STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

(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
E 000	Initial Comments	E 000		
	An unannounced Emergency Preparedness survey was conducted 10/04/2021 through 10/06/2021. The facility's Emergency Preparedness Plan was reviewed. Corrections are required for compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.			
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		11/2/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2021

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

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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to review and update the emergency preparedness plan annually.	E 006	E006 The facility will document that the Emergency Preparedness Plan was reviewed and updated annually.	

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E 006	Continued From page 2 Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding an annual review and update. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the plan had been reviewed and revised annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 006		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.	E 013		11/2/21

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E 013	Continued From page 3 *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

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E 013	Continued From page 4 be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to review and update the emergency policies and procedures annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding an annual review and update of the emergency policies and procedures. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the policies and procedures had been reviewed and revised annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 013	E013 The facility will document that the policies and procedures in the Emergency Preparedness Plan was reviewed and updated annually.	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c),	E 029		11/2/21

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	495230		C 10/06/2021

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E 029	Continued From page 5 §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to review and update the emergency communciation plan annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding an annual review and update of the facility's communication plan. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the communication plan had been reviewed and revised annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 029	E 029 The facility will document that the communication plan in the Emergency Preparedness Plan was reviewed and updated annually.	

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	495230		C 10/06/2021

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E 030	Continued From page 6	E 030		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The	E 030		11/2/21

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E 030	Continued From page 7 communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030		

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E 030	Continued From page 8 *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to review and update the facility contact information at least annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding an annual review and update of the facility's contact information. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the contact information had been reviewed and revised. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 030	E 030 The facility will document that the facility contact information in the Emergency Preparedness Plan was reviewed and updated annually.	
E 031 SS=C	Emergency Officials Contact Information	E 031		11/2/21

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	495230		C 10/06/2021

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E 031	Continued From page 9 CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.	E 031		

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E 031	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure the emergency officials contact information was review and updated at least annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding a review and update of the emergency officials contact information at least annually. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the emergency officials contact information had been reviewed and revised at least annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 031	E 031 The facility will document that the emergency official contact information in the Emergency Preparedness Plan was reviewed and updated annually.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).	E 032		11/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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E 032	Continued From page 11 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure the communication plan including primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies was reviewed and updated at least annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding a review and update of the communication plan for alternate means of communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies.	E 032	E 032 The facility will document that the communication plan including primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies was reviewed and updated annually.	

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E 032	Continued From page 12 The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the above information had been reviewed and revised at least annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 032		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.	E 036		11/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

(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
E 036	Continued From page 13 *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and	E 036		

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E 036	Continued From page 14 updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure the training and testing program was reviewed and updated at least annually. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding an annual review and update of the training and testing program. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if there was documentation that the training and testing program had been reviewed and updated annually. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 036	E 036 The facility will document that the training and testing program in the Emergency Preparedness Plan was reviewed and updated annually.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).	E 037		11/2/21

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E 037	Continued From page 15 *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and	E 037		

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E 037	Continued From page 16 others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in	E 037		

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E 037	Continued From page 17 case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of	E 037		

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E 037	Continued From page 18 alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide	E 037		

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E 037	Continued From page 19 emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility failed to ensure facility staff received annual emergency preparedness training. Findings were: The facility's Emergency Preparedness Plan was reviewed on 10/06/2021 at approximately 2:00 p.m. No documentation was located in the Emergency Preparedness binder regarding annual emergency preparedness training for the facility staff. The administrator who was listed in the Emergency Preparedness Plan as the chief officer was not available for interview. The DON (director of nursing) was asked if annual emergency preparedness training had been done and if the was any documentation regarding the training. At approximately 2:45 p.m., the DON reported that she had spoken with the administrator, "We don't have it." No further information was received by the survey team prior to the exit conference on 10/06/2021.	E 037	E 037 The facility will provide the staff annual emergency preparedness training.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/4/2021 through 10/6/2021. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints (VA00051048, VA00052131, VA00052464 and	F 000		

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F 000	Continued From page 20 VA00000052713) were investigated during the survey with all allegations unsubstantiated. The Life Safety Code survey/report will follow. The census in this sixty certified bed facility was 55 at the time of the survey. The survey sample consisted of fifteen current resident reviews and three closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to assess one of eighteen (18) residents for self-adminstration of medications, Resident #31. Resident #31 was observed with an albuterol inhaler at her bedside for self administration as needed. Resident #31 had not been assessed by the interdisciplinary team to ensure safe usage of the inhaler. Findings were: Resident #31 was admitted to the facility on 03/12/2020 with the following diagnoses, including but not limited to: Fibromyalgia, depression, respiratory disorder, and chronic ischemic heart disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment	F 554	F554 Resident Self-Administration of Medication 1. The Interdisciplinary team assessed Resident #31 to ensure safe usage of their inhaler at bedside. The facility provided the appropriate storage for the medication at bedside. 2. The Director of Clinical Services (DCS)/Designee will audit current residents for request for medication at bedside and provide interdisciplinary team assessment. 3. The DCS/designee will educate the nurses on the right to self-administer medication if the interdisciplinary team, has determined that this practice is clinically appropriate. 4. The DCS/designee will review new requests for self-administration of medication weekly x 4 weeks then	11/2/21

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F 554	Continued From page 21 reference date) of 08/19/2021, assessed Resident #31 as cognitively intact with a summary score of "15". On 10/05/2021 at approximately 8:00 a.m., Resident #31 was observed sitting on her bed. She was wearing oxygen via a nasal cannula at 3 liters per minute. Resident #31 was interviewed about life at the facility and was asked about her oxygen. She stated, "I got pneumonia a while back. I didn't wear it before then. Now I get short of breath when I take it off and to walk to the bathroom. My oxygen sats drop...sometimes I wheeze, that's why I have this." Resident #31 held up an albuterol inhaler that was laying on her bed. She stated, "The doctor told me to keep it here at my bedside so that's where it is...I use it when I am short of breath or wheezing." Resident #31 was asked how often she used her inhaler. She stated, "Whenever I need it...he [her doctor] said I can use it every four hours if I need to. Sometimes it's four hours, sometimes it's longer, sometimes if I'm wheezing I might use it a little before the four hours is up." Resident #31 was asked if she had to get one of the staff to come and help her with the inhaler when she used it or watch her use it. She stated, "No, I do it myself, I don't need anybody to help me." She was asked if she had used an inhaler at home or prior to having pneumonia. She stated, "No, I never had any problems breathing until then." The clinical record was reviewed at approximately 11:00 a.m. The physician order sheet contained the following order dated 06/09/2021: "VENTOLIN [albuterol] HFA DOSE COUNTER 200 INH 90MCG 2 puff inhale orally every 4 hours as needed for Shortness of breath. May keep at bedside per MD."	F 554	monthly x 2 months to ensure the interdisciplinary team assessed for clinical appropriateness. Findings will be brought to QAPI monthly for three months, for further review 5. Date of Compliance: 11/2/21	

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F 554	Continued From page 22 There was no assessment by the interdisciplinary team for safe self administration of the inhaler observed in the clinical record. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was keeping medication at her bedside for self administration. She stated, "There should be an assessment, a doctor's order, and it should be on the care plan...it should be in the clinical record." The DON stated she would look to see what she could find. On 10/06/2021 at approximately 9:00 a.m., the DON provided information regarding Resident #31. She stated, "She did not have an assessment, we did one this morning." A copy of the facility policy for self administration of medications was requested and received. Per the facility policy, "Self-Administration of Medication at Bedside": "...Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions....Complete Self-administration of Medications Evaluation. The Interdisciplinary Team will review the evaluation and will document...approval granted must be checked "yes" or "no"..." No further information was received prior to the exit conference on 10/06/2021.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584		11/2/21

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F 584	Continued From page 23 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §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	F 584		

