PRINTED: 08/02/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495361	B. WING _				C <b>21/2022</b>
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		Z 172422
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 035 SS=D	survey was conducted Corrections are requil CFR Part 483.73, Rec Care Facilities. No er complaints were invested. The complaints were invested to the complaints were invested to the complaints were invested. The complaints were invested to the complaints were invested to the complaints with Ferman and the complies with respect to the complete complete the complete comp	\$483.73(c):]  sust develop and maintain edness communication plan deral, State and local laws and updated at least unication plan must include  8.475(c):]  develop and maintain an ess communication plan deral, State and local laws and and updated at least every expension of the	E	0000	1. The facility provided a posting at the entrance and all other notice boards as of sharing EP information with current residents, their families, or representatives.  2. All residents, their families, or representatives are at risk for being impost the alleged deficient practice.  3. Information will be included in the Adr packet to ensure each new resident, the family, or representative is aware of the Emergency Preparedness plan and how facility will ensure their safety during an emergency All staff will be educated regarding the emergency prepardness plan and how/residents/families or RPs can receive information about it.  4. The ED/designee to conduct quality monitoring of 10 residents/RPs weekly weeks regarding understanding the EP information location The findings of thes quality monitoring's to be reported to the Quality Assurance/Performance Improve Committee monthly. Quality Monitoring schedule modified based on findings wit quarterly monitoring by the RDCS (Regi Director of Clinical Services) / designee.	res and acted mission ir this where x 6 plan e e ement h onal	9/1/2022 (X6) DATE

**Executive Director** 

Facility ID: VA0278

8/26/2022

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		495361	B. WING _		07	/21/2022
	F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		
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	staff failed to provide place to inform reside facility's emergency p  The findings include:  On 7/19/22 at 11:26 a staff member) #1, the provide the facility's e evidence that the faci inform residents and semergency plan.  On 7/20/22 at 5:17 p.1 asked to provide evidinform residents and semergency plan. ASM place the plan at the fistations." He stated seat the front elevator. We evidence that any of the ASM #1 stated: "I will there is no facility polifamilies being informed emergency plan.  No further information EP Training Program CFR(s): 483.73(d)(1), §440.8441.184(d)(1), §440.8483.73(d)(1), §485.68(d)(1), §4	evidence of a system in onts and staff about the lan.  I.m., ASM (administrative administrator, was asked to mergency plan, including lity has a system in place to staff about the facility's  I.m., ASM #1 was again ence that facility's system to staff about the facility's was a system in place to staff about the facility's was again ence that facility's system to staff about the facility's was again ence that facility's was again ence that facility's system to staff about the facility's was again ence that facility's was		035		
	-	3.748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs				

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ENVOTO	F WOODBRIDGE, LLC			WOODBRIDGE, VA 22191		
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E 037	E 037 Continued From page 2 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.		E 03	,	esource weekly x ed the ining. source oming /e ttor will paredness	9/1/2022
	least every 2 years. (iv) Periodically review emergency preparedr employees (including special emphasis plac procedures necessary others.	ey preparedness training at v and rehearse its ness plan with hospice nonemployee staff), with sed on carrying out the v to protect patients and tation of all emergency				

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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
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E 037	procedures are signifimust conduct training procedures.  *[For PRTFs at §441. program. The PRTF r (i) Initial training in en policies and procedur staff, individuals proviarrangement, and vol expected roles.  (ii) After initial training preparedness training (iii) Demonstrate staff procedures.  (iv) Maintain document preparedness training (v) If the emergency procedures are signifimust conduct training procedures.  *[For PACE at §460.8 organization must do (i) Initial training in en policies and procedur staff, individuals proviarrangement, contract volunteers, consisten (ii) Provide emergence least every 2 years.  (iii) Demonstrate staff procedures, including	preparedness policies and icantly updated, the hospice on the updated policies and 184(d):] (1) Training must do all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their updated, provide emergency gevery 2 years. It knowledge of emergency greparedness policies and icantly updated, the PRTF on the updated policies and identify and the following: nergency preparedness es to all new and existing iding on-site services under thors, participants, and the with their expected roles. By preparedness training at the knowledge of emergency informing participants of go, and whom to contact in the propertical identification of the go, and whom to contact in the preparedness informing participants of go, and whom to contact in the preparedness in the preparedness informing participants of go, and whom to contact in the preparedness in the preparedness informing participants of go, and whom to contact in the preparedness in the preparednes	E	037			

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E 037	procedures are signifimust conduct training procedures.  *[For LTC Facilities at Program. The LTC facilities and Program. The LTC facilities and procedures.  (i) Initial training in empolicies and procedures and procedures arrangement, and volexpected role.  (ii) Provide emergence least annually.  (iii) Maintain document preparedness training (iv) Demonstrate staff procedures.  *[For CORFs at §485 CORF must do all of (i) Provide initial training preparedness policies and existing staff, indunder arrangement, awith their expected ro (ii) Provide emergence least every 2 years.  (iii) Maintain document (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergentheir first workday. The	preparedness policies and icantly updated, the PACE on the updated policies and is \$483.73(d):] (1) Training cility must do all of the inergency preparedness test to all new and existing iding services under unteers, consistent with their management of all emergency preparedness training at intation of all emergency is knowledge of emergency in emergency in emergency is and procedures to all new initials providing services and volunteers, consistent ites. By preparedness training at intation of the training at intation of the training. If knowledge of emergency personnel must be oriented in responsibilities regarding cy plan within 2 weeks of the training program must the location and use of	E	037			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
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E 037	procedures are sign must conduct trainin procedures.  *[For CAHs at §485. The CAH must do al (i) Initial training in e policies and procedure reporting and exting and where necessar personnel, and guest cooperation with fire authorities, to all nevindividuals providing and volunteers, constroles.  (ii) Provide emergent least every 2 years.  (iii) Maintain docume (iv) Demonstrate star procedures.  (v) If the emergency procedures are sign must conduct trainin procedures.  *[For CMHCs at §48 CMHC must provide preparedness policies and existing staff, in under arrangement, with their expected redocumentation of the demonstrate staff kn procedures. Therea	y preparedness policies and ficantly updated, the CORF g on the updated policies and 625(d):] (1) Training program. I of the following: mergency preparedness ures, including prompt uishing of fires, protection, y, evacuation of patients, ts, fire prevention, and fighting and disaster w and existing staff, services under arrangement, sistent with their expected cy preparedness training at entation of the training. If knowledge of emergency y preparedness policies and ficantly updated, the CAH g on the updated policies and 5.920(d):] (1) Training. The initial training in emergency and procedures to all new dividuals providing services and volunteers, consistent	EC	37				

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	<b>,</b>	0172172022	
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E 037	by: Based on staff interverview, it was determ failed to have a compreparedness plan. I provide evidence of a staff have received a preparedness trainin.  The findings include: On 7/19/22 at 11:26 staff member) #1, the provide the facility's evidence that the statime of hire) and ann preparedness trainin. On 7/19/22 at 4:59 pmember) #5, the hun asked to provide evidence that the statime of hire) and ann preparedness trainin. On 7/19/22 at 4:59 pmember) #5, the hun asked to provide evidence that the statime of hire and received initial apreparedness trainin. On 7/20/22 at 5:17 pmember yes trainin. On 7/20/22 at 5:17 pmember yes trainin. A review of the facility revealed, in part: "The training and education specific guidance and handling of a crisis of members, contract eare trained upon hire	T is not met as evidenced view and facility document nined that the facility staff plete emergency The facility staff failed to documentation that facility nnual emergency g.  a.m., ASM (administrative e administrator, was asked to emergency plan, including ff have received initial (at the ual emergency g.  m., OSM (other staff nan resources director, was dence that the facility staff nd annual emergency	EO	37			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	' '	E SURVEY PLETED
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E 037	is organized and cond within the organization resources, such as lo qualified vendors, and	oceduresDisaster training ducted by qualified persons n or from other credible cal emergency responders, d consultants."	E	037		
F 000	No further information INITIAL COMMENTS	n was provided prior to exit.	F	000		
	survey was conducted 7/21/22/22. Two compound (VA00055351-substant deficiency and VA000 deficiency) were investigated to the conducted that the co	plaints ntiated with a related 054154-substantiated with stigated during the survey. red for compliance with 42 al Long Term Care fe Safety Code				
	96 at the time of the s	cise of Rights	F	550		
	self-determination, ar	ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner	ty must treat each resident ity and care for each and in an environment that be or enhancement of his or				

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		E SURVEY PLETED
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	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		12112022
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her ind property services serv	dividuality. The facility of the rights of the rights of the same the rights of the same the rights of the same the rights and make the residents regarding the residents regardless of the resident of the United Sa. 10(b) (1) The facts and the resident of the United Sa. 10(b) (1) The facts are resident of the United Sa. 10(b) (2) The resident can exercise the reference, coercion of the facility.  83. 10(b) (2) The resident of the facility.  83. 10(b) (2) The resident of the facility of the same the facility.  83. 10(b) (2) The resident of the same the facility of the same the facility of the same the supposeries of his or her resident on observation cument review, it was said to be supposed on observation cument review, it was said to be serving meals in the facility staff failed to provide the serving meals in the facility staff serves and gave disposable of the same the residual staff serves and gave disposable of the rights and the same the residual staff serves and the same the rights and the rights and the same the rights and the same the rights and the rights an	gnizing each resident's ty must protect and he resident.  ility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  f Rights. ight to exercise his or her the facility and as a citizen	F 5	1.The facility recognizes that Styrused for a meal during the survey  2.All residents have the potential impacted by the alleged deficient  A quality review will be conthe Dietary Manager and ED to eadequate dishware is available for meals as indicated. Meals will be dishware.  3.All dietary staff will be re-educa Social Service Director/Assistant Resident Rights. The resident had dignified existence, self-determin communication with and access the and services inside and outside the including those specified in this sefacility must treat each resident wand dignity and care for each resimanner and in an environment the maintenance or enhancement of quality of life, recognizing each resindividuality. The facility must propromote the rights of the resident must provide equal access to quaregardless of diagnosis, severity or payment source. A facility must propromote the rights of the resident must provide equal access to quaregardless of diagnosis, severity or payment source. A facility must proprovision of services under the Sall residents regardless of payme Exercise of Rights. The resident to exercise his or her rights as a the facility and as a citizen or resultied States. The facility must ethe resident can exercise his or his without interference, coercion, disor reprisal from the facility. The rethe right to be free of interference discrimination, and reprisal from the exercising his or her rights and to supported by the facility in the exor her rights as required. In the AM meeting, the Dietary M report to the ED any situations the impact dishware availability.	to be a practice.  ducted by ensure or use for e served on atted by the related to a pation, and to persons the facility, section. A with respect sident in a promotes his or her esident's of condition, steet and the practices of the tate plan for ent source. The facility ality care of condition, steet and the tate plan for ent source. The facility ality care of condition, steet and the tate plan for ent source. The facility ality care of condition, steet and the tate plan for ent source. The facility in the tate of the ensure that the e	9/1/2022

