, it was noted that the daily posting for 8/1/21 did not document any census data for each shift as required. On Sunday 8/8/21, the daily posting documented 1 RN for 8 hours of coverage. The as-worked schedule did not have any RN's identified as being on the shift. On 8/16/21 at 2:20PM in an interview with ASM #2 (Administrative Staff Member) the Director of Clinical Services, she was notified that the daily staff posting vs the as-worked schedules did not accurately reflect each other on the above dates, regarding whether or not there was an RN on duty. On 8/16/21 at approximately 2:30 PM, ASM #2	F 727	2. Facility is required to have 8 consecutive hours of R.N. Staffing on a daily basis. DCS/ADCS/Nurse Manager/Staffing Coordinator to review staffing RN coverage for the past 30 days by 9/22/2021. 3. ED educated Staffing Coordinator on ensuring 8 consecutive hours of R.N. coverage on a daily basis on 9/2/2021. 4. Staffing Coordinator/Designee to review R.N. staffing with DCS/Designee and track 5 days a week for 4 weeks. 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. Date of Compliance 9-22-2021	

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 _____	08/17/2021

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 727	Continued From page 48 provided time clock evidence that an RN was on duty on 7/25/21 and 8/8/21. However, she stated that on 8/1/21 and 7/31/21 there was no RN coverage. She stated that there was an RN doing coverage on the weekends and that he switched his status and was no longer full time and is now only part time. ASM #2 stated that, "As of now I do not have any other RN's on the payroll." On 8/16/21 at 2:50 PM, ASM #1, the Executive Director, was made aware of the findings. On 8/17/21 at approximately 1:00 PM, a policy was requested regarding RN coverage. In an email dated 8/17/21 at 4:12 PM, ASM #1 documented that there was not a policy for this. No further information was provided by the end of the survey.	F 727		
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.	F 732		9/3/21

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 _____	08/17/2021

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 732	Continued From page 49 (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 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 post the nurse staffing posting prior to each shift on 8/14/21 and 8/15/21; and failed to post daily staffing that was complete and accurate on 7/31/21 and 8/1/21. The findings include: On 8/15/21 (Sunday) upon entry to the facility at 1:30 PM, the staff posting board was observed. The staff posting was dated 8/13/21. Posting for the weekend, Saturday 8/14/21 and Sunday 8/15/21, had not been posted. On 8/16/21 at 11:30 AM in an interview with ASM #2 (Administrative Staff Member), the Director of	F 732	F 732 SS C Posted Nurse Staffing Information 1. Staffing posting corrected with accurate staffing numbers and in-house census upon notification by staffing coordinator on 8/15/2021. Residents did not suffer harm due to in-accurate staffing information and in-house census posting. 2. Facility is required to post accurate staffing numbers and in-house census on a daily basis. DCS/ADCS/Nurse Manager/Staffing Coordinator to review staffing RN coverage for the past 30 days by 9/22/2021. 3. ED educated Staffing Coordinator on ensuring 8 consecutive hours of R.N. coverage on a daily basis on 9/2/2021. 4. Staffing Coordinator/Designee to review	

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 _____	08/17/2021

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 732	Continued From page 50 Clinical Services, she stated that the posting is completed for the weekend and placed in staffing book for weekend charge nurse to post and that they should be posting it each day. She stated that the posting is done daily, not each shift. When asked if it is updated prior to each shift regarding any changes related to census and call outs, she stated that the changes are made to the schedule but may not get transferred to the staff posting that is posted. On 8/16/21 at 11:50 AM in a follow up interview, ASM #2 stated that there was not a facility policy on the staff posting; that the requirement is clearly documented on the bottom of the staff posting form. A review of the staff posting form documented, "Post beginning of each shift in a prominent place that is readily accessible to residents and visitors. Daily posting of this information is required for nursing homes participating in Medicare and Medicaid...." On 8/16/21 at 2:20PM in a follow up interview with ASM #2, she was notified that the daily staff posting vs the as-worked schedules did not accurately reflect each other as follows: On Sunday, 7/25/21 the daily posting documented 1 RN (Registered Nurse) for 8 hours of RN coverage. The as-worked schedule did not have any RN's identified as being on shift. On Saturday, 7/31/21, the daily posting documented 1 RN for 8 hours of RN coverage. The as-worked schedule did not have any RN's identified as being on shift. On Sunday 8/1/21, the daily posting documented	F 732	R.N. staffing with DCS/Designee and track 5 days a week for 4 weeks. 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. Date of Compliance 9-22-2021	