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F 584	Continued From page 24 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a safe, operational bed for one of eighteen residents in the survey sample, Resident #11. Resident #11 was in a bed with no functional controls to raise the head, foot or height of the bed. The findings include: Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely impaired cognitive skills. On 10/5/21 at 11:48 a.m., accompanied by a hospice registered nurse (RN #1), Resident #11 was observed in bed. The head of the bed was raised approximately 30 degrees. RN#1 repositioned the resident for a dressing change and stated the resident's bed did not work. RN #1 stated the bed controls were broken and she was unable to move the resident's bed up/down or raise/lower the head of the bed. RN #1 stated she reported the broken bed to maintenance last Thursday (9/30/21) and the bed had not been fixed. RN #1 stated, "They could have called me. We would have gotten a bed." RN #1 stated she was unable to reposition the bed when turning the	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment 1. During the survey, the facility provided residents #11 with a bed that has functional controls to raise the head, foot and height of the bed. 2. The Maintenance Director/designee reviewed the beds in the facility to ensure the bed has functional controls to raise the head, foot, and height of the bed. 3. The Executive Director(ED)/designee will educate the Maintenance staff on the resident□s right to have maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 4. The Maintenance Director/designee will assess the beds on a hall a week x 4 weeks then monthly x 2 months to ensure the beds have functional controls to raise the head, foot, and height of the bed. Findings will be brought to QAPI monthly for three months for further review. 5. Date of Compliance 11/2/21	

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	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

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F 584	Continued From page 25 resident and she was concerned the bed height was not as low as possible. RN #1 stated the resident was a fall risk and had experienced previous falls from the bed. RN #1 demonstrated that the remote did not work. RN #1 stated she was also concerned about the inability to raise the head of the bed for meals and/or resident comfort. On 10/5/21 at 3:40 p.m., the certified nurses' aide (CNA #1) that routinely cared for Resident #11 was interviewed about the bed controls. CNA #1 stated there was a short in the wiring to the bed remote. CNA #1 picked up the remote and there was tape around the wiring near the handset. CNA #1 stated he was aware the bed controls were not working but he did not know how long the bed had been out of service. CNA #1 stated he could move the wiring around and sometimes get the bed to move. On 10/5/21 at 3:43 p.m., the maintenance director (other staff #1) was interviewed about Resident #11's bed. The maintenance director stated the controls on the bed did not work. The maintenance director stated Resident #11's bed was one of several that were "donated" to the facility and he was unable to get repair parts for the bed or the controls. The maintenance director stated he was told about the broken bed last Friday (10/1/21) and he thought hospice was going to replace the bed. The maintenance director stated he currently had no extra or replacement beds in the facility. Resident #11's plan of care (revised 8/31/21) listed the resident required the extensive assistance of one to two people for bed mobility, transfers and activities of daily living including	F 584		

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F 584	Continued From page 26 dressing and incontinence care and was at risk for falls. This finding was reviewed with the director of nursing and regional director of clinical services on 10/5/21 at 5:35 p.m.	F 584		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to implement their abuse prevention policies regarding promptly reporting an injury of unknown origin to the state agency for 1 for 18 in the survey sample, Resident #48; and failed to follow their pre-employment screening policies for 13 out of 25 employees reviewed. Resident #48 was found with a medium size gash to the back of his head of unknown origin requiring 5 staples. This injury of unknown origin was not reported to the state survey agency or other local agencies as required by the facility's policy for abuse reporting/investigation.	F 607	F 607 Develop/Implement Abuse/Neglect Policies 1. a) The facility reported the injury of unknown origin for Resident #48 during the survey. Completed the investigation. One to one abuse education was provided to the supervisor during survey b) The Human Resources Coordinator (HRC)/Designee obtained the following information i.) Employee hire date 8/14/19-sworn statement and reference checks ii) Employee hire date 9/27/19-background check was already	11/2/21

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F 607	Continued From page 27 The findings include: Resident #48 was admitted to the facility on 07/27/2020 with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated 9/28/2021 was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 as requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: "9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated 'I did not fall, the door hit me.' [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness)..... [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with	F 607	obtained before survey iii) Employee hire date 4/3/20-reference checks iv) Employee hire date 8/31/20-criminal background check was already obtained before survey v) Employee hire date 10/1/20-criminal background check and reference checks vi) Employee hire date 12/10/20-reference checks vii) Employee hire date 12/15/20-sworn statement viii) Employee hire date 1/14/21-background check was already obtained before survey ix) Employee hire date 5/25/21-sworn statement and reference checks x) Employee hire date 8/31/21-refernece checks xi) Employee hire date 9/21/21-sworn statement xii) Employee hire date 9/28/21 (two employees) reference checks 2. a) The DCS/Designee (This should be ED) will review incidents for the last 30 days to ensure possible abuse allegations are reported to the state survey agencies as required by policy. b) The HRC/Designee will review other employee□s records for implementation of the facility□s pre-employment screening policies. 3. a) The DCS/Designee will educate the staff on the facility□ abuse policy b) The ED/Designee will educate the HRC on the facility□s pre-employment screening policy. 4. a) the DCS/Designee will review Resident□s Change of Condition and the	

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F 607	Continued From page 28 resident." "09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor." Observed in the clinical record was a Change in Condition (SBAR) form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note and docmented notification to Resident #48's guardian. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the State Agency and for the investigation. On 10/06/2021 at 9:36 a.m., the assistant director of nursing (RN #2) was interviewed regarding the incident. RN #2 was asked if there was an initial investigation and if the fall was reported to the state agency. RN #2 stated, "no, I had worked a double shift and had just got home when the licensed practical nurse (LPN) called and notified me of the incident. When I returned to work I didn't complete investigation or notify the State Agency. I know that's not a valid reason not to complete the investigation. The LPN stated she had notified the MD (medical director) and completed the SBAR (change of condition) form	F 607	24-hour report to ensure the facility is following the abuse policy. b) The ED/Designee will review new hire employee records upon hire weekly 4 weeks then monthly x 2 months to ensure the facility is following the facility□s pre-employment screening policy. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance 11/2/21	

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F 607	Continued From page 29 and sent [Resident #48] to the ER (emergency room) per MD orders." RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, "no, [Resident #48] is constantly moving. We have to monitor him because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents." On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, "no the incident was not reported to the State Agency. I am in the process of reporting it today. The investigation wasn't completed either. I started that on yesterday and will give you a copy of the witness statements." The DON was asked why incident was not reported and why the investigation was not completed. The DON stated, "I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process..." The DON was asked if she was able to determine what caused the injury of unknown origin. The DON stated, "no unfortunately not. [Resident #48] is active and moves around a lot. I can't really say what happened to him." The DON was asked if she and/or the administrator were notified of the incident. The DON stated "no, I was out of work on sick leave due to shoulder surgery and unfortunately the administrator went out on sick leave for COVID. I feel like my staff did what they were supposed to regarding assessing the resident and reporting it the ADON and MD, who gave orders to send the resident to the ER. However, the ADON failed to complete the additional steps to notify the state agency and start and complete the investigation." The DON	F 607		

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F 607	Continued From page 30 was asked to provide the facility's abuse policy. A review of the facility policy titled "Abuse, Neglect, Exploitation & Misappropriation (Rev. 11/28/2017) documented the following: "7. Reporting/Response - Any employee contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hors after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials with the State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law... Review of Report: Report all results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken....	F 607		

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F 607	Continued From page 31 The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies..." On 10/05/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident (FRI) dated 10/6/2021 sent to the state agency and the witness statements. The LPN and the CNA who provided care for Resident #48 on 09/25/2021 were not available for interview during the survey. No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m. 2. On 10/6/21 at 10:30 a.m., twenty-five employee records were reviewed for compliance with the facility's pre-employment screening protocols. Ten out of the 25 records reviewed were incomplete with missing sworn statements, reference checks and a criminal background check. Three employees worked from five to twenty months in the facility before criminal background checks were obtained. The thirteen employee records with missing pre-employment screening information included the following listed by hire date. 8/14/19 - no sworn statement, no reference checks 9/27/19 - no criminal background check until 6/3/21 4/03/20 - no reference checks 8/31/20 - no criminal background check until 6/2/21 10/1/20 - no criminal background check	F 607		