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F 550	member) #1, the diet as he served all resid line in the facility's or each and every meal container. The food with the container, and the was folded over to creatility dishware were adjacent to the tray list seven Styrofoam corwith disposable plast stated: "I don't know forks are going. We jeverybody."  On 7/19/22 at 1:46 pmanager at a sister fobserved the lunch train interviewed. She stated Styrofoam "because stated if the facility stated if the facility stated if the facility stated if the facility stated there was not wash the dishware. Versidents on disposal convenience promoted ignity, she said it die On 7/20/22 at 5:17 pstaff member) #1, the the director of nursin	.m., OSM (other staff ary manager, was observed dent lunches from the tray ally kitchen. OSM #1 served on a disposable Styrofoam was placed on one side of e other side of the container eate a cover. Two stacks of e observed in a dish cart ane. Additionally, the last attainers served were paired ic eating utensils. OSM #1 where the [stainless steel] ust don't have enough for .m., OSM #2, the dietary acility, who had also any line service, was seed OSM #1 was serving on they are short staffed." She saff did not serve on there is no way they would he dishware around on time al "out at a decent time." She enough staff at the facility to When asked if serving the ble dishware for staff ed a sense of resident	F 5	4.The Executive Director/Assiconduct quality monitoring of weekly x 6 weeks to ensure prodishware is utilized. The finding quality monitoring's to be reported to the provided finding schedule modified findings with quarterly monitor Regional Director of Clinical Services/designee.	10 meals oper gs of these orted to the ce thly. Quality based on	

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F 550 F 574	revealed, in part: "A redignity and respect."	policy, "Resident Rights," esident shall be treated with a was provided prior to exit.		550 574			
SS=C	S483.10(g)(4) The respective notices or ally writing (including Brail language he or she ure (i) Required notices at The facility must furnit description of legal right (A) A description of the personal funds, under section;  (B) A description of the procedures for estable including the right to resources under sections security Act.  (C) A list of names, and email), and telephone State regulatory and it resident advocacy grows and advocacy grows are section. State Long-Term Careprotection and advocacy services where state in long-term care facil agency for information community and the Mand  (D) A statement that the complaint with the States.	sident has the right to (meaning spoken) and in ille) in a format and a inderstands, including: is specified in this section. sh to each resident a written ghts which includes - in emanner of protecting in paragraph (f)(10) of this increase and ishing eligibility for Medicaid, request an assessment of ion 1924(c) of the Social inderses (mailing and enumbers of all pertinent informational agencies, oups such as the State increase of ion increase of ion increase of ion increase in the state ion increase in the state ion increase in the state ion increase in the ion ion increase in the ion					

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F 574	not limited to resident exploitation, misappro in the facility, non-condirectives requirement information regarding (ii) Information and condirectives requirement information regarding (ii) Information and condition and local advocacy of not limited to the State Long-Term Care Ombe (established under sea Americans Act of 196 U.S.C. 3001 et seq) and advocacy system (as as established under Disabilities Assistance 2000 (42 U.S.C. 1500 (iii) Information regardeligibility and coverage (iv) Contact information Disability Resource Control Unit; and (vi) Contact information Control Unit; and (vi) Information and control unit; and (vii) Information and control unit; and (vii) Info	regulations, including but abuse, neglect, priation of resident property inpliance with the advance its and requests for returning to the community. Intact information for State information for State information including but its Survey Agency, the State indistrict of the Older information of the Older information of the Older information and information and information and information and information information, inf	F 57	1.The Ombudsman email was pot to the end of the survey.  2.All residents are at risk for bein by the alleged deficient practice.  A quality review was conducted a Executive Director/designee of a postings to ensure complete Ominformation present.  3.The SSD will be re-educated be ED/designee related to ensuring Ombudsman information is poster posters and information is shared.  4.The ED (Executive Director)/DCS/designee to condumonitoring of the Ombudsman prensure complete information is pweekly x 6 weeks. The findings of quality monitoring's to be reported Quality Assurance/Performance Improvement Committee monthly Monitoring schedule modified based findings with quarterly monitoring RDCS (Regional Director of Clini Services) / designee.	by the all notification budsman by the complete ed where d. buct quality ostings to present of these ed to the by. Quality ised on g by the	9/1/2022

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		•	14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	-	
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F 574	The findings include:  On 7/19/22 at 2:30 Pt the information poster elevators on the ground it was observed that the mailing address and places.  On 7/20/22 at 7:00 At confirmed the email address.  On 7/20/22 at 7:00 At confirmed the email at the information poster.  On 7/20/22 at approximate (administrator, ASM #3. ASM #3. the regional were made aware of the waste of the confidentiality of his or records.  §483.10(h) Privacy at The resident has a rig confidentiality of his or records.	M, this surveyor reviewed don't he wall by the and, first and second floors. The information included the chone number of the State budsman but was missing.  M, RN (registered nurse) #1 address was not included in don'the wall.  Imately 5:30 PM, ASM member) #1, the 2, the director of nursing and director of clinical services the findings.  In was provided prior to exit. Infidentiality of Records (3)(i)(ii)  and Confidentiality. In the personal privacy and or her personal and medical all privacy includes dical treatment, written and attions, personal care, visits, y and resident groups, but the facility to provide a		574			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191			21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delivered to including those delivered to including those delivered than a postal service.  §483.10(h)(3) The resident has the office of the state laws. (ii) The resident has the office of the State Lower to examine a resident administrative records law.  This REQUIREMENT by:  Based on observation document review and facility staff failed to not residents' medical record the survey sample, Reference.  The findings include:  1. The facility staff failed to not resuscitate) on the wall in R7's rocket.	cility must respect the conal privacy, including the or her oral (that is, spoken), communications, including promptly receive unopened packages and other the facility for the resident, ared through a means other sident has a right to secure onal and medical records. The right to refuse the release cal records except as (2) or other applicable. How representatives of the ing-Term Care Ombudsman is medical, social, and is in accordance with State. The is not met as evidenced in the state of the ingential of the ingential record review, the inaintain confidentiality of cords for 4 of 33 residents in the ingential residents #7, #88, #25 and and the ingential record review. The order was posted in	F	583	1.Residents' #7, #25, #88, and #96 with DNRs posted on the wall in their rooms immediately removed.  2.All residents are at risk for being impaint by the alleged deficient practice.  A quality monitoring audit of rooms on the first and second floor was complete 07/20/2022 to ensure that no other DNF were posted on the walls in other reside rooms.  3.The ADON/designee will provide eductorall staff to ensure that when rounding residents' rooms, they remove any and confidential information visible.  Quality monitoring teams will audit their assignment and report in the AM meeting any issues with confidentiality of residence records discovered.	were acted  ooth d on Rs ent cation in all	9/1/2022

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		495361	B. WING _		C <b>07/21/2022</b>	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	<b>,</b>	0172172022
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F 583	reference date) of 4 cognitive skills for d coded as severely in On 7/19/22 at 2:46 proom was conducted. DNR order was postesident's bed. The name, the date the following: "I, the unabona fide physician/patient named above patient's medical requitionized to consedirected that life-prowithheld or withdraw respiratory arrestI qualified health care the effective date not cardiopulmonary rescompression, endot advanced airway may ventilation, defibrilla from the patient in the cardiac or respiratory personnel to provide interventions, such a comfort care or allew On 7/20/22 at 3:24 property in the context of the comfort care or allew On 7/20/22 at 3:24 property in the context of the context of the comfort care or allew On 7/20/22 at 3:24 property in the context of the context o	nt with an ARD (assessment //24/22, the resident's aily decision making was impaired.  D.m., an observation of R7's id. The resident's durable ted on the wall behind the order documented R7's form was signed and the dersigned, state that I have a patient relationship with the ide. I have certified in the cord that he/she or a person int on the patient's behalf has alonging procedures be within the event of cardiac or hereby direct any and all it is personnel, commencing on obtain the patient of the patient of the patient, artificial tion, and related procedures) in event of the patient's ry arrest. I further direct such it is a patient other medical as intravenous fluids, oxygen, evemed necessary to provide viate pain"	F 5	,		
	LPN #4 stated the p alert nurses to not in resuscitation) on a r emergency where C stated a DNR order	I (licensed practical nurse) #4.  Purpose of a DNR order is to nitiate CPR (cardiopulmonary esident if there is an CPR is needed. LPN #4 contains confidential usually gets the DNR from				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
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F 583	made the decision to on the wall in resider out. On 7/20/22 at 4 was conducted with during the time of CC rapidly declining so t made the decision to in residents' rooms so to withhold CPR. LP document should not residents' rooms.  On 7/20/22 at 5:37 p staff member) #1 (the ASM #2 (the director aware of the above of the above of the clinical record, but protected right of information of the clinical record, but protected right of information of the most recent for the clinical record, but protected right of information of the most recent for the clinical record, but protected right of information of the most recent for the clinical record, but protected right of information of the most recent for the clinical record of the wall in the confidential the status), indicating the status), indicating the status), indicating the	ated she didn't know who place residents' DNR orders ats' rooms but she would find :01 p.m., another interview LPN #4. LPN #4 stated that DVID, some residents were the former executive director is post DNR orders on the wall to nurses would know when the stated a confidential to be posted on the wall in the posted on the wall in the posted on the wall in the executive director) and of nursing) were made concern.  The detail of the property in the property right to be the resident has the property right to be the resident has the property in the promation."  The was presented prior to exit. The order was the product the resident has the property right to be the property of the property right to be	F 5	83			

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	07/21/202	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE COMPL	ETION
F 583	Continued From pa	ge 16	F 5	83		
	room was conducted DNR order was post resident's bed. The name, the date the following: "I, the undona fide physician patient named above patient's medical reauthorized to consedirected that life-prowithheld or withdraw respiratory arrest! qualified health care the effective date not cardiopulmonary recompression, endot advanced airway moventilation, defibrillation the patient in the cardiac or respiratory personnel to providinterventions, such	tracheal intubation and other anagement, artificial anagement, artificial ation, and related procedures) the event of the patient's ry arrest. I further direct such the patient other medical as intravenous fluids, oxygen, seemed necessary to provide				
	conducted with LPN LPN #4 stated the palert nurses to not i resuscitation) on a semergency where 0 stated a DNR order information and she the chart. LPN #4 smade the decision to on the wall in reside	p.m., an interview was I (licensed practical nurse) #4. Durpose of a DNR order is to initiate CPR (cardiopulmonary resident if there is an CPR is needed. LPN #4 contains confidential e usually gets the DNR from stated she didn't know who to place residents' DNR orders ents' rooms but she would find 4:01 p.m., another interview				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 583	during the time of CC rapidly declining so to made the decision to in residents' rooms so to withhold CPR. LP document should not residents' rooms.  On 7/20/22 at 5:37 p staff member) #1 (the ASM #2 (the director aware of the above of the	LPN #4. LPN #4 stated that DVID, some residents were he former executive director post DNR orders on the wall on nurses would know when N #4 stated a confidential to be posted on the wall in .m., ASM (administrative executive director) and of nursing) were made concern.  In was presented prior to exit. illed to maintain dical information for Resident to had posted on the wall bed, a DDNR (durable do  MDS (minimum data set) erly assessment, with an everage date of 5/22/2022, the out of 15 on the BIMS (brief status) score, indicating the attely cognitively impaired for ins.	F 583			