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 _____	08/17/2021

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 732	Continued From page 51 1 RN for 8 hours of coverage. The as-worked schedule did not have any RN's identified as being on the shift. In addition, it was noted that the daily posting for 8/1/21 did not document any census data for each shift as required. On Sunday 8/8/21, the daily posting documented 1 RN for 8 hours of coverage. The as-worked schedule did not have any RN's identified as being on the shift. On 8/16/21 at approximately 2:30 PM, ASM #2 provided time clock evidence that an RN was on duty on 7/25/21 and 8/8/21. She stated that on 8/1/21 and 7/31/21 there was no RN coverage. She stated that there was an RN doing coverage on the weekends and that he switched his status and was no longer full time and is now only part time. ASM #2 stated that, "As of now I do not have any other RN's on the payroll." This evidenced that the staff posting for 7/31/21 and 8/1/21, that documented there was RN coverage in the facility, did not accurately reflect to the residents and visitors that there in fact was not an RN on duty on those dates; and what the census was on 8/1/21. On 8/16/21 at 2:50 PM, ASM #1 (Administrative Staff Member) the Executive Director, was made aware of the findings. No further information was provided by the end of the survey.	F 732		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails	F 909		9/3/21

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 _____	08/17/2021

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 909	Continued From page 52 and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review, and clinical record review, it was determined the facility failed to evidence safety inspection for side rails for one of 28 residents in the survey sample, Resident #45. The facility staff failed to evidence an inspection of Resident #45's bed for safety for the use of side rails. The findings include: Resident #45 was admitted to the facility on 5/24/19 with diagnoses including COPD (1) and bipolar disorder (2). On the most recent MDS, a quarterly assessment with an ARD of 7/29/21, Resident #45 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS. He was coded as demonstrating no behaviors during the look back period. He was coded as requiring extensive assistance of one staff member for bed mobility and transfers, and as not walking during the look back period. On the following dates and times: 8/15/21 at 3:02 p.m.; 8/16/21 at 8:46 a.m. and 12:16 p.m.; and 8/17/21 at 8:35 a.m., Resident #45 was observed lying on his back in bed. At each observation, two side rails were observed to be within the resident's reach at the head of his bed. On 8/17/21 at 8:35 a.m., Resident #45 was asked if he uses the rails for positioning. He stated he	F 909	F SS D 909 Resident Bed 1. Resident #45 was assessed for side rail use and care plan was revised upon notification by MDS Nurse on 8/17/21. Maintenance Director inspected side rails for resident #45 on 8/17/2021 2. Current residents with side rails on their beds are at risk. Current residents to be reviewed by DCS/ADS/Nurse Manager to determine if side rails are being utilized appropriately per the assessment and care plan order by 9/22/2021. Whole house bed audit was completed by Maintenance Director on 8/30/2021. 3. Maintenance Director educated by ED on 9/2/2021 on inspecting side rails on a timely basis and ensuring they are not present unless resident has been assessed and ordered per Care Plan. Maintenance Director will utilize an updated list provide by the DCS/ADCS/Nurse Manager to remove side rails from resident beds for residents that have not been assessed and care planned for their use by 9/22/2021. 4. Maintenance Director/Designee to conduct weekly side rail audit and track for 4 weeks. 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 _____	08/17/2021

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 909	Continued From page 53	F 909		

does.

A review of Resident #45's clinical record revealed a Side Rail Evaluation dated 9/28/20. The evaluation documented Resident #45's had been assessed for safety for the use of side rails, and of his need for the side rails for positioning.

Further review of Resident #45's clinical record revealed a Consent for Side Rails dated 3/9/20. The consent was signed verbally by the resident's RR (resident representative).

A review of Resident #45's comprehensive care plan, dated 6/4/19 and most recently updated 12/23/20, revealed no evidence of the resident's use of side rails for positioning.

A review of facility bed/side rail inspections for June, July, and August 2021 failed to reveal evidence that Resident #45's bed/side rails had been inspected for safety.

On 8/17/21 at 11:56 a.m., ASM (administrative staff member) #1, the executive director, and OSM (other staff member) #1, the director of maintenance, were informed of these concerns. OSM #1 stated he performs a weekly inspection of all beds with side rails in the facility due to concerns about the safety of side rails. He stated Resident #45's bed does not allow for the side rails to removed, or to be lowered any additional amount. He stated that, at the current height, the side rails are "technically not in use." He stated he did not consider Resident #45 as having usable side rails on the bed. However, he stated the height was conducive for Resident #45 to use the side rails for positioning. He stated: "We don't have a lower rail for him." He stated he performs

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 _____	08/17/2021

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 909	Continued From page 54 a weekly side rail safety inspection for all residents who have side rails included in the care plan. A review of the facility policy "Side Rail/Bed/Rail" failed to reveal information related to side rail safety inspection protocols. No further information was provided prior to exit. REFENCES (1) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd. (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 909		