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F 607	Continued From page 32 performed, no reference checks 12/10/20 - no reference checks 12/15/20 - no sworn statement 1/14/21 - no criminal background check until 6/2/21 5/25/21 - no sworn statement, no reference checks 8/31/21 - no reference checks 9/21/21 - no sworn statement 9/28/21 - (two employees) - no reference checks On 10/6/21 at 11:50 a.m., the human resources (HR) coordinator (other staff #6) was interviewed about the missing pre-employment screening information for the identified thirteen employees. The HR coordinator stated she had worked at the facility since April 2021 and had recognized a problem with incomplete pre-employment screening. The HR coordinator stated several of the criminal background checks were late because she had them done when she recognized they were missing. The HR coordinator stated that sometimes there was a delay because staff had not signed permission forms for the background check. The HR coordinator stated she obtained reference checks by telephone for the most recent hires (August 2021, September 2021) but she was unable to find where she documented the calls/references. When asked about the licensed practical nurse hired 10/1/20 that had no criminal background or reference checks, the HR coordinator stated this nurse currently worked prn (as needed). The HR coordinator stated this nurse had not returned the consent for the criminal background check. The HR coordinator stated this employee worked in the facility "occasionally" since 10/1/20 with the most recent days worked as 9/22/21 and 9/24/21.	F 607		

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F 607	Continued From page 33 The facility's abuse prevention policy (N-1265 revised 11/28/17) documented the following concerning employee screening, "Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation of resident property. This includes but not limited to: Employment history...Criminal Background check...Abuse check with appropriate licensing board and registries, prior to hire...Licensure or Registration verification prior to hire...Information from former employers..." This finding was reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:50 p.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		11/2/21

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F 609	Continued From page 34 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure an injury of unknown origin was reported to the State Survey Agency and adult protective services for 1 of 18 in the survey sample, Resident #48. Resident #48 was found with a medium size gash to the back of his head of unknown origin requiring 5 staples. The findings include: Resident #48 was admitted to the facility on 07/27/2020 with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated 9/28/2021 was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 has requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS	F 609	F 609- Reporting of Alleged Violations 1.The facility reported the injury of unknown origin for Resident #48 during the survey. 2. One to one abuse education was provided to the supervisor during survey The DCS/Designee will review incidents for the last 30 days to ensure injuries of unknown origin and possible abuse allegations were report to the State Survey Agency and Adult Protective Services. 3. The ED/Designee will educate the staff on the abuse policy to include report to the State Survey Agency and Adult Protective Services. 4. The DCS/Designee will review Resident□s Change of Condition and the 24-hour report 5 times a week x 4 weeks then weekly x 2 months to ensure allegations of abuse and injuries of unknown origin were reported to the State Survey Agency and Adult Protective Services. Findings will be brought to QAPI for three months for further review. 5. Date Of Compliance 11/2/21	

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F 609	Continued From page 35 assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: "9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated "I did not fall, the door hit me". [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness)..... [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident." "09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o (complaints of) pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor." Observed in the clinical record was a Change in Condition (SBAR) form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note and docmented notification to Resident #48's guardian. On 10/05/2021 at 5:34 p.m. during a meeting with	F 609		

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	495230		C 10/06/2021

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ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

(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 609	Continued From page 36 the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the state agency and for the investigation. On 10/06/2021 at 9:36 a.m., the assistant director of nursing (RN #2) was interviewed regarding the incident. RN #2 was asked if there was an initial investigation and if the fall was reported to the state agency. RN #2 stated, "no, I had worked a double shift and had just got home when the licensed practical nurse (LPN) called and notified me of the incident. When I returned to work I didn't complete investigation or notify the state agency. I know that's not a valid reason not to complete the investigation. The LPN stated she had notified the MD (medical director) and completed the SBAR (change of condition) form and sent [Resident #48] to the ER (emergency room) per MD orders." RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, "no, [Resident #48] is constantly moving. We have to monitor him because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents." On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, "no the incident was not reported to the state agency. I am in the process of reporting it today." The DON was asked why incident was not reported. The DON stated, "I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process..." The DON was asked if she and/or the	F 609		

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F 609	Continued From page 37 administrator were notified of the incident. The DON stated "no, I was out of work on sick leave due to shoulder surgery and unfortunately the administrator went out on sick leave for COVID. I feel like my staff did what they were supposed to regarding assessing the resident and reporting it the ADON and MD, who gave orders to send the resident to the ER. However, the ADON failed to complete the additional steps to notify the state agency and start and complete the investigation." The DON was asked to provide the facility's abuse policy. A review of the facility policy titled "Abuse, Neglect, Exploitation & Misappropriation (Rev. 11/28/2017) documented the following: "7. Reporting/Response - Any employee contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hors after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials with the State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of	F 609		

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F 609	Continued From page 38 Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law... Review of Report: Report all results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.... The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies..." On 10/05/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident (FRI) dated 10/6/2021 sent to the state agency and the witness statements. No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m.	F 609		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		11/2/21

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F 645	Continued From page 39 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F 645		

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F 645	Continued From page 40 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to accurately completed a PASARR (Preadmission screening) for one of eighteen residents in the survey sample, Resident #46. Findings were: Resident #46 was admitted to the facility on 07/14/2015. His diagnoses included but were not limited to: Schizophrenia, dementia with behavioral disturbance, alcohol abuse, chronic viral hepatitis, and post traumatic stress syndrome. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/09/2021. Resident #46 was assessed as cognitively intact with a summary score of "15". Resident #46's clinical record was reviewed on	F 645	F 645 PASARR Screening for MD&ID 1. The facility completed an accurate PASARR for Resident #46. 2. The Social Services Director (SSD)/Designee will review current residents to ensure accuracy of PASARR. 3. The ED/Designee will educate the SSD and the Admissions Department regarding the accuracy of the PASARR 4. The facility will review new admissions and residents who receive a new diagnosis weekly x 4 weeks then monthly x 2 months to ensure the PASARR is accurate. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	

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F 645	Continued From page 41 10/05/2021 at approximately 3:00 p.m. There was no PASARR observed in the clinical record. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant, the above information was discussed. The DON stated that she would locate the PASARR. The copy of a PASARR dated 11/26/2018 was presented on 10/06/2021 at approximately 8:00 a.m. The PASARR did not list any mental disorder diagnoses for Resident #46. Resident #46's medical record documented multiple mental illness diagnoses including but not limited to: Schizophrenia, bipolar disorder, major depressive disorder, and post traumatic stress syndrome. The PASARR was shown to the DON on 10/06/2021 at approximately 9:00 a.m., and she was asked who had completed the document. She observed the signature and stated, "I'm not sure who that was." It was pointed out to her that the information on the document was not reflective of the diagnoses listed on Resident #46's clinical record. She stated, "I will have to look into that." No further information was received prior to the exit conference on 10/06/2021.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		11/2/21