PRINTED: 08/02/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 583	patient named above patient's medical reconsultation and she with the patient in the cardiac or respiratory personnel to provide interventions, such as or other therapies decomfort care or allevial The physician order of documented in part, "DNR (do not resuscitation) on a reemergency where CF stated a DNR order of information and she uther chart. LPN #4 stamade the decision to on the wall in resident with the cardiac or respiratory personnel to provide interventions, such as or other therapies decomfort care or allevial. The comprehensive of documented in part, "DNR (do not resuscitation) on a reemergency where CF stated a DNR order of information and she uthe chart. LPN #4 stamade the decision to on the wall in resident.	atient relationship with the . I have certified in the ord that he/she or a person to on the patient's behalf has onging procedures be in the event of cardiac or ereby direct any and all personnel, commencing on eed above, to withhold ascitation (cardiac acheal intubation and other magement, artificial on, and related procedures) are event of the patient's arrest. I further direct such the patient other medical intravenous fluids, oxygen, emed necessary to provide ate pain"  The patient other medical are plan dated 8/16/2018 are plan dat	F	583			

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	· · · · · ·	0772172022	
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F 583	during the time of CC rapidly declining so the made the decision to in residents' rooms so to withhold CPR. LP document should not residents' rooms.  ASM (administrative executive director, Annursing, and ASM #3 services were made on 7/20/2022 at 5:23  No further information  4. The facility staff faconfidentiality of median with the resident's not resuscitate) form  On the most recent in assessment, a quarter assessment reference resident scored a 12 interview for mental services form was moderal making daily decision.  Observation was manous manou	LPN #4. LPN #4 stated that DVID, some residents were the former executive director post DNR orders on the wall to nurses would know when N #4 stated a confidential to be posted on the wall in staff member) #1, the SM #2, the director of the director of clinical aware of the above concern p.m.  In was provided prior to exit.  It is to maintain the director of the director of the wall bed, a DDNR (durable do the wall bed, a DDNR (durable do the wall bed, a DDNR (durable do the wall bed).  In the director of the bids (brief status) score, indicating the teley cognitively impaired for the status) score, indicating the teley cognitively impaired for the status is the status in the status indicating the status is the status in	F 5	83			

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F 583	the following: "I, the universe a bona fide phy with the patient name the patient's medical person authorized to behalf has directed the procedures be withher of cardiac or respirate any and all qualified he commencing on the eto withhold cardiopuli (cardiac compression and other advanced a ventilation, defibrillatiform the patient in the cardiac or respiratory personnel to provide interventions, such as or other therapies decomfort care or allevion.  The physician order of documented, "Do NO The comprehensive of does not address the resuscitation.  On 7/20/22 at 3:24 p. conducted with LPN alert nurses to not iniverse to not iniverse to not iniverse to the chart. LPN #4 state the puralert nurses to not and the chart. LPN #4 state the chart.	e the form was signed and indersigned, state that I sician/patient relationship and above. I have certified in record that he/she or a consent on the patient's nat life-prolonging and or withdrawn in the event ory arrestI hereby direct nealth care personnel, affective date noted above, monary resuscitation in, endotracheal intubation airway management, artificial on, and related procedures) are event of the patient's arrest. I further direct such the patient other medical intravenous fluids, oxygen, emed necessary to provide ate pain"  dated 7/17/2020, or resuscitate."  care plan dated, 4/9/2021, resident's status for  m., an interview was (licensed practical nurse) #4. Impose of a DNR order is to tiate CPR (cardiopulmonary sident if there is an PR is needed. LPN #4	F 5	83			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495361	B. WING			07/:	21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY /OODBRIDGE, VA 22191		
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F 585 SS=D	out. On 7/20/22 at 4: was conducted with L during the time of CO rapidly declining so the made the decision to in residents' rooms so to withhold CPR. LPN document should not residents' rooms.  ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made as on 7/20/2022 at 5:23  No further information Grievances CFR(s): 483.10(j)(1)-(1)-(1)-(1)-(1)-(1)-(1)-(1)-(1)-(1)	ts' rooms but she would find 01 p.m., another interview PN #4. LPN #4 stated that VID, some residents were be former executive director post DNR orders on the wall or nurses would know when N #4 stated a confidential be posted on the wall in staff member) #1, the SM #2, the director of the director of clinical aware of the above concern p.m.  In was provided prior to exit.  (4)  S. dident has the right to voice lity or other agency or entity without discrimination or nees include those with eatment which has been that which has not been or of staff and of other concerns regarding their LTC dident has the right to and the ompt efforts by the facility to be resident may have, in		583			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 585	§483.10(j)(3) The facion how to file a grievato to the resident.  §483.10(j)(4) The facigrievance policy to enofall grievances regale contained in this paraprovider must give a contained in this paraprovider in the grievance in the contained in this paraprovider in the grievance; and the contained in the paraprovider in the paraprovider in the paraprovider in this paraprovider in the grievance; and the contained in the paraprovider in the paraprovider in the grievance in the griev	lity must make information ince or complaint available  lity must establish a sure the prompt resolution reding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must individually or through locations throughout the sele grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone expected time frame for of the grievance; the right cision regarding his or her intact information of with whom grievances may extinent State agency, Organization, State Surveying-Term Care Ombudsman and advocacy system; ance Official who is being the grievance process, if grievances through to their any necessary investigations ining the confidentiality of all	F	585	1. The facility ordered a new Prevalon (boot to keep the heel lifted off the bed moisture and keep the foot and ankle in place) in a timely manner for R32. The grievance the facility had was about "to shoes"  2. All residents with orders for specialt boots/shoes are at risk to be impacted alleged deficient practice. A quality review was conducted by the SSD/designee of grievances since July ensure follow up completed and closed 3.SSD will be re-educated by the ED/designee related to the completion grievances including the documentation follow up.  The IDT will review grievances in AM into discuss follow up and ensure each is resolved and closed out with follow up the grievant.  4. The ED (Executive Director)/DCS to conduct quality monitoring of grievance weekly x 6 weeks to ensure follow up a resolution. The findings of these quality monitoring's to be reported to the Qual Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the RDCS (Reg Director of Clinical Services) / designeed.	y wick on the second of all on of all on of second of all on other sec	9/1/2022

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ENVOY O	F WOODBRIDGE, LLC			14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191			
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F 585	prevent further poten right while the alleged investigated; (iv) Consistent with § reporting all alleged vabuse, including injur and/or misappropriati anyone furnishing seprovider, to the adminas required by State (v) Ensuring that all vinclude the date the gammary statement of the steps taken to invalument of the pertinas to whether the gric confirmed, any correct taken by the facility and the date the writt (vi) Taking appropriation accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or local confirms a violation for rights within its area of (vii) Maintaining evideresult of all grievance 3 years from the issurdecision.  This REQUIREMENT by:  Based on resident in clinical record review	specific allegations; sing immediate action to tial violations of any resident diviolation is being  483.12(c)(1), immediately violations involving neglect, ries of unknown source, son of resident property, by rvices on behalf of the instrator of the provider; and law; vritten grievance decisions grievance was received, a sof the resident's grievance, restigate the grievance, a ment findings or conclusions at's concerns(s), a statement evance was confirmed or not cive action taken or to be a result of the grievance, en decision was issued; e corrective action in e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents'	F 5	85			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
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F 585	missing personal ite the survey sample,  The findings included.  The facility staff fail grievance regarding (boot to keep the hemoisture and keep a timely manner for R32 was admitted that included but we and chronic ulcer or On the most recent quarterly assessment reference date) of 515 out of 15 on the mental status), indicognitively intact for Section G document assistance of two opersonal hygiene a one person for dres R32 using a wheeld limitations in range extremities. Section	reported grievance for a em for one of 33 residents in Resident #32 (R32).  e: ed to respond to a known g a missing Prevalon boot eel lifted off the bed, wick the foot and ankle in place) in R32.  o the facility with diagnoses ere not limited to paraplegia	F 5			
	On 7/19/2022 at 12 conducted with R32 special boots with a supposed to wear tworn out and would stated that the supp	:59 p.m., an interview was 2. R32 stated that they had a hard bottom that they were but the pair they had were I not fasten anymore. R32 bly clerk had ordered for them but they had never				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		' '	COMPLETED
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
F 585	had re-evaluated the wear the boots for the another pair. R32 sthe boots in about sthey had were worn that when they check the new boots they already received the reported that they depair that was ordere physical therapist by them.  Review of the facility to the present were grievances for R32 Prevalon Boots.  The comprehensive documented in part, (activities of daily live deficit r/t (related to) Mobility, Limited RC Paraplegia. Date In care plan further do at risk for skin break paraplegia, anxiety, infection), Afib (atria vascular disease), in incontinence of bow (history) of altered se sacrum, right should 06/26/2021. Revisic "Interventions" it does boots to bilateral fee 03/14/2022"	em and recommended they me supply clerk to order tated that they had not worn ix months because the ones and did not work. R32 stated exed the status of the order for were told that they had em. R32 stated that they had id not have the replacement of to the social worker and the at no one had followed up with a grievances from 12/20/2020 reviewed, there were no related to the missing  care plan for R32  "[Name of R32] has an ADL ring) self-care performance  Impaired balance, Limited of (range of motion), itiated: 01/20/2021" The cumented, "[Name of R32] is adown r/t disease process: complicated UTI (urinary tract all fibrillation), PVD (peripheral mpaired mobility, fragile skin, rel, suprapubic catheter, hx skin integrity: scarring:	F 5	85		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION  NG	l <sup>(X</sup>	3) DATE SURVEY COMPLETED
		495361	B. WING _			C
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	433301		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		07/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	bilateral feet as need (every) shift"  On 7/20/2022 at 3:3 conducted with OSN central supply. OSN boots were ordered department. OSM # evaluated and deter they would come to them. OSM #11 sta OSM #13, the direct to order the boots for they had ordered the delivered them to provide them to the that the facility would as they were approved they were approved they had arrived and beed On 7/20/2022 at 4:0 conducted with OSN physical therapy ass R32 had reported the broken and they had a new one. OSM #1 had come in and the OSM #13 stated that them that they had r #13 stated that they stated that the facility the grievance to the stated that the facility of the stated that the facility of the stated that the facility shifts"	22. Prevalon boots to ded, check skin integrity Q  3 p.m., an interview was (other staff member) #11,	F	585		
		gs. OSM #13 stated that the investigated by the social lve it.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3	) DATE SURVEY COMPLETED
		495361	B. WING			C
	ROVIDER OR SUPPLIER  WOODBRIDGE, LLC	493301		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		07/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 585	conducted with OSM assistant and OSM services. OSM #3 signievance regarding that it was in the gridentry for the survey. It a grievance was book, and stated the again and their officithat it was reported sometimes give mis because they show stated that if the booreplace it.  On 7/20/2022 at app #11, central supply order dated 3/25/20 AFO Boot." OSM # when the boot was a the facility policy "C Grievance" dated 10"The intent of this resident's right to vote about treatment, calcothing, or violation after receiving a coractively seeks a resappropriately apprise resolution. Prompt of	2 p.m., an interview was M #12, social services #3, the director of social stated that they had received a a missing boot for R32 and evance book provided on OSM #3 was made aware is not found in the grievance at they would check the book is to find it. OSM #3 stated about 3 weeks ago and they sing items a little more time up out of no where. OSM #3 of was not found they would proximately 4:30 p.m., OSM provided a copy of a purchase 22 for a "SoftProAmbulating 11 stated that 3/25/2022 was	F 5	85		
	residentsThe residence expectations of care should address those	o the behavior of other dent should have reasonable e and services and the center be expectations in a timely, ansistent mannerAn				

	OF DEFICIENCIES CORRECTION						
						(	
		495361	B. WING _			07/	21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY /OODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622 SS=E	resident, family membrinitiate a Complaint/G equivalentOriginal growth submitted to the Grievi further actionThe growth completed in a reason should not exceed 14 voicing the grievance communication with the grievance resolution with the grievance resident upon requestion with the grievance resident made aware of the commander of the grievance of the commander of the commander of the grievance of t	complaint/grievance from a per and/or visitor shall rievance Form or electronic grievance forms are then vance Officer /designee for rievance follow-up should be hable time frame; this daysThe individual shall receive follow up the resolution, a copy of the will be provided to the t"  coximately 9:45 a.m., ASM member) #1, the executive director of nursing and ASM for of clinical services were encern.  In was presented prior to exit. The Requirements i)(ii)(2)(i)-(iii)  and discharge-requirements-remit each resident to and not transfer or the facility unless-scharge is necessary for the difference is health has improved dent no longer needs the the facility; viduals in the facility is e clinical or behavioral		585			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495361	B. WING				C
NAME OF B	20,4252.02.0422452	433301	B: Wiito _			07/	21/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	F WOODBRIDGE, LLC				906 JEFFERSON DAVIS HIGHWAY		
				W	OODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	(D) The health of indivotherwise be endange (E) The resident has appropriate notice, to under Medicare or Filter or Sident who become admission to a facility resident while the app § 431.230 of this charge notice from 431.220(a)(3) of this or discharge or transfer or safety of the reside facility. The facility medical return or Medicare or Medicare or Medicare or Sident under any of in paragraphs (c)(1)(i) section, the facility medical record and a communicated to the institution or provider. (i) Documentation in the must include:	viduals in the facility would bered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party hird party, including the decision of the pay for his or her stay. For a seligible for Medicaid after the facility may charge a se charges under Medicaid; as to operate. On transfer or discharge the decision of the facility pursuant to other, when a resident ght to appeal a transfer or the facility pursuant to schapter, unless the failure to would endanger the health and or other individuals in the ust document the danger or discharge would pose.  The facility pursuant to seem of the facility pursuant to such a president ght to appeal a transfer or the facility pursuant to seem of the facility pursuant to seem of the facility pursuant to such a president the control of the facility pursuant to such a president to such a president to such a president to the facility pursuant to such a president to such a presiden	F 6	322	1.The facility recognizes that it was unal provide complete hospital transfer documentation for Residents #37, 40, 35 1.  2.All residents that are transferred to the hospital are at risk to be impacted by the alleged deficient practice.  A quality review was conducted by the Director of Clinical Services)/designee or residents discharged to the hospital since 1 to gauge hospital transfer documentation 1 to gauge hospital transfer documentation required upon discharge The IDT will review hospital transfers in meeting to ensure hospital transfer documentation was provided to the hospital to conduct quality monitoring of transfer residents' medical record to ensure properties to ensure properties to the Quality Monitoring so be reported to the Quality Monitoring's to be reported to the Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regin Director of Clinical Services) / designee.	DCS of e July ion. I by nsfer the AM oital. gnee ed er eveekly	9/1/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495361	B. WING			07/	21/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	F WOODBRIDGE, LLC			1	4906 JEFFERSON DAVIS HIGHWAY		
LIVOIO	WOODBINDOL, LLO			V	VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	section, the specific robe met, facility attempreds, and the service facility to meet the ne (ii) The documentation (2)(i) of this section met. (A) The resident's phydischarge is necessare (A) or (B) of this section. (B) A physician when necessary under parathis section. (iii) Information provide must include a minimeration (A) Contact information responsible for the care (B) Resident represer contact information (C) Advance Directive (D) All special instruction ongoing care, as apple (E) Comprehensive of (F) All other necessare copy of the resident's consistent with §483.3 any other documentation as afe and effective to the transport of the resident's consistent with safe and effective to the transport of the resident's consistent with safe and effective to the transport of the resident's complaint investigation facility staff failed to prequired information of the required informatio	agraph (c)(1)(i)(A) of this esident need(s) that cannot onto to meet the resident e available at the receiving ed(s).  In required by paragraph (c) must be made by-ysician when transfer or rry under paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of elect to the receiving provider um of the following: on of the practitioner are of the resident. Intative information including enter information for ropriate.  In are plan goals; rry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure transition of care.  It is not met as evidenced in the survey and in the course of a sin, it was determined the provided evidence that all was provided to the hospital of residents in the survey ared to the hospital;	F	622			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		495361	B. WING _				
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	COMPLETED  C  07/21/202  SS, CITY, STATE, ZIP CODE  ON DAVIS HIGHWAY  E, VA 22191  PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE  COMPLETED  (COMPLETED  (COMPL		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
F 622	Continued From page	e 31	F 6	522			
	The findings include:						
	required resident info	led to evidence provision of rmation to a receiving facility ge for Resident #37. nsferred to the hospital on					
	5/16/16 with diagnosi	mitted to the facility on s that included but were not renal disease, diabetes and encephalopathy.					
	ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident review of the MDS Secoded the resident as assistance for bed mygiene and bathing; and independence for	erly assessment, with an ference date) of 5/21/22, s scoring a 14 out of 15 on iew for mental status) score, t was cognitively intact. A ection G-functional status					
	2/26/22, which reveal on Hemodialysis via I related to End Stage to hospital for clogge	ommunicate with dialysis ialysis 3 times/week:					
		clinical record failed to entation of any documents;					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		OATE SURVEY COMPLETED
		495361	B. WING _			C
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	19999		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	I	07/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	goals, having been transfer.  A review of the facil Document Checklis tool)", "Copies of Document Patient (cl. 2014 transfer form a 4.current medication (medication adminis (Situation, Backgron Recommendation) a condition progress a Documents recommendation progress and the sed ocuments recommended by the sed ocument for the	dent information and care plan sent to the hospital upon ities "Acute Care Transfer t (INTERACT version 4.0 ocuments sent with neck all that apply): dated are enclosed 3.face sheet in list or current MAR stration record) 5.SBAR und, Assessment, and and/or other change in includes the following: nended to accompany Resident/Patient transfer formings identified on e if completed 6.Advance	F	<u> </u>		
	which is to contain to off front page which to keep with the res  An interview was co	on the front of an envelope the forms and includes a tear reveals, "Tear off front page ident's medical record.  Onducted on 7/20/22 at 9:30 sed practical nurse) #3. When tion is provided to the hospital				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	DE	GITZ IIZGZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE
F 622	upon transfer of a resyou a sample of what the acute care facility checklist and we tear go to medical records.  An interview was cor PM, with OSM (other medical records coor has copies of the transand shown the regional were made aware of what top form and was document checklist expage.  A review of the facility Notification and Right 9/2017, revealed the Notice: The written recollection to which the discharged; A statem rights including the nemail), and telephon receives such requestion an appeal form	sident, LPN #3 stated, "I'll get t we send with the resident to y. It is a transfer document off the top copy, it should s."  Inducted on 7/20/22 at 2:12 of staff member) #6, the redinator. When asked if she enser document checklist, for document checklist, offer document of the fer or first asked as shown the transfer envelop with the tear off front of the opening of the entity dated following: "Contents of the resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; The resident is transferred or the offer or discharge; or the or the offer or discharge; or the o	F	522		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495361	B. WING				21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 011	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	email) and telephone Long-Term Care Omk Transfer or Discharge and document sufficie orientation, in a form resident understands transfer or discharge.  No further information  2. The facility staff fai required resident info at the time of discharg Resident #40 was tra 3/22/22, 4/1/22, 4/12/ Resident #40 was ad 2/18/22 with diagnosi limited to: hemiplegia mellitus and cerebrov  The most recent MDS assessment, a quarte ARD (assessment ref coded the resident as the BIMS (brief interv indicating the resident review of the MDS Se coded the resident as assistance for bed mo hygiene; supervision dependence for bathi  Further review of the evidence any docume medication list, resident	name, address (mailing and number of the State oudsman. Orientation for e: The Center must provide ent preparation and and manner that the to ensure safe and orderly "  In was provided prior to exit.  Iled to evidence provision of rmation to a receiving facility ge for Resident #40.  Insferred to the hospital on 122 and 4/26/22.  Imitted to the facility on so that included but were not the hemiparesis, diabetes rescular disease.  In the first of the facility on so that included but were not the hemiparesis, diabetes rescular disease.  In the first of the facility on so that included but were not the hemiparesis, diabetes rescular disease.  In the first of the facility on so that included but were not the hemiparesis, diabetes rescular disease.  In the first of the facility on so that included but were not the first of the facility on second of the facility on seco	F	622			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	, ,	ATE SURVEY OMPLETED
		495361	B. WING			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191		0772172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 35	F 62	22		
	2/19/22, which reveal has (chronic) pain re Diabetes, and back pto pain per resident's evaluation related to 4/1/2022. 4/12 sent resident. 4/15 medicunrelieved pain. 4/20 pain. INTERVENTIC effectiveness of pain Review for compliant dosing schedules an	pain. ER evaluation related request 3/22/22. ER pain per residents request to ER for unrelieved pain per particular adjustment related to 6/22 Sent to ER for chest				
	Document Checklist tool)", "Copies of Doc Resident/Patient (che 2014 transfer form at 4.current medication (medication administ (Situation, Backgrout Recommendation) at condition progress in Documents recommeresident/patient: 1.R 2.Personal belonging resident/patient note Directives 7.Advance Send these documer recent history and ph discharge summary (physician/nurse pracand Specialist orders results 6.relevant x-race	eck all that apply): dated re enclosed 3.face sheet list or current MAR ration record) 5.SBAR and, Assessment, and and/or other change in cludes the following: ended to accompany esident/Patient transfer form as identified on if completed 6.Advance ac Care Orders. ats if available: 1.most pysical 2.recent hospital				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING  A. BUILDING				ATE SURVEY DMPLETED			
		495361	B. WING	<del></del> -		C 07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	DEPARTMENT: Ple documents are forwarchis resident/patient.  This checklist was on which is to contain the off front page which to keep with the resident of the was conformed with the resident of the was asked what informat upon transfer of a regular you a sample of what the acute care facility checklist and we teat go to medical record.  An interview was conformed in the was conformed	hecklist. EMERGENCY ase ensure that these anded to the hospital unit if is admitted."  In the front of an envelope are forms and includes a tear reveals, "Tear off front page dent's medical record.  Inducted on 7/20/22 at 9:30 and practical nurse) #3. When on is provided to the hospital sident, LPN #3 stated, "I'll get to two send with the resident to y. It is a transfer document off the top copy, it should so."  Inducted on 7/20/22 at 2:12 are staff member) #6, the redinator. When asked if she insfer document checklist, for document checklist, osh onot get a copy of that for the original property of the form of it to the hospital with the climately 5:30 PM, ASM	F 62	2			
	A review of the facilit	ies "Transfer/Discharge it to Appeal" policy dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495361	B. WING		07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 622	Notice: The written recollowing: The reason for transference of transference of transformation to which the discharged; A statem rights including the nemail), and telephone receives such requesobtain an appeal form completing the form a hearing request; The email) and telephone Long-Term Care Omit Transfer or Discharge and document sufficiorientation, in a form resident understands transfer or discharge No further information 3. The facility staff farequired resident information at the time of dischar Resident #350 was to 1/11/22.  Resident #350 was to 1/129/21 with diagnolimited to: atrial fibrill coronary artery disease.  The most recent MDS assessment, a 5 day an ARD (assessment coded the resident as	following: "Contents of the notice must include the fer or discharge; The resident is transferred or tent of the resident's appeal ame, address (mailing and enumber of the entity which st; and information on how to mand assistance in and submitting the appeal name, address (mailing and enumber of the State budsman. Orientation for the entity preparation and and manner that the state to ensure safe and orderly the manufacture of the state and orderly the state of the entity provide the entity preparation and the manufacture of the state and orderly the state of the ensure safe and orderly the ensure safe and order	F 622			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	COMPLETED	<b>'</b>
		495361	B. WING		07/21/202	2
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		1 0/12/12/22	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPL	(5) LETION ATE
F 622	impaired. A review of G-functional status requiring extensive transfer, dressing at eating and total dep Further review of the evidence any docur medication list, resignals, having been transfer.  A review of the com 12/18/21, which review an ADL (activiting performance deficit stroke. INTERVEN ADLs. A second for revealed "FOCUS: cooperate with care nursing home, personal medication and refused medication and refused medication refuses to be turned INTERVENTIONS: decisions about treasense of control. If ADLs so that the redecision making produced in the produced in the facil Document Checklisticol)", "Copies of Document Checklistico	of the MDS Section coded the resident as assistance for bed mobility, and hygiene; supervision for bendence for bathing.  e clinical record failed to mentation of any documents; dent information and care plan sent to the hospital upon  aprehensive care plan dated realed, "FOCUS: The resident resident does not related to limited mobility and TIONS: Provide assist with all cus dated 12/30/21, which The resident does not related to adjustment to conal choice: refuses reses to allow staff to change brief, refusing shower, prior to wound care and and repositioned by staff. Allow the resident to make atment regime to provide a possible, negotiate a time for sident participates in the coess."	F 62	22		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, 50.25.	_		С	
		495361	B. WING			07/	21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	2.Personal belonging resident/patient note in Directives 7.Advance Send these document recent history and phydischarge summary (physician/nurse pract and Specialist orders results 6.relevant x-rat results 7.SNF/NF (skif facility) capabilities of DEPARTMENT: Pleat documents are forwarthis resident/patient is This checklist was on which is to contain the off front page which reto keep with the resident An interview was con AM with LPN (license asked what informatic upon transfer of a resyou a sample of what the acute care facility checklist and we tear go to medical records  An interview was con PM, with OSM (other medical records coord has copies of the transfer of the residual records cords).	ad, Assessment, and addor other change in cludes the following: anded to accompany esident/Patient transfer form is identified on if completed 6.Advance Care Orders. Its if available: 1.most ysical 2.recent hospital 3.recent MD/NP/PA attitioner/physician assistant) 4.Flow sheets 5.relevant lab mays and other diagnostic test and other diagnostic test and other diagnostic test and other diagnostic test and includes a tear eveals, "Tear off front page ent's medical record.  The front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.  In the front of an envelope ent's medical record.	F	622			