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F 656	Continued From page 42 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 43 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to develop a comprehensive care plan for four of eighteen residents in the survey sample, Resident #31, #38, #46, and #11. Resident #31 was not care planned for self-administration of an albuterol inhaler; Resident #38 was not care planned for smoking; Resident #46 was not care planned for dental issues; and Resident #11 was not care planned with interventions for an existing pressure ulcer. Findings were: 1. Resident #31 was admitted to the facility on 03/12/2020 with the following diagnoses, including but not limited to: Fibromyalgia, depression, respiratory disorder, and chronic ischemic heart disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/19/2021, assessed Resident #31 as cognitively intact with a summary score of "15". On 10/05/2021 at approximately 8:00 a.m., Resident #31 was observed sitting on her bed. She was wearing oxygen via a nasal cannula at 3 liters per minute. Resident #31 was interviewed about life at the facility and was asked about her oxygen. She stated, "I got pneumonia a while back. I didn't wear it before then. Now I get short of breath when I take it off and to walk to the bathroom. My oxygen sats drop...sometimes I wheeze, that's why I have this." Resident #31 held up an albuterol inhaler that was laying on her bed. She stated, "The doctor told me to keep it	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. The facility has developed a self-administration of medication care plan for Resident #31. The facility has developed a smoking care plan for resident # 38. The facility has developed a dental issue care plan for resident #46. The facility developed a Pressure Ulcer care plan with interventions for Resident #11. 2. The DCS/designee will review new orders and incidents for the last 30 days to ensure the facility developed a comprehensive care plan for the residents. 3. The DCS/Designee will educate the nurses on developing a comprehensive care plan. 4. The DCS/Designee will review the new orders and incidents 5 times a week 4 weeks then weekly x 2 months to ensure a comprehensive care plan was developed. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	

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F 656	Continued From page 44 here at my bedside so that's where it is...I use it when I am short of breath or wheezing." Resident #31 was asked how often she used her inhaler. She stated, "Whenever I need it...he [her doctor] said I can use it every four hours if I need to. Sometimes it's four hours, sometimes it's longer, sometimes if I'm wheezing I might use it a little before the four hours is up." Resident #31 was asked if she had to get one of the staff to come and help her with the inhaler when she used it or watch her use it. She stated, "No, I do it myself, I don't need anybody to help me." She was asked if she had used an inhaler at home or prior to having pneumonia. She stated, "No, I never had any problems breathing until then." The clinical record was reviewed at approximately 11:00 a.m. Her care plan did not contain any interventions or references to the self-administration of albuterol. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was keeping medication at her bedside for self administration. She stated, "There should be an assessment, a doctor's order, and it should be on the care plan...it should be in the clinical record." The DON stated she would look to see what she could find. On 10/06/2021 at approximately 9:00 a.m., the DON provided information regarding Resident #31. She stated, "She did not have anything on her care plan regarding self administration of the inhaler." A copy of the facility policy for self administration of medications was requested and	F 656		

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F 656	Continued From page 45 received. Per the facility policy, "Self-Administration of Medication at Bedside": "...Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions....Complete the Care Plan for approved self-administered drugs. Self-administration of meds is reviewed by the Care Plan Team with each quarterly review, and when any change in status is noted." No further information was received prior to the exit conference on 10/06/2021. 2. Resident #38 was admitted to the facility on 04/25/2021 and readmitted on 08/18/2021. His diagnoses included but were not limited to: Diabetes Mellitus, peripheral vascular disease, hypertension, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/02/2021. Resident #38 was assessed as cognitively intact with a summary score of "15". During the entrance conference to the facility on 10/04/2021 at approximately 6:15 p.m., a list of smokers was requested. Resident #38 was on the list. On 10/05/2021, Resident #38 was observed outside during the morning smoke break at approximately 11:15 a.m. smoking a cigarette.	F 656		

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F 656	Continued From page 46 Resident #38's clinical record was reviewed at approximately 1:00 p.m. There were no interventions on the care plan regarding smoking. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was a smoker. She stated, "There should be an assessment done quarterly, and it should be on the care plan...it should be in the clinical record." The DON stated she would look to see what she could find. A copy of the facility's smoking policy was requested. On 10/06/2021 at approximately 9:00 a.m., the DON stated, "He [Resident # 38] did not have a smoking care plan. We did it today." The facility policy regarding smoking was received and contained the following: "During designated smoking times staff will be assigned to assist or supervise residents whose care plans indicate assistance or supervision is required while smoking." No further information was obtained prior to the exit conference on 10/06/2021. 3. Resident #46 was admitted to the facility on 07/14/2015. His diagnoses included but were not limited to: Schizophrenia, dementia with behavioral disturbance, alcohol abuse, chronic viral hepatitis, and post traumatic stress syndrome. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment	F 656		

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F 656	Continued From page 47 reference date) of 09/09/2021. Resident #46 was assessed as cognitively intact with a summary score of "15". The clinical record was reviewed on 10/05/2021 at approximately 3:00 p.m. Review of the progress note section contained the following information: "09/27/2021 07:14 [a.m.] Resident c/o [complains of] left lower gum/mouth pain. Resident teeth are decayed. Tylenol 650 mg given for c/o pain. MD notified RP [responsible party] aware." "09/27/2021 07:58 [a.m.] MD called with order for Amoxicillin tid [three times per day] X [times] 7 day[s] and arrange for dental consult." The care plan was reviewed. There were no interventions or problem areas listed for dental care or his tooth infection. At approximately 3:45 p.m., Resident #46 was interviewed. He was asked about his tooth infection. He stated, "Yeah, they gave me something for it. It was really hurting." He was asked if he had an appointment to see the dentist. He stated, "I'm not sure if I have one yet or not." During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked if Resident #46's care plan should contain information about his tooth decay and pending appointment. She stated, "Yes, it should be on there. I will look for it."	F 656		

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F 656	Continued From page 48 On 10/06/2021 at approximately 9:00 a.m., the corporate nurse presented a care plan for dental interventions for Resident #46. She stated, "We just created this, he didn't have one." She was asked who was supposed to be doing care plans in the facility. She stated, "MDS normally does them but she is out. Nursing does them too...nursing should have care planned his dental problems when he went on the antibiotics." No further information was obtained prior to the exit conference on 10/06/2021. 4. Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented the resident had ongoing treatment for a pressure ulcer on her right gluteal fold requiring daily dressing changes and wound care. On 10/5/21 at 11:48 a.m., registered nurse (RN) #1 was observed performing a dressing change to Resident #11's gluteal pressure ulcer. The ulcer was irregular shaped and approximately one inch in length and .5 inches wide. The wound depth was superficial and the wound bed was pink/red. Resident #11's plan of care (revised 8/31/21) included no interventions regarding the resident's gluteal pressure ulcer. The care plan listed the resident had a pressure ulcer on the right gluteal	F 656		

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	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

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F 656	Continued From page 49 fold with goals that included no progression or infection of the wound. The care plan documented no interventions for care or treatment of the wound. On 10/6/21 at 4:45 p.m., the director of nursing (DON) was interviewed about Resident #11's care plan. The DON stated treatments were in place and the resident had an air mattress for prevention of further ulcers. The DON stated the care plan had been started but not completed. This finding was reviewed with the DON and regional director of clinical services on 10/5/21 at 5:35 p.m.	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 657		11/2/21

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	495230		C 10/06/2021

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F 657	Continued From page 50 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clincial record review, the facility staff failed to review and revise a comprehensive care plan for 1 of 18 in the survey sample, Resident #48. Resident #48's care plan was not revised for falls, including an injury of unknown origin. The findings include: Resident #48 was admitted to the facility on 07/27/2020 with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated 9/28/2021 was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 has requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment.	F 657	F 657 Care Plan Timing and Revision 1. The facility updated Resident #48□s care plan for the injury to his head and his falls. 2. The DCS/Designee will review incidents for the past 30 days to ensure care plans were updated. 3. The DCS/Designee will educate the nurses on reviewing and revising care plans. 4. The DCS/Designee will review new orders and incidents weekly x 4 weeks then monthly x 2months to ensure the comprehensive care plan was reviewed and revised. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	

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	495230		C 10/06/2021

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F 657	Continued From page 51 Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: "8/21/2021 18:14 (6:14 p.m.)... Resident s/p (status post) fall day 1 of 3. No pain or distress noted from fall. Resident up in w/c (wheelchair) during shift, at times attempting to walk behind w/c). Resident redirect and assisted back into w/c for safety purposes. No bruising or open areas related to fall noted at this time." "8/23/21 11:25 Fall Meeting Note: Resident observed sitting on the floor by the bedside unable to let staff know what happened due to cognition. Increase in behaviors and unable to be redirected. New intervention Frequent monitoring to ensure safety. MD/RP aware." "8/23/21 12:02 he also had a fall later in afternoon, found on floor up against his drawers. No injuries, no c/o (complaints of) pain, ROM (range of motion) intact. new intervention: Ensure appropriate footwear. MD/RP (responsible party) aware of 2nd fall." "9/13/2021 15:39 (3:39 p.m.)... Resident noted sitting on floor in room. Assisted back into bed. No c/o pain or distress. No skin issues noted. Resident placed on Q (every) 15 min checks, encouraged to use call bell for assistance. Message left for guardian ad litem. MD (medical director) and DON (director of nursing) aware." "9/25/2021 09:00... Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated "I did not fall, the door hit me".	F 657		

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	495230		C 10/06/2021

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F 657	Continued From page 52 [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness)..... [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident." "09/25/2021 19:25 (7:25 p.m.)... Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o complications. Will continue to monitor." The clinical record included fall evaluations completed on 8/21/21 and 9/13/2021, both which assessed Resident #48 has a high risk for falls. The 8/21/2021 fall evaluation assessed a score of 65, with interventions of non-skid foot wear and ensuring the call bell was in reach. The 9/13/2021 fall evaluation assessed a score of 80 with an intervention of 15 minute checks. A review of Resident #48's care plans did not include the falls from 08/21/21 and 9/13/21, or the injury of unknown origin on 9/25/21. The care plan did not include the intervention of 15 minute checks. On 10/05/2021 at 5:34 p.m., the above information was discussed during a meeting with the director of nursing (DON) and corporate consultant. The DON was asked who was responsible for updating the care plans. The DON stated the MDS (minimum data set) coordinator	F 657		

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	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 53 nurse was responsible for updating care plans, however she was out sick at this time. The DON was asked how often was Resident #48 monitored. The DON stated, "it can vary every 15, every 30 minutes, it just all depends on the particular resident." The DON stated she would review the record and follow-up. On 10/06/2021 at 8:51 a.m., the DON was interviewed regarding the care plans not being updated. The DON stated the MDS coordinator should have updated the care plans. No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 a.m.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure care in accordance with the resident's plan of care for 1 of 18 in the survey sample, Resident #27. Resident #27 was not weighed per facility standing orders, and to ensure that she was maintaining weight as directed in her care plan. The findings include:	F 684	F 684 Quality of care 1. The physician discontinued Resident #27□s weights due to refusals. 2. The DCS/Designee will review current residents□ weights to ensure that weights were obtain per facility□s best practice. 3. The DCS/Designee will educate the Interdisciplinary Team (IDT) on	11/2/21

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	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 54 Resident #27 was admitted to the facility on 08/21/2020 with diagnoses that included hypertension, anemia, paraplegia, mild-protein-calorie malnutrition, adult failure to thrive, gastro-esophageal reflux disease (GERD), depression, and dementia with behavioral disturbance. The most recent minimum data set (MDS) dated 08/09/2021 was the annual/comprehensive assessment and assessed Resident #27 has having long and short term memory problems with continuous inattention and behaviors including delusions, rejection of care and behaviors towards others. Resident #27's clinical record was reviewed on 10/05/2021. The weights section of the clinical record documented the last recorded weight as "1/4/2021 129.0 pounds" and was entered by the director of nursing (DON). Resident #27's care plan documented, [Resident #27] has nutritional problem or potential nutritional problem r/t (related to) HTN (hypertension), dementia, anemia, history of UTIs (urinary tract infection). Goal: [Resident #27] will maintain adequate nutritional status as evidenced by maintaining weight, no s/sx (signs/symptoms) of malnutrition. (Revision Date: 8/12/2021). Interventions: ....observe/document report PRN any s/sx of.... refusing to eat, appears concerned during meals..." The care plan documented Resident #27 having behaviors including rejection of care including refusing showers, pocketing medications and spitting them out and yelling and hitting at staff. Neither the care plan nor the clinical record documented Resident #27 refusing to have	F 684	documentation of refusals and current weight management system. 4. The DCS/Designee will review weights weekly x4 then monthly x 2 to ensure weights or refusal are documented in the medical record. Findings will be brought to QAPI for three months for further review 5. Date of Compliance 11/2/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

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F 684	Continued From page 55 weights done. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked how often were weights obtained on residents. The DON stated weights were obtained monthly by standing order unless otherwise ordered by the physician more frequently. The DON stated Resident #27 often refused having her weights obtained. The DON was advised there was no refusals documented in the clinical record or on the care plan. The DON stated she would follow-up with additional information. On 10/06/2021 at 8:30 a.m., the DON provided a copy of the Annual Nutritional Evaluation completed on 08/20/2021 by the dietitian. Observed on the evaluation under the weights section was the most recent weight "01/04/2021 129.0 pounds." The evaluation documented the weight history in monthly increments of 1 month, 3 months and 6 months as "unknown" and documented "no weights since 1/4/21 due to resident refusal...." The DON stated, "I checked and you were right there was no documentation on the care plan or clinical record about her refusing weights. Her meal intake documents she has been consistent between 76-100% of each meal. The dietitian and doctor are now aware and we will get an order to d/c (discontinue) the weights due to her refusals." The DON was asked if there was a concern about weight loss. The DON stated, "I would think not since her meal intake has been consistent. This should have been done months ago and there should have been some	F 684		

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F 684	Continued From page 56 documentation about her refusals." No additional information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to perform a pressure ulcer dressing change in a manner to prevent infection for one of eighteen residents in the survey sample, Resident #11. A nurse failed to perform hand hygiene and gloves changes during a dressing change to Resident #11's pressure ulcer. The findings include: Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21.	F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. The staff member that performed the pressure ulcer change during the survey was a contracted employee. The facility contacted the hospice agency and they provided education for their staff. 2. The DCS/designee will observe the nurses during a dressing change to ensure proper infection control practices are being followed. 3. The DCS/designee will educate the nurses on the proper procedure to follow	11/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495230		C 10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

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F 686	Continued From page 57 Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented physician orders dated 9/14/21 with instructions to cleanse the wound, pat dry, apply Santyl ointment and alginate foam dressing daily for treatment of the right gluteal fold pressure ulcer. On 10/5/21 at 11:48 a.m., hospice registered nurse (RN) #1 was observed performing a dressing change to Resident #11's right gluteal fold pressure ulcer. RN #1 entered the room with supplies and without prior hand hygiene, put on clean gloves. RN #1 positioned supplies on the over-bed table, pulled down bed covers and assisted the resident to position on her left side in bed. RN #1 removed the soiled dressing and without removing gloves or performing hand hygiene, proceeded to cleanse the wound with cleanser/gauze. After patting the wound dry with gauze, RN #1 applied Santyl ointment to the wound bed with a cotton-tipped applicator. RN #1 placed the new dressing on the bed, wrote the date and her initials on the dressing and then applied the dressing over the wound. Without removing gloves or performing hand hygiene, RN #1 repositioned the resident in bed and pulled covers over the resident. RN #1 discarded used supplies, removed gloves and then washed her hands prior to exiting the room. On 10/5/21 at 12:00 p.m., RN #1 was asked about glove changes and hand hygiene after	F 686	during a dressing change. 4. The DCS/designee will observe dressing change weekly x 4 weeks then monthly x 2 months to ensure proper infection control practices are followed. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance 11/2/21	

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F 686	Continued From page 58 removing the soiled dressing. RN #1 stated, "We don't do that." On 10/6/21 at 9:03 a.m., the director of nursing (DON) was interviewed about the observed dressing change for Resident #11's pressure ulcer. The DON stated hand hygiene was supposed to be performed prior to any dressing change and glove changes with additional hand hygiene after removing a dirty dressing. The DON stated hand sanitizer was acceptable as long as hands were not visibly dirty. The DON stated the hospice nurses were expected to follow the facility's infection control protocols during dressing changes. The DON stated, "They [hospice] should abide by our standards." The facility's policy titled Hand Hygiene (revised 2/5/21) documented, "The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e., alcohol-based sanitizer including foam or gel)...Purpose: To reduce the spread of germs in the healthcare setting..." This policy documented that hand hygiene should be performed, "...before initiating a clean procedure...Before and after patient care...After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings...When hands are moved from a contaminated-body site to a clean body site during patient care...After glove removal..." The Lippincott Manual of Nursing Practice 11th edition on page 843 documents concerning infection prevention, "Hand hygiene is the single most recommended measure to reduce the risks	F 686		