PRINTED: 08/02/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495361	B. WING				24/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC	10000		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	<u>  077.</u>	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	medical records. I do it. I bet they send all resident."  On 7/20/22 at approx (administrative staff n administrator, ASM # ASM #3, the regional were made aware of what top form and shichecklist envelop with A review of the faciliti Notification and Right 9/2017, revealed the Notice: The written n following: The reason for transfeffective date of translocation to which the discharged; A statem rights including the naemail), and telephone receives such reques obtain an appeal form completing the form a hearing request; The email) and telephone Long-Term Care Ombores Transfer or Discharge and document sufficient orientation, in a form resident understands transfer or discharge.  No further information 4. The facility staff fai	not get a copy of that for the not know what they do with of it to the hospital with the simately 5:30 PM, ASM nember) #1, the 2, the director of nursing and director of clinical services the findings. ASM #1 asked own the transfer document in the tear off front page.  Transfer/Discharge to Appeal" policy dated following: "Contents of the otice must include the error discharge; The resident is transferred or ent of the resident's appeal ame, address (mailing and enumber of the entity which t; and information on how to an and assistance in and submitting the appeal name, address (mailing and number of the State pudsman. Orientation for extra the content of the center must provide ent preparation and and manner that the to ensure safe and orderly	F	622			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495361	B. WING		C 07/21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191	WINE    12022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 622	On the most recent assessment, an ann assessment reference resident was coded term memory difficult. The Change In Cond 12:35 p.m. documer facility, report receive rounds done, treatmeroom to do (their) treesident twitching arwriter, writer rush to (blood pressure),90 (temperature) o2 (ox MD (medical doctor) documented, "new cresident to hospital I (emergency ambula a.m.) 911 call, at 073 the facility, at 0745, resident via stretche of) the ER nurse, RF aware resident sister Further review of the evidence any documedication list, residents and commedication list, residents was made approximately 12:30 of 7/21/2022 at 10:0 provide any further considerations.	MDS (minimum data set) ual assessment, with an ce date of 7/7/2022, the as having both short and long lties.  dition form dated 5/4/2022 at need in part, "On arrival at the ed from the outgoing nurse, ent nurse went to Resident eatment and observed nd jerging (sic) she alerted the room vs done 132/94 (heart rate),98.0 kygen) sat (saturation) 88-90. In notified." The form further order in place to transfer ER (emergency room) via 911 nnce service). At 0720 (7:20 30 (7:30 a.m.) 911 arrived at 911 left the facility with the er. Report given to KD (initials or (responsible party) made or in law and brother."  et clinical record failed to mentation of any documents; dent information and care plan sent to the hospital upon	F 62	22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495361	B. WING				21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	practical nurse) #5 or When asked what do the hospital when a re #5 stated they send the SBAR (change in concontrol sheet that inclimedication list and be where that is docume clinical record and on resident's information tore off the first copy envelope to keep at the she did not remember ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made as on 7/21/2022 at 10:00	ducted with LPN (licensed in 7/21/2022 at 7:40 a.m. cuments the nurses send to resident is transferred, LPN in the face sheet, care plan, addition form), an infection reduced immunization status, and hold notice. When asked rented, LPN #5 stated in the rented in it. When asked if she of the multiple copies on the facility, LPN #5 stated in the rearing anything off.	F	622			
F 623 SS=E	S483.15(c)(3) Notice Before a facility transing resident, the facility modified in the reasons for the modified must send a control of the reasons for the modified must send a control of the Long-Term Care Ombodischarge in the resident reasons for the Long-Term Care Ombodischarge in the resident send a control of the Long-Term Care Ombodischarge in the resident send send send send send send send send	before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman.	F	623			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPARTMENT OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495361	B. WING			l	C <b>/21/2022</b>
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14	REET ADDRESS, CITY, STATE, ZIP CODE 906 JEFFERSON DAVIS HIGHWAY OODBRIDGE, VA 22191	, <u> </u>	ZIIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required unimade by the facility at resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's health of individual this section; (C) An immediate transferred by the resident under paragraph (c)(1) (E) A resident has not days.  §483.15(c)(5) Contennotice specified in paramust include the follow (i) The reason for transferred or dischard (iii) The location to what transferred or dischard (iv) A statement of the including the name, a and telephone number	ce the items described in is section.  of the notice. If in paragraphs (c)(4)(ii) and the notice of transfer or or ider this section must be a least 30 days before the ideast 30 days before the ideas soon as practicable charge when-riduals in the facility would paragraph (c)(1)(i)(C) of ideast in the facility would paragraph (c)(1)(i)(D) of ideast in the facility would reparagraph (c)(1)(i)(D) of ideast in the facility would reparagraph (c)(1)(i)(D) of ideast in the facility would reparagraph (c)(1)(i)(D) of ideast in the facility for ideast in the facility for 30 in	F 6	23	1.The facility recognizes that it was un to provide written RP notification for resident #37, #40, #29 and #1.  2.All residents that are transferred to the hospital are at risk to be impacted by the alleged deficient practice.  A quality review was conducted by the (Director of Clinical Services)/designer residents discharged to the hospital sit July 1 to gauge written RP/Ombudsman notification documentation.  3.All licensed nurses and Social Works be re-educated by the DCS/designee related to hospital transfer and RP/Ombudsman notification/documentation required upon discharge.  The IDT will review hospital transfer ar/Ombudsman notification/documentation the AM meeting to ensure RP's and Ombudsman are notified when resider are transferred to the hospital.  4.The ED (Executive Director)/DCS/designee to conduct question of transferred residents' mercord to ensure proper documentation provided to the hospital weekly x 6 we The findings of these	DCS e of nce an er will on the deficients	9/1/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING	<del></del>		C <b>7/21/2022</b>	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623	hearing request; (v) The name, addrest telephone number of Long-Term Care Omb (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disabilities of the Act Codification of the Case of facility the administrator of the State Survey A State Long-Term Care	orm and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental isabilities, the mailing and lephone number of the or the protection and alls with a mental disorder e Protection and Advocacy uals Act.	F 62	23			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251	_		С	
		495361	B. WING			07/	21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	by: Based on staff interviand facility document the facility staff failed written RP (responsib notification was provid Residents #37, #40, # The findings include:  1. The facility staff fail written RP notification #37. Resident #37 woon 6/27/22.  Resident #37 was add 5/16/16 with diagnosis limited to: end stage remellitus, heart failure  The most recent MDS assessment, a quarte ARD (assessment refeoded the resident as the BIMS (brief intervindicating the resident review of the MDS Secoded the resident as assistance for bed monthlygiene and bathing; and independence for procedures/treatment dialysis "no".  A review of the comprise the staff of the staff of the comprise the staff of th	is not met as evidenced iew, clinical record review review, it was determined to provide evidence of le party) and/or ombudsman ded for 4 of 33 residents, \$29 and \$1.  Ided to evidence provision of a was provided for Resident as transferred to the hospital  mitted to the facility on as that included but were not renal disease, diabetes and encephalopathy.  Is (minimum data set) arry assessment, with an arrence date) of 5/21/22, as coring a 14 out of 15 on a liew for mental status) score, at was cognitively intact. A action G-functional status	F	523			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		1 01/21/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	related to End Stage to hospital for clogge INTERVENTIONS: Clacility as needed. Description of acility acility acility as needed. Description of acility a	Left arterial-venous Fistula Renal Disease. Transferred d AV shunt 6/27/22. communicate with dialysis dialysis 3 times/week: d Saturday.  Inducted on 7/20/22 at 7:45 ded practical nurse) #3. When de of RP or ombudsman ded upon transfer of a resident d stated, we call the family, t know that we send anything do anything with the  Inducted on 7/20/22 at 2:33 staff member) #3, the vices. When asked what inbudsman notification is der of a resident to the sted, the ombudsman rechair for your residents.  Inducted on 7/21/22 at 7:41 Then asked what evidence of otification is provided upon to the hospital, LPN #3 mily, we do not give them we do not do anything with  Inducted on 5:30 PM, ASM member) #1, the difference of clinical services the findings.	F 6	23		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495361	B. WING		C 07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP COI 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 623	following, "All signification documented. This is transfer, discharges roommate, signification systems, etc."  No further information in the facility staff for	inti/2014, revealed the icant family contact will be should include discussion of a problem with care or not changes in family support on was provided prior to exit.  Intelligible to evidence provision of the p	F 62	3		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495361	B. WING		C 07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 0112112022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI	
F 623	pain. INTERVENTIC effectiveness of pair Review for compliant dosing schedules ar results, impact on fur cognition."  An interview was concent asked what evidence notification is provided to the hospital, LPN the doctor and do not to them. We do not ombudsman.  An interview was concent provided upon transportation of RP or one provided upon transportation is by your concent asked with LPN #3 standification is by your concentration of a resident stated, we call the far anything in writing.	16/22 Sent to ER for chest ONS: Evaluate the interventions (q shift) are, alleviating of symptoms, and resident satisfaction with notional ability and impact on inducted on 7/20/22 at 7:45 ed practical nurse) #3. When e of RP or ombudsman ed upon transfer of a resident #3 stated, we call the family, of know that we send anything do anything with the inducted on 7/20/22 at 2:33 is staff member) #3, the vices. When asked what imbudsman notification is fer of a resident to the lated, the ombudsman in chair for your residents.  Inducted on 7/21/22 at 7:41 when asked what evidence of notification is provided upon at to the hospital, LPN #3 amily, we do not give them to the lated, the director of nursing and all director of clinical services.	F 62	23		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		495361	B. WING _			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	I	0112112022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	following, "All significon documented. This significant systems, etc."  No further information in the facility staff facility resident was coded to the most recent assessment, an annuassessment referent resident was coded term memory difficulated the compact of the control of	ty's policy "Family 1/2014, revealed the cant family contact will be hould include discussion of problem with care or not changes in family support on was provided prior to exit. Called to provide the resident party with a written notification cansfer to the hospital on not #1 (R1).  MDS (minimum data set) qual assessment, with an oce date of 7/7/2022, the cas having both short and long lities.  dition form dated 5/4/2022 at noted in part, "On arrival at the lead from the outgoing nurse, the nurse went to Resident catment and observed and jerging (sic) she alerted the room vs done 132/94	F 6	23		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3	) DATE SURVEY COMPLETED
		495361	B. WING _			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	1111		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	<u> </u>	07/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	evidence any docur notification to the reparty for the reason hospital.  A request was madapproximately 12:30 of a written notificated on 7/21/22 8:34 a.r. # 3, the social work form, "Virginia Invol Notice." with R1's name was documented nelonger meet the resident's name was documented nelonger meet the resident party), they use this ombudsman.  ASM (administrative executive director, where the secutive director, which was documented nelonger meet the resident party), they use this ombudsman.  ASM (administrative executive director, which was documented nelonger meet the resident party), they use this ombudsman.  ASM (administrative executive director, which was a services were made on 7/21/2022 at 10:10.10.  No further information of the reason for Resident party of the reason for Resident party of the reason for the r	e clinical record failed to mentation of a written esident and/or responsible for the transfer to the e on 7/20/2022 at 0 p.m. for the documentation ion.  m., OSM (other staff member) er. OSM # 3 presented a untary Transfer/Discharge ame. The form documented a date of transfer and an X ext to: "The facility can no ident's medical needs." OSM o't give the Transfer/Discharge and/or RP (responsible form to notify the estaff member) #1, the estaff member is estaff member is estaff member) #1, the estaff member is estaff member	F6	23		
	assessment, a quar assessment referer	MDS (minimum data set) terly assessment, with an nce date of 7/15/2022, the 2 out of 15 on the BIMS (brief				