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F 686	Continued From page 59 of transmitting microorganisms...Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control. It may be necessary to clean hands between tasks on the same patient to prevent cross-contamination of different body sites..." (1) This finding was reviewed with the DON and regional director of clinical services on 10/5/21 at 5:35 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide adequate supervision and/or services to prevent accidents for 2 of 18 residents in the survey sample, Resident #48 and Resident #11. Resident #48 was not provided adequate monitoring/supervision, sustained an injury of unknown origin on his head that required 5	F 689	F 689 Free of accident Hazards/Supervision/Devices 1. a)The facility completed a current fall risk assessment for resident # 48. b) The facility provided fall mats for Resident #11 as required in her care plan. 2. The DCS/designee will complete	11/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 60 staples, resulting in harm. Resident #11 was not provided fall mats as required in her care plan. The findings include: 1. Resident #48 was admitted to the facility on 07/27/2020 with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated 9/28/2021 was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 as requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: "9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated "I did not fall, the door hit me". [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (level of consciousness)..... [Ambulance Service]	F 689	current fall risk assessments on current residents of the facility. The DCS/designee will update the CP as necessary per assessment. 3. The DCS/designee will educate the staff on incident and accident reporting and fall best practices 4. The DCS/designee will review 5 resident at risk for falls, a week x 4 weeks then monthly x 2 months, to ensure the facility is providing adequate supervision and/or services to prevent accidents. Findings will be brought to QAPI for three months for further review. 5 Date of Compliance: 11/2/21	

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	495230		C 10/06/2021

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F 689	Continued From page 61 transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident." "09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o (complaints of) pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor." Observed in the clinical record was a Change in Condition form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note, and documented notification to Resident #48's guardian. A review of the order summary documented the following orders: "....Wound Healing every shift for infection for 5 Days Clean the wound with wound cleanser, pat dry and apply bacitracin each shift for 5 days. Order Date: 09/25/2021. Start Date: 09/25/2021. End Date: 09/30/2021.... Remove staples to back of head for wound healing 10/01/2021. Order Date: 09/25/2021. Start Date: 10/01/2021. End Date: 10/01/2021..." Resident #48's care plan documented the following: "[Resident #48] is at risk for falls r/t (related to) Gait/balance problems, Incontinence, recent CVA, history of falls, Poor communication/comprehension. Date Initiated/Revision Date: 08/04/2020. Goal: Minimize risk of minor injury. Date Initiated	F 689		

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F 689	Continued From page 62 8/4/2020. Revision Date: 08/16/2020. Interventions: Anticipate and Meet [Resident #48] needs. Be sure [Resident #48] call light is within reach and encourage him to use it for assistance as needed. Bed in low position. Ensure that [Resident #48] is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c (wheelchair). Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). " A review of the IDT (interdisciplinary team) Fall Team Meeting Notes documented the following: "08/23/2021 12:02. he also had a fall later in afternoon, found on floor up against his drawers. No injuries, no c/o pain, ROM (range of motion) intact. new intervention: Ensure appropriate footwear. MD/RP aware of 2nd fall." "8/23/2021 11:25. IDT Fall Meeting Note: Resident observed sitting on the floor by the bedside unable to let staff know what happened due to cognition. Increase in behaviors and unable to be redirected. New intervention Frequent monitoring to ensure safety. MD/RP aware." Resident #48's care plan was not updated to include the intervention of frequent monitoring to ensure safety from the 8/23/2021 IDT meeting. The clinical record only included resident safety check sheets dated 08/21/2021 through 8/24/2021. A fall risk assessment dated 09/13/2021 assessed Resident #48 as a high risk for falls with a score of 80. The assessment documented Resident #48 with a history of falls, having a weak	F 689		

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F 689	Continued From page 63 gait, and overestimating/forgetting his limitations. The assessment documented call bell within reach and Q15 (every 15) minutes check as previous interventions that worked. On 10/05/2021 at 9:15 a.m., Resident #48 was observed self-propelling on the unit near the nurses station in a wheelchair. Resident #48 was observed speaking loud and fast in a foreign language and hitting the nurses station counter, pulling at his pants and attempting to stand up from the wheelchair. Various staff were observed asking the resident what was wrong and to speak in English. Resident #48 was overheard saying, "English, Hell no." Staff members redirected Resident #48 and he was taken to his room. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the State Agency and for the investigation. On 10/06/2021 at 9:36 a.m., the assistant director of nursing (registered nurse - RN #2) was interviewed regarding the incident. RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, "No, [Resident #48] is constantly moving. We have to monitor him frequently because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents." RN #2 was asked if the LPN (licensed practical nurse) and CNA who provided care to Resident #48 on 09/25/2021 were available for interview. RN #2 stated, "The CNA is scheduled off today	F 689		

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F 689	Continued From page 64 and the LPN will come into work at 3 p.m. today. I can see if I can reach them by phone and follow-up with you." On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, "No the incident was not reported to the State Agency. I am in the process of reporting it today. The investigation wasn't completed either. I started that on yesterday and will give you a copy of the witness statements." The DON was asked why the incident was not reported and why the investigation was not completed. The DON stated, "I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process..." The DON was asked if she was able to determine what caused the injury of unknown origin. The DON stated, "no unfortunately not. [Resident #48] is active and moves around a lot. I can't really say what happened to him. There should be resident safety check sheets uploaded in the clinical record." The DON was advised the clinical record only included resident safety check sheets dated 08/21/2021 through 8/24/2021. On 10/06/2021 at approximately 11:45 a.m., the DON was asked to contact the LPN and CNA who provided care to Resident #48 on 09/25/21 for an interview. The DON stated the LPN wasn't feeling well and had called out for her shift and the CNA was already scheduled off; however, she would try to reach them for a phone interview. On 10/06/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident	F 689		

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F 689	Continued From page 65 (FRI) dated 10/6/2021 sent to the State Agency and the witness statements. The DON was asked what was considered frequent checks since the clinical record documented frequent checks as an intervention for Resident #48. The DON stated, "depending on the resident it can vary between every 15 minutes, 30 minutes, up to an hour." The corporate consultant stated, "at least every 2 hours." A review of the resident safety sheets provided were dated for 09/26/2021 through 10/05/2021. There were no sheets provided for 9/24/2021 or 9/25/2021. The sheets included 15 minute interval slots for first, second and third shift. The following dates were not completed for each 15 minute slot for the entire first and second shift: 9/26/21, 9/27/21, and 10/2/21; 10/3/21 was not completed for the entire first shift. There was no documentation in the progress notes, safety sheets, or elsewhere in the clinical record evidencing that the staff had monitored or supervised Resident #48 prior to finding him with the injury to his head on 9/25/2021. A review of the witness statement from the CNA who provided care on 09/25/21 documented the following: "On the morning of 9/25/21 I went into check on [Resident #48] and he was in his bed sleeping. I noticed blood on his pillow. I then looked at his head and he had a gash in the back of his head. I told the nurse immediately and they proceeded to care for him." A review of the witness statement from the LPN who provided care on 09/25/21 documented the following:	F 689		