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) IDENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY COMPLETED		
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		0112 H2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	resident is moderatel making daily decision.  The nurse's note date documented, " Patier pain around 11:40am notified. Order receiv	status) score, indicating the ly cognitively impaired for loss.  ed 7/18/2022 at 2:31 p.m. lost c/o (complained of) chest loss.  MD (medical doctor) was lost losend Patient to ER for	Fé	523		
	came in around 11:4: plan, transfer form, fa advance directive an given to paramedics. (name of Charge Nu	911. 911 was called and 8am. Medication list, care ace sheet, recent labs d bed hold policy for were Report was called in to rse). Emergency contact contact) is oriented to the				
	evidence any docum notification to the res party for the reason f hospital.  A request was made	ident and/or responsible for the transfer to the				
	of the written notifica On 7/21/22 8:34 a.m # 3, the social worke form, "Virginia Involu Notice." with R29's n the resident's name, was documented new longer meet the resid # 3 stated, they don't form to the resident a party), they use this to ombudsman. OSM #	tion.  ., OSM (other staff member) r. OSM # 3 presented a ntary Transfer/Discharge ame. The form documented date of transfer and an X kt to: "The facility can no lent's medical needs." OSM give the Transfer/Discharge and/or RP (responsible				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		405204				С	
		495361	B. WING _		07	/21/2022	
	ROVIDER OR SUPPLIER  WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 623	on 7/21/2022 at 10:00  No further information	nt. staff member) #1, the SM #2, the director of the director of clinical aware of the above concern		623			
SS=E	S483.15(d) Notice of I §483.15(d) (1) Notice nursing facility transfethe resident goes on a nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume resfacility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi paragraph (e)(1) of the resident to return; and (iv) The information so of this section.  §483.15(d)(2) Bed-hot the time of transfer of hospitalization or ther facility must provide to	ped-hold policy and return- before transfer. Before a ers a resident to a hospital or cherapeutic leave, the provide written information to ent representative that  state bed-hold policy, if resident is permitted to sidence in the nursing  ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a d pecified in paragraph (e)(1)  Id notice upon transfer. At a resident for apeutic leave, a nursing					

		TE SURVEY MPLETED				
	495361	B. WING			C 07/21/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		772172022	
			14906 JEFFERSON DAVIS HIGHWAY			
ENVOY OF WOODBRIDGE, LLC			WOODBRIDGE, VA 22191			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
described in paragraph This REQUIREMENT by: Based on staff intervitand facility document the facility staff failed hold notification was presidents in the surveto the hospital; Resident The findings include:  1. The facility staff failed hold notification facility staff fail bed hold notification facility staff fail bed hold notification facility was transferred to Resident #37 was and 5/16/16 with diagnosis limited to: end stage ranellitus, heart failure  The most recent MDS assessment, a quarter ARD (assessment refered to the resident as the BIMS (brief intervitational the resident as assistance for bed monthly indicating the resident as as as as as a second the resident as a	of the bed-hold policy on (d)(1) of this section. It is not met as evidenced sew, clinical record review review, it was determined to provide evidence that bed provided when 3 out of 33 ye sample were transferred ents #37, #40 and #1.  The ded to evidence provision of or Resident #37. Resident to the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.  The mitted to the facility on the hospital on 6/27/22.	F 6.	25 1.The facility recognizes that it wa provide evidence of offered bed h Residents #37, 40 upon transfer the Both residents returned back to the Prisk to be impacted by the alleged practice.  A quality review was conducted by (Director of Clinical Services)/deshospital transfers since July 1 to goompliance with bed hold policy.  3.All licensed nurses will be re-ed DCS/designee related to the bed and documentation.  The IDT will review hospital transferenting to ensure documentation policy being provided at time of transfers in the provident of the documentation of bed hold policy at time of transfer weekly x 6 weefindings of these quality monitorin reported to the Quality Assurance Improvement Committee monthly Monitoring schedule modified bas with quarterly monitoring by the R (Regional Director of Clinical Services).	old for o the hospital ne facility.  nospital are at deficient  y the DCS ignee of gauge  lucated by the hold policy  fers in the AM of bed hold ansfer.  esignee to harged re being offered ks. The g's to be yellows. Quality sed on finding: DCS	9/1/2022	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 011	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	bed hold. When aske the bed hold, LPN #3 records has it.  An interview was con PM with OSM (other smedical records coordevidence of bed hold records, OSM #6 statthose residents.  On 7/20/22 at approx (administrative staff madministrator, ASM #. ASM #3, the regional were made aware of ASM #2 verified therefor this resident.  A review of the facility 11/2017, which reveat Representative will be at the time of transfer therapeutic leave) of according to Federal  No further information  2. The facility staff failed hold notification of #40 was transferred to 4/1/22, 4/12/22 and 4. Resident #40 was add 2/18/22 with diagnosi	al, LPN #3 stated, we send a d if there is any evidence of stated, maybe medical  ducted on 7/20/22 at 2:12 staff member) #6, the dinator. When asked what there was in the medical ed there is not bed hold for imately 5:30 PM, ASM nember) #1, the 2, the director of nursing and director of clinical services the findings. ASM #1 and a was not bed hold evidence  by "S "Bed Hold" policy dated led, "Resident or Resident e notified on admission, and to the hospital or the bed hold policies, and/or State requirements."  In was provided prior to exit.  Iled to evidence provision of for Resident #40. Resident of the hospital on 3/22/22, /26/22.  mitted to the facility on s that included but were not, hemiparesis, diabetes	F	625			