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F 689	Continued From page 66 "I was alerted by the CNA that resident had blood on his pillow. Upon inspection a medium sized gash was noted to back of head, blood on pillow. Resident stated he did not fall & that the door went boom. Writer inspected both the bathroom door & outside room door & found no blood or any other indication that resident was injured by door. Bedroom floor, sink, & bed post were all inspected & also yielded no evidence of blood. Writer contacted ADON & MD, pressure applied to site & resident sent out to [ER]." The LPN and CNA who provided care on 09/25/2021 and wrote the witness statements were not available for interview during the survey. The above findings were discussed during a meeting on 10/06/2021 at 4:38 p.m. with the DON and corporate consultant. The staff were advised of the concerns of harm related to lack of supervision for Resident #48 who was identified as a fall risk and sustained an injury of unknown origin. The DON was asked if the facility had any additional information to present regarding the incident. The DON stated, "No I think we have presented all that we have at this time." No other information was presented to the survey time prior to exit on 10/06/2021 at 5:15 p.m. 2. Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely impaired cognitive skills.	F 689		

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F 689	Continued From page 67 Resident #11 was observed in bed on 10/5/21 at 10:50 a.m., 12:00 p.m. and 3:30 p.m. with no protective floor mats on either side of her bed. Resident #11's clinical record documented the resident had experienced previous falls from the bed. A nursing note dated 3/31/21 documented, "Found on floor at foot of bed. Resident was on her bottom...Skin tear was observed on her right elbow following fall..." A nursing note dated 5/26/21 documented, "Writer heard residents roommate calling for help. When writer got to room resident had rolled out of bed on to the floor. Resident was on her stomach. The bed was in lowest position when resident rolled out...redness on residents face and under her left arm near armpit area..." (Sic) Resident #11's plan of care (revised 8/31/21) listed the resident was at risk of falls and had experienced actual falls due to dementia and incontinence. Interventions to minimize falls included,"...Mat to bilateral sides of bed..." On 10/5/21 at 3:38 p.m., accompanied by certified nurses' aide (CNA) #1 that routinely cared for Resident #11, the resident was observed in bed with no mats in the floor. CNA #1 was interviewed at this time about mats. CNA #1 stated he was not aware the resident required floor mats. CNA #1 stated the resident had a history of falls but "had not fallen in awhile." CNA #1 stated he did not recall any recent use of mats with Resident #11. Resident #11 was observed in bed on 10/6/21 at 8:11 a.m. without use of protective floor mats. On 10/6/21 at 8:14 a.m., the registered nurse (RN	F 689		

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F 689	Continued From page 68 #2) working on Resident #11's unit was interviewed about the floor mats. RN #2 stated he was not sure about the mats. RN #2 stated the resident had mats in place at one time but he did not know if they were still required. On 10/6/21 at 10:37 a.m., RN #2 stated he checked Resident #11's care plan and the floor mats were supposed to be in place for fall/injury prevention. RN #2 stated, "It is care planned. She [Resident #11] should have them [mats]." This finding was reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:50 p.m.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		11/2/21

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F 690	Continued From page 69 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed follow infection control practices with placement of urinary catheter bag for one of eighteen residents in the survey sample, Resident #11. Resident #11's catheter bag was observed in the floor beside the resident's bed. The findings include: Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely impaired cognitive skills.On 10/5/21 at 8:50 a.m., Resident #11 was observed in bed. The resident's urinary catheter bag was in the floor beside the bed on the window side of the room. On 10/5/21 at 10:51 a.m., Resident #11's urine	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. During the survey the hospice nurse placed Resident #11□s catheter bag off of the floor. 2. The DCS/Designee will review the placement of current catheter bag for proper placement. 3. The DCS/Designee will educate the nursing staff on the proper placement of a catheter bag 4. The IDT will review placement of catheter bag during zone rounds to ensure proper placement 5 times a week x 4 weeks then monthly x 2 months. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	

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F 690	Continued From page 70 collection bag was again observed in the floor beside the bed. On 10/5/21 at 11:48 a.m., accompanied by hospice registered nurse (RN #1), Resident #11's urinary catheter bag was observed clipped to the bottom sheet on the resident's bed. RN #1 was interviewed at this time about the catheter bag previously in the floor. RN #1 stated she found the bag in the floor when she came in to assess the resident. RN #1 stated she did not find a hook or place to hang the bag so she clipped it to the bottom sheet to get it off the floor. On 10/6/21 at 9:08 a.m., the director of nursing (DON) was interviewed about the catheter bag in the floor. The DON stated the urine collection bag was not supposed to be in the floor and was supposed to be in a privacy bag hanging from the bed rail. On 10/6/21 at 9:36 a.m., the licensed practical nurse (LPN #1) routinely caring for Resident #11 was interviewed about the catheter bag. LPN #1 stated the catheter bag was supposed to be hanging from the bed rail and not in the floor. LPN #1 stated she was not aware of an issue with hanging the bag and she had seen the bag hanging from the bed on previous days. The facility's policy titled Catheter Care, Urinary (revised 9/5/17) documented steps for cleansing/care of the catheter tubing that included, "...Remove catheter securement device while maintain connection with drainage tube...Wash perineal area...Rinse well and dry...Clean Catheter tubing with soap and water...Rinse well...Reattach catheter securement device...Return equipment to proper place..."	F 690		

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F 690	Continued From page 71 These findings were reviewed with the DON and regional director of clinical services on 10/6/21 at 2:50 p.m.	F 690		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to store food in a sanitary manner in the main kitchen. The findings include: On 10/4/21 at 6:25 p.m., accompanied by the dietary manager (other staff #2) the kitchen and food storage areas were inspected. Stored in the dry storage room were the following: one carton	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary 1. During the survey, Other Staff #2 discarded the opened Thickened liquid containers. 2. There were no other storage issues throughout the kitchen during the survey. Inventory the dry storage area was checked to ensure correctly dated stored.	11/2/21

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	495230		C 10/06/2021

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F 812	Continued From page 72 of Thick and Easy dairy beverage - opened and not dated; one 46-ounce carton of nectar thick orange juice - opened and not dated; two 46-ounce cartons of thickened apple juice - opened and not dated. The seals on these beverage were punctured and the product partially used from the cartons. These beverages were not refrigerated but were stored in the dry storage room along with unopened cartons of thickened beverages and juices. The manufacturer's label on each of these cartons stated to "Refrigerate after opening." On 10/4/21 at 6:30 p.m., the dietary manager was interviewed about the opened, unrefrigerated dairy/juice beverages. The dietary manager stated the opened beverages should have been dated when opened and stored in the refrigerator. The dietary manager stated he did not know why the opened beverages were returned to the dry storage room. The dietary manager stated, "I've got a couple of new people." The Food Storage and Retention Guide (reference FDA Food Code 2013) provided by the dietary manager documented supplements and thickened beverages should be stored per manufacturer's guidelines. This finding was reviewed with the director of nursing and regional director of clinical services on 10/5/21 at 5:35 p.m.	F 812	3. The Dietary Manager/designee will educate the dietary staff on labeling, dating, and storing of liquids and items in the dry storage area. 4. The Executive Director/designee will tour the kitchen to ensure food is stored in a sanitary manner, weekly x 4 weeks then monthly x 2 months. Findings will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F 887		11/2/21

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	495230		C 10/06/2021

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F 887	Continued From page 73 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical	F 887		

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F 887	Continued From page 74 contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to administer the COVID vaccine in a timely manner to one of 18 residents, Resident #27. Resident #27's Responsible Party consented to administration of the COVID vaccine on 06/04/2021, the vaccine was not given until 09/30/2021. Findings were: Resident #27 was admitted to the facility on 08/21/2020 with the following diagnoses, including but not limited to: hypertension, paraplegia, mild-protein-calorie malnutrition, adult failure to thrive, gastro-esophageal reflux disease (GERD), depression, and dementia with behavioral disturbance. The most recent minimum data set (MDS) with an ARD (assessment reference date) of 08/09/2021 was an annual assessment. Resident #27 was assessed as has having long and short term memory problems with continuous	F 887	F 887 COVID-19 Immunization 1. Resident #27□s vaccine was given. The facility cannot fix the deficient practice for the resident. 2. The DCS/Designee will review unvaccinated residents□ consent forms to ensure the facility administered the COVID vaccine in a timely manner and documented in the medical record. 3. The DCS/Designee will educate the nurses on the COVID-19 vaccine policy to include documentation and administration of the vaccine in the medical record. 4. The DCS/designee will review new admissions weekly x 4 weeks then monthly x 2 months that are unvaccinated to ensure COVID-19 documentation is accurate and vaccine is administered timely, if necessary. Finding will be brought to QAPI for three months for further review. 5. Date of Compliance: 11/2/21	