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	<b>495361</b> B.	B. WING		C <b>07/21/2022</b>	
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191	01/21/2022	
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE.	
The most recent MDS (minimulassessment, a quarterly assessment, a quarterly assessment reference of coded the resident as scoring the BIMS (brief interview for mindicating the resident was cogreview of the MDS Section G-flooded the resident as requiring assistance for bed mobility, transpigner; supervision for eating dependence for bathing.  An interview was conducted on AM with LPN (licensed practice asked if a bed hold is provided resident to the hospital, LPN #bed hold. When asked if there the bed hold, LPN #3 stated, in records has it.  An interview was conducted on PM with OSM (other staff memmedical records coordinator. Nevidence of bed hold there was records, OSM #6 stated, there those residents.  On 7/20/22 at approximately 5 (administrative staff member): administrative staff member): administrator, ASM #2, the director of were made aware of the findin ASM #3, the regional director of were made aware of the findin ASM #2 verified there was not for this resident.  A review of the facility's "Bed H1/2017, which revealed, "Reseresentative will be notified."	esment, with an ate) of 5/28/22, a 14 out of 15 on pental status) score, gnitively intact. A functional status g extensive ensfer, dressing and g and total	F 6.	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODI 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 625	Continued From page at the time of transfer therapeutic leave) of according to Federal	(to the hospital or	F 6	25		
	3. The facility staff fai	n was provided prior to exit. led to provide a bed hold o the hospital on 5/4/2022				
	assessment, an annu assessment reference	IDS (minimum data set) al assessment, with an e date of 7/7/2022, the s having both short and long es.				
	12:35 p.m. document facility, report receive rounds done, treatmer room to do (their) treat resident twitching and writer, writer rush to t (blood pressure),90 ((temperature) o2 (oxy MD (medical doctor) documented, "new or resident to hospital E (emergency ambulan a.m.) 911 call, at 073 the facility, at 0745, 9 resident via stretcher of) the ER nurse, RP aware resident sister	d jerging (sic) she alerted the room vs done 132/94 the art rate),98.0 trgen) sat (saturation) 88-90. the proof of the form further der in place to transfer R (emergency room) via 911 to the service). At 0720 (7:20 to (7:30 a.m.) 911 arrived at 11 left the facility with the Report given to KD (initials (responsible party) made in law and brother."				
	evidence any docume	clinical record failed to entation of a bed hold notice esident and/or responsible on 5/4/2022.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495361	B. WING			07/	21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY /OODBRIDGE, VA 22191		
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F 636 SS=D	the bed hold notice w As of 7/21/2022 at 10 provide any further do notice was provided to responsible party upo ASM #1 stated they h related to the bed hold  ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made a on 7/21/2022 at 10:00  No further information Comprehensive Asse CFR(s): 483.20(b)(1)(s)  §483.20 Resident Ass The facility must conca a comprehensive, acc reproducible assessm functional capacity.  §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resic goals, life history and	on 7/20/2022 at co.m. for the documentation as provided upon transfer. 1:00 a.m. the facility did not ocumentation that a bed hold to the resident and/or on transfer to the hospital. It and no further information do notification for R1.  Staff member) #1, the SM #2, the director of the director of clinical aware of the above concern to a.m.  In was provided prior to exit. It is saments & Timing (2)(i)(iii)  Seessment duct initially and periodically curate, standardized ment of each resident's sent Assessment Instrument. In comprehensive dent's needs, strengths, preferences, using the		636			
	by CMS. The assess the following:						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	A. BUILDING COM			LETED
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 1906 JEFFERSON DAVIS HIGHWAY OODBRIDGE, VA 22191	011	Z 172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	(v) Vision.  (vi) Mood and behave (vii) Psychological were (viii) Physical function (ix) Continence.  (x) Disease diagnosis (xi) Dental and nutriti (xii) Skin Conditions.  (xii) Activity pursuit.  (xiv) Medications.  (xv) Special treatmer (xvi) Discharge plant (xvii) Documentation regarding the addition on the care areas trighted Minimum Data Scotti (xviii) Documentation assessment. The assinclude direct observed with the resident, as licensed and nonliced members on all shifts (x483.20(b)(2) When timeframes prescribed chapter, a facility mutassessment of a resitimeframes specified through (iii) of this seprescribed in §413.3-apply to CAHs.  (i) Within 14 calendal excluding readmission in mental condition. (For "readmission" means in the condition in the condit	for patterns. fell-being. fining and structural problems. for and health conditions. for and health conditions. for and procedures. fining. for summary information final assessment performed figered by the completion of fet (MDS). for participation in finitesessment process must fation and communication finitesessment process for a trequired. Subject to the finitesessment process for a trequired for a comprehensive for a comp	F	336	1. Resident #25 was screened for ther 7/21/2022  2. All residents have the potential to be affected. A quality monitoring audit will be comp to ensure that all ordered therapy scre have been completed as ordered.  3. The IDT will be education by the ED/designee regarding carrying out screens/orders as indicated. IDT team will review and identify any residents with a change in functional s in the AM meeting. The MDS Coordina submit a list of residents weekly to the nursing leadership team and therapy of for screening.  4. The ED (Executive Director)/DCS/designee to conduct quamonitoring of residents with screen or ensure appropriate follow up weekly x weeks. The findings of these quality monitoring be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the RDCS (ReDirector of Clinical Services) / designe	leted ens tatus attor will lept.	9/1/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC	433301		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		07/21/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 636	This REQUIREMENT by: Based on staff inter and clinical record of facility staff failed to assessment with a cliving) status for one sample, Resident #2  The findings include On the most recent assessment, a quar ARD (assessment of the resident scored (brief interview for of the resident is mode making daily decision Status, the resident extensive assistance physical assistance transfers, moving or personal hygiene ar coded as requiring somember physical as The MDS prior to the assessment, with an resident scored a 10 indicating the reside impaired for making - Functional Status, independent with semoving in the bed, the hygiene. The reside limited assistance of toileting. The activity	ce every 12 months.  IT is not met as evidenced  rview, facility document review eview, it was determined the complete a comprehensive change in ADL (activity of daily e of 33 residents in the survey 25 (R25).  E:  MDS (minimum data set) terly assessment, with an eference date) of 5/22/2022, a 10 out of 15 on the BIMS mental status) score, indicating erately cognitively impaired for ons. In Section G - Functional was coded as requiring e of one staff member for moving in the bed, in the unit, dressing, toileting, and bathing. The resident was supervision with one staff	F 6	36			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 01/21/2022
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F 636	once and required s staff.  An interview was co nurse) #2, the MDS 3:25 p.m. RN #2 wa MDS assessments of requested to look in survey team. RN #2 granddaughter was closer to her and that that had caused a b asked to explain wh assessment was no	ge 60 ng off the unit, only occurred et up assistance from the  nducted with RN (registered coordinator, on 7/20/2022 at s asked to review the two documented above. RN #2 to it and get back to the returned and stated that the trying to find placement at did not occur. RN #2 stated it of depression. RN #2 was y a significant change t completed when there was dent's functional status. RN	F 63	· ·	
	#2 was also asked to consults for this decompleted. On 7/20/2022 at 4:00 was no therapy scresignificant change a completed, RN #2 so that. When asked if assessment and a robeen completed due resident's functional believe it was an own significant change at The RAI (resident as manual, documente change" is a major or resident's status that itself without interve implementing standarinterventions, the designed in the resident's properties of the resident's status that itself without interve implementing standarinterventions, the designed in the resident's properties of the resident properties of the resident's properties of the resident properties of the	o provide any therapy line in condition.  1 p.m. RN #2 stated there sen done. When asked why a ssessment was not tated she could not answer a significant change eferral to therapy should have to the decline in the status, RN #2 stated, I ersight. It should have been a ssessment completed.  ssessment instrument) d in part, "A "significant decline or improvement in a t: 1. Will not normally resolve			

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IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
member) #1, the #2, the director of clinical re of the above concern	F6	336			
assessments. curately reflect the not met as evidenced resident interview, and clinical record I the facility staff failed to ssment for one of 33 complete an accurate cannual assessment for ed to the facility on at included but were not I disease, diabetes encephalopathy. inimum data set) assessment, with an	F	541			
	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  and/or revision of the care  member) #1, the #2, the director of director of clinical re of the above concern  see sessments. curately reflect the not met as evidenced resident interview, and clinical record I the facility staff failed to ssment for one of 33  complete an accurate annual assessment for  ed to the facility on at included but were not I disease, diabetes encephalopathy.  inimum data set)	A. BUILDIE  495361  B. WING  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  Formula in the director of director of clinical region of the above concerns.  See Seessments.  Curately reflect the resident interview, and clinical record  The facility staff failed to sement for one of 33  Complete an accurate rannual assessment for set to the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at included but were not I disease, diabetes encephalopathy.  In the facility on at the facility on at included but were not I disease, diabetes encephalopathy.	A BUILDING  495361  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  14906 JEFFERSON DAVIS HICHWAY  WOODBRIDGE, VA 22191  ENT OF DEFICIENCIES STS BE PRECEDED BY FULL JENTIFYING INFORMATION)  F 636  F 636  F 636  F 641  SSESSMENTS.  Currately reflect the not met as evidenced resident interview, and clinical record the facility staff failed to ssment for one of 33  complete an accurate annual assessment for  ad to the facility on at included but were not I disease, diabetes encephalopathy.  Inimum data set) INIMUM STREET ADDRESS, CITY, STATE, ZIP COD  14906 JEFFERSON DAVIS HICHWAY WOODBRIDGE, VA 22191  PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)  F 636  F 641  SSESSMENTS.  CURRECTIVE ACTION (EACH CORRECTIVE ACTION) F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  F 641  SSESSMENTS.  COMPLETE AND PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) F 636  F 641  SSESSMENTS.  F 641  SSESSMENTS.  F 641  SSESSMENTS.  F 641  SSESSMENTS.  SSESS	A BUILDING  A 95361  A 95361  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191  PROVIDER'S PLAN OF CORRECTION  SET BE PRECEDED BY FULL  DENTIFYING INFORMATION)  F 636  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191  PROVIDER'S PLAN OF CORRECTION  CROSS-REFERENCED TO THE APPROPRIAT  DEFICIENCY)  F 636  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191  PROVIDER'S PLAN OF CORRECTION  CROSS-REFERENCED TO THE APPROPRIAT  DEFICIENCY)  F 636  F 636  F 641  SSESSMENTS.  Curately reflect the  not met as evidenced  resident interview, and clinical record  Ithe facility staff failed to  ssment for one of 33  complete an accurate  annual assessment for  at included but were not  I disease, diabetes  encephalopathy.  inimum data set)  ssessment, with an  coed date) of 5/21/22,  ring a 14 out of 15 on	