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F 887	Continued From page 75 inattention and behaviors including delusions, rejection of care and behaviors towards others. Resident #27's clinical record was reviewed on 10/06/2021 at approximately 10:30 a.m. Observed in the progress note section was the following entry: 06/04/2021 12:01 [p.m.] Spoke with residents RP [responsible party]...regarding the covid 19 vaccine. Risks and benefits education discussed at this time. Consent received to provide either Janssen or Moderna vaccine." There was no further documentation in the clinical record regarding administration of the vaccine. The MARS (medication administration records) for June, July, August, September, and October were reviewed. There were no entries regarding the administration of the COVID 19 vaccine. The DON was interviewed at approximately 11:30 a.m. regarding whether or not Resident #27 had received the COVID vaccine per her RP's request. The DON stated that she would check with the ADON (assistant director of nursing) and see what she could find. At 11:55 a.m., an interview was conducted with the DON and the ADON. The ADON stated that the resident had refused the vaccine in June when he attempted to give it to her and again in July. He stated, "I actually gave it to her last week." The DON and the ADON were told that there was no documentation in the clinical record on the MAR or in the progress notes that the vaccine had been administered. The ADON stated, "I have that in my binder." At approximately 2:45 p.m., the ADON presented	F 887		

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F 887	Continued From page 76 a handwritten verbal order from the physician for the COVID 19 vaccine: "9/30/2021 @1920 [7:20 p.m.] Administer 1st dose of Pfizer Covid Vaccine 0.3 ml-IM today Pfizer Lot: (lot number) Exp [expires]: 11/30/2021 RBTO [read back telephone order] (followed by the physician and ADON's name)." The order was not signed by the physician nor was the order noted indicating the vaccine had been administered as ordered. The ADON also presented a "COVID-19 VACCINE INFORMATION AND CONSENT FORM" dated 09/30/2021 and signed by the resident. The Question "Have you ever received a dose of COVID -19 vaccine?" was marked as "No". Underneath that answer the above mentioned vaccine lot number and expiration date were written in. The ADON was asked why the vaccine was not given in June when the RP requested it. He stated, "At that time the pharmacy preferred that we have ten vaccines to give before we requested it...the vial is multidose and that kept it from being wasted." He presented a COVID-19 Vaccine Order Form dated 06/23/2021 with Resident # 27's name and nine other names on it. We got the vaccine then, but she refused to take it." He was asked where that was documented. He stated, "That wasn't a choice on the form...she refused again in August." He presented a Vaccine Intake Form with Resident #27's name at the top was handwritten "Refused 8-11-21". The ADON was asked if there was a consent form that the resident or RP had signed indicating that the vaccine had been refused in August. He stated, "We didn't have that choice on the form at the time." The clinical record was again reviewed for evidence that the vaccine had been	F 887		

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F 887	Continued From page 77 offered/refused/given. No documentation was observed. The facility policy, "COVID-19 Vaccine" was obtained and reviewed. Per the facility policy: "Documenting COVID -19 Vaccine-Review consent with the staff, resident/resident representative...obtain signature indicating accept of declination...documentation includes, but is not limited to: whether the resident/representative consented or declined vaccine. If consented and administered: Vaccine manufacturers name, dose, location, lot number and expiration date, date of administration, resident monitoring for 72 hours. If declined...reason for declination: Contradiction, refusal, previously obtained outside the center..." A meeting was held on 10/06/2021 at 3:10 p.m., with the DON and corporate nurse consultant. The DON was asked about the handwritten order. She stated, "That is just the order, it should be noted that it was done and it is not...the order should also be in (name of electronic record), not on paper." She was asked if the electronic system had been down on the day the order was taken. She stated, "No, and it should be on the MAR...after the injection we should be monitoring for signs and symptoms of reaction for 3 days, documenting where given the vaccine was given, the type, lot number, expiration date, all of the information. It should also be on the immunization screen in the system." She was told that the Immunization screen still said "SARS-COV-2 (COVID-19) (Dose 1) Consent Refused." She stated, "That should have been done when it was given...we don't have anything documenting why it wasn't done when requested by the RP or about when it was given."	F 887		

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F 887	Continued From page 78 No further information was obtained prior to the exit conference on 10/06/2021.	F 887		
F 909 SS=E	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 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, facility document review, staff interview and clinical record review, the facility staff failed to inspect a bed frame and mattress for possible entrapment risks for one of eighteen residents in the survey sample. Resident #11's bed, installed with a specialty air mattress for over 5 months, had not been inspected for entrapment risks. The facility's most recent bed inspections had no documented date of completion and did not include all facility beds in use. The findings include: Resident #11 was admitted to the facility on 9/28/20 with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated 7/22/21 assessed Resident #11 with severely	F 909	F 909-Resident Bed 1. During the survey Resident #11 was provided a new bed and measurements were taken during the survey. 2. The Maintenance Director/Designee will inspect beds in the facility for possible entrapment risk. 3. The ED/Designee will educate the Maintenance Director on the bed inspections and entrapment risks. 4. The Maintenance Director/designee will inspect beds, 1 hall per week x 4 weeks then monthly x 2 months, for possible entrapment risk. Findings will be brought to QAPI for three months for further review. 4. Date of Compliance 11/2/21	11/2/21

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F 909	Continued From page 79 impaired cognitive skills. Resident #11's clinical record documented a nursing note dated 4/28/21 stating, "Outside vendor arrived at facility at 2130 [9:30 p.m.] to deliver new air mattress. Resident was transferred OOB [out of bed] by staff to wheelchair while new bed was set up...No issues noted with new mattress." On 10/5/21 at 11:48 a.m., Resident #11 was observed in bed with an air mattress in use. On 10/5/21 at 4:37 p.m., the maintenance director (other staff #1) was interviewed about the facility's bed inspection program for entrapment risks. The maintenance director stated he inspected mattresses periodically for cracks and holes and replaced mattress as needed. The maintenance director stated beds were inspected routinely for function, condition and operation and that all beds installed with side rails had inspections for entrapment risks. The inspection for Resident #11's bed with the installed air mattress was requested. On 10/6/21 at 8:23 a.m., the maintenance director stated he checked gaps/measurements for beds/mattresses installed with side rails. The maintenance director stated Resident #11's bed was not a "standard" bed but was one of several that had been donated to the facility. The maintenance director stated he had no inspections of Resident #11's bed and had not inspected the bed with the specialty air mattress installed for entrapment risks. The maintenance director stated several of the donated beds had been in the facility for "months" and he did not remember exactly when they were put in use with	F 909		

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F 909	Continued From page 80 residents. The maintenance director stated, "I haven't gotten to that bed yet." The maintenance director presented a completed bed inspection sheet with measurements for FDA zone 7 (gap between the head and/or footboard and the end of the mattress). The completed form was not dated and listed bed make, model, type, serial number and mattress type. Gap measurements for zone 7 were documented as 2 inches or less. The form did not indicate if the measurements were between the headboard or footboard and the mattress. The list did not include the two beds and/or mattresses in Resident #11's room (Resident #11 and her roommate). The maintenance director presented an inspection list for beds in the facility with side rails dated "2021" that documented measurements for FDA bed zones 1 to 6. There was no safety inspection performed on Resident #11's bed with a standard mattress and there had been no review for entrapment risks since the bed was installed with an air mattress on 4/28/21. There was no formal policy/protocol regarding bed/mattress inspections and documented bed reviews included undated checklists and did not identify and include several "donated" beds in use or the beds in Resident #11's room. These findings were reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:45 p.m.	F 909		