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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		<u> </u>	1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 641	review of the MDS Secoded the resident as assistance for bed mon hygiene and bathing; and independence for procedures/treatment dialysis "no".  A review of the composite 2/26/22, which reveal on Hemodialysis via Larelated to End Stage to hospital for clogged INTERVENTIONS: Confacility as needed. Dial Tuesday, Thursday & A review of physician revealed the following week, Tuesday, Thursday & A interview was comply with RN (registere coordinator. When as Section O for Resider MDS, that should not dialysis resident and this myself. I will do a asked what standard a MDS, RN #2 stated (resident assessment On 7/20/22 at approx (administrative staff in administrator, ASM #5	t was cognitively intact. A action G-functional status requiring extensive obility, transfer, dressing, supervision for locomotion reating. Section O-special scoded the resident as rehensive care plan dated ed, "FOCUS: The resident is ceft arterial-venous Fistula Renal Disease. Transferred AV shunt 6/27/22. In the summaricate with dialysis alysis 3 times/week: Saturday.  Orders, dated 10/21/20, plansfer,	F 6		1.Resident #37 had a modified MDS to their dialysis status.  RN #2 was re-educated on coding section the MDS correctly.  2.All residents on dialysis caseload are for being impacted by the alleged deficie practice.  A quality review was conducted by the Information (Director of Clinical Services)/designed residents' on dialysis section O to ensurt accuracy.  3.The MDS coordinator will be re-educated the DCS/designed related to section O completion per the RAI.  The MDS coordinator will have the DCS review section O of any dialysis resident to submission to validate accuracy.  4.The Regional MDS coordinator/design conduct quality monitoring of dialysis reand their MDS section O weekly x 6 were the findings of these quality monitoring reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regionical Services) / designed 5.9/1/2022	on O of at risk ent  OCS of e ted by t prior nee to sidents eks. s to be	9/1/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER  WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	11/2014, reveals the f conducts initial and po- comprehensive and re- less than every three including, but not limit regarding functional s weaknesses and pref	r's policy "MDS" dated following, "The center eriodic standardized, eproducible assessments no months for each resident ted to, the collection of data status, strengths, erences using the federal RAI. Procedure: Each section or portion of a gns the Attestation	F	641			
F 656 SS=E	No further information Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each resersident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483.	ensive Care Plans comprehensive cantered comprehensive person-centered comprehensive care plans comprehensive com	F	856			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING		1	C / <b>21/2022</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY	1 077	21/2022	
ENVOY O	F WOODBRIDGE, LLC			WOODBRIDGE, VA 22191			
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F 656	rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representat (A) The resident's god desired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's community was assest local contact agencie entities, for this purpor (C) Discharge plans it plan, as appropriate, requirements set forth section.  This REQUIREMENT by:  Based on observation document review and facility staff failed to it comprehensive care if the survey sample, R #83 and #94.  The findings include:  1. The facility staff fail #82's (R82) comprehensive	ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and eference and potential for ilities must document as desire to return to the assed and any referrals to as and/or other appropriate ase. In the comprehensive care in accordance with the in in paragraph (c) of this  is not met as evidenced In, staff interview, facility clinical record review, the inplement the colan for 6 of 33 residents in esidents #82, #88, #37, #25,  Iled to implement Resident ensive care plan for weights	F 65	1.Resident #82's medical recorreviewed and updated as indicacare plan.  Resident #83 Care Plan was reupdated to reflect Hospice coop Hospice plan of care assessme were obtained and uploaded or 8/2/2022  Resident #88's medical record reviewed and updated as indicacare plan.  Resident #94's oxygen was immat 2L/min as prescribed by the Care Plan updated.  Resident #37's medical record/communication book was revieupdated as indicated.  Resident #25 was evaluated fo services.  2.All residents with daily weight dialysis and requiring a therapy at risk to be impacted by the all deficient practice.  A quality review was conducted (Director of Clinical Services)/d residents with daily weight orde weights are being obtained as of A quality review was conducted DCS/designee of dialysis commonly the sum of the process of the services of DCS/designee of those needing screens to ensure they are considered by the all of the process of the services of DCS/designee of those needing screens to ensure they are considered by the sum of the process of the services in the process of the services of the process of the pro	exiewed and per the exiewed and per tion. Ent notes in PCC on was ated per the mediately set physician.  Idialysis wed and in the rapy is orders, on excreen are leged if by the DCS esignee of ers to ensure ordered. If by the munication is to the general per the general	9/1/2022	
	quarterly assessment reference date) of 6/3	IDS (minimum data set), a with an ARD (assessment 60/22, the resident scored 9 6 (brief interview for mental		3.All licenses nurses and theral be re-educated by the DCS/des related to following orders and to include obtaining daily weight compliance with dialysis community therapy screens completed as	py staff will signee plans of care its, unication and		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC	455501		STF	REET ADDRESS, CITY, STATE, ZIP CODE  906 JEFFERSON DAVIS HIGHWAY  DODBRIDGE, VA 22191	<u>  071</u>	/21/2022
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F 656	status), indicating the cognitively impaired  R82's comprehensive documented, "(R82) ineffective breathing status due to: CHF (failure)weights as clinical record revea 6/3/22 for daily weight clinical record only refollowing dates: 6/7/  On 7/20/22 at 3:24 preconducted with LPN LPN #4 stated the pweights is to monito weight, residents who weight, residents who weight and residents stated the order for on the MAR (medicated the CNAs (cerobtain daily weights the weights on the MN weights on the MN weights were do 2022 or July 2022 MN On 7/20/22 at 4:01 preconducted with LPN purpose of the care current condition of nurses can ensure the residents' care plans.  On 7/20/22 at 5:37 preconducted to the care current condition of nurses can ensure the residents' care plans.	e resident was moderately for making daily decisions.  The care plan dated 10/2/18 The	F	656	The IDT will review daily weight and oxygen records in the AM meeting to determine compliance. They will als review dialysis communication in the meeting to ensure each visit has a communication sheet present. The also review orders for therapy scree ensure they are completed as indicated.  4. The ED (Executive Director)/DCS/designee to conduct of monitoring of 10 records to ensure of weights obtained, therapy screens completed and dialysis communications sheets are present weekly x 6 week findings of these quality monitoring's reported to the Quality Assurance/Performance Improveme Committee monthly. Quality Monitor schedule modified based on findings quarterly monitoring by the RDCS (Regional Director of Clinical Service designee.	o AM  DT will his and ted.  quality aily on s. The to be nt ng with	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	<b>,</b>	OTT 1/2022	
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F 656	Continued From pa	•	F 6	56			
	Individualized Person plan of care by the I No further information 2. The facility staff for #88's (R88) compressions and the staff for the st						
	quarterly assessme reference date) of 7 out of 15 on the BIM status), indicating the cognitively impaired.  A review of R88's claphysician's order date for CHF (congestive comprehensive care documented, "The realluredaily weug	esident has Congestive Heart nt (sic)" Further review of I only revealed weights for the					
	conducted with LPN LPN #4 stated the p weights is to monito weight, residents wh weight and resident stated the order for on the MAR (medication TAR (treatment adm	o.m., an interview was I (licensed practical nurse) #4. Purpose of obtaining daily It residents who are losing It on are gaining too much It is who have CHF. LPN #4 It daily weights should appear It is attached and administration record) or It inistration record). LPN #4 It is attached and inistration record). LPN #4 It is attached and inistration administration assistants)					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING				21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	the weights on the Market No weights were door 2022 or July 2022 Market 2022 or July 2022 Market 2022 or July 2022 Market 2022 at 4:01 p. conducted with LPN 4 purpose of the care pourrent condition of the nurses can ensure the residents' care plans.  On 7/20/22 at 5:37 p. staff member) #1 (the ASM #2 (the director aware of the above converse of the above cannot be supported by the staff fail comprehensive care proposed in the Resident #37.  Resident #37 was ad 5/16/16 with diagnosi limited to: end stage is mellitus, heart failure.  The most recent MDS assessment red coded the resident as the BIMS (brief intervindicating the resident as assistance for bed market as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as assistance for bed market 2022 at 4:01 p. conducted the resident as a 4:01 p. conducted the resident as a 4:01 p. conducted the resident as a 4:01 p. conducted the resident as 4:01 p. conducted the resident as 4:01 p.	men the nurses document AR or TAR.  Jumented on R88's June ARs or TARs.  Im., another interview was 44. LPN #4 stated the lan is to know the status and he residents. LPN #4 stated ey are implementing by reviewing the care plans.  Im., ASM (administrative executive director) and of nursing) were made oncern.  In was presented prior to exit.  Just the dialysis care for mitted to the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the dialysis care for mitted to the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the dialysis care for mitted to the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the dialysis care for mitted to the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the facility on so that included but were not renal disease, diabetes and encephalopathy.  Just the facility on so that included but were not renal disease, diabetes and encephalopathy.	F	656			

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		495361	B. WING			·	21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE  4906 JEFFERSON DAVIS HIGHWAY  NOODBRIDGE, VA 22191	1 077	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	procedures/treatment dialysis "no".  A review of the composition of th	reating. Section O-special is coded the resident as  rehensive care plan dated ed, "FOCUS: The resident is Left arterial-venous Fistula Renal Disease. Transferred d AV shunt 6/27/22.  communicate with dialysis alysis 3 times/week: Saturday.  orders, dated 10/21/20, g, "Dialysis three times a saday and Saturday @  #37's dialysis revealed missing dialysis facility for 21 of 52 e/22.  ducted on 7/20/22 at 9:30 d practical nurse) #3. When the care plan, LPN #3 of the care plan is to insure interventions that are unique	F	656			
	asked if this informati care plan being follow	sing assessments. When on is not provided, is the ved, LPN #3 stated if the implemented then the care					

	TEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	ATE SURVEY OMPLETED				
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191				
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F 656	(administrative staff administrator, ASM ASM #2, the region were made aware of the facil dated 9/2017, which implement an Indivicomprehensive plan Interdisciplinary Teal limited to - the atternurse with responsibility of food and nutrition appropriate staff or determined by the repracticable, the part the resident's representation or maintain the practicable physical well-being as requir regulatory requirem as applicable."	lowed.  eximately 5:30 PM, ASM member) #1, the #2, the director of nursing and al director of clinical services of the findings.  ity's "Plans of Care" policy n revealed, "Develop and dualized Person-Centered of care by the m that includes but is not ading physician, a registered bility for the resident, a nurse ility for the resident, a member n services staff, and other professionals in disciplines as esident's needs or as sident, and, to the extent ticipation of the resident and	F 6	56				
	evaluate Resident # On the most recent assessment, a quar	e plan to have therapy #25 (R25). MDS (minimum data set) terly assessment, with an eference date) of 5/22/2022,						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	DE	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 656	the resident scored a (brief interview for me the resident is moder making daily decision Status, the resident wextensive assistance physical assistance for transfers, moving on personal hygiene and coded as requiring somember physical assistance of the decision of the	and 10 out of 15 on the BIMS ental status) score, indicating rately cognitively impaired for the staff code of the unit, dressing, toileting, distance for eating.  The resident was supervision with one staff sistance for eating.  The 15/22/2022, an annual ARD of 2/10/2022, the out of 15 on the BIMS score, and is moderately cognitively daily decisions. In Section GR25 was coded as being up assistance only for ansfers, eating and personal at was coded as requiring one staff member for of moving on the unit, only o assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the staff. The unit, only occurred et up assistance from the unit, only of the unit, only occurred et up assistance from the unit, only of the unit, only occurred et up assistance from the unit, only occurred	F	556		

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		495361	B. WING _			1	21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY /OODBRIDGE, VA 22191		
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F 656	that implementing the no.  An interview was connurse) #2, the MDS of 3:25 p.m. When aske consults for the declir status, RN # 2 stated survey team.  On 7/20/2022 at 4:01 was no therapy scree believe it was an oversignificant change asstherapy screen should An interview was conmember) #12, the direction of the therapy depart that are in need of the	ducted with RN (registered coordinator, on 7/20/2022 at d to provide any therapy in in the resident's functional she would get back to the p.m. RN #2 stated there in done. RN #2 stated, I resight. It should have been a sessment completed and a d have been completed.  ducted with OSM (other staff fector of therapy, on in. When asked the process the grapy, OSM #12 stated that disher a list of resident to	F	356	DEFICIENCY)		
	R25 since his 5/22/20 #12 stated she had la January of this year (in therapy has worked we assessment, OSM #1 ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made as on 7/20/2022 at 5:23	with him since the MDS 2 stated, no.  Staff member) #1, the SM #2, the director of the director of clinical aware of the above concern					

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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 011	21/2022
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F 656	On the most recent Massessment, a signification with an assessment of the resident scored a (brief interview for methe resident was sever making daily decision Treatments, Proceduresident was not code.  The comprehensive of documented in part, "prognosis r/t (related hospice) DX: Alzheim documented in part, "hospice team to ensure emotional, intellectual are met."  The physician order of documented, "Reside hospice) DX (diagnos of hospice) (phone not questions, concerns of Review of the clinical documentation or not company.  A request was made approximately 11:00 a notes.	led to implement the clan to work cooperatively of for Resident #83 (R83).  IDS (minimum data set) cant change assessment, reference date of 7/1/2022, 6 out of 15 on the BIMS rental status) score, indicating rely cognitively impaired for s. In Section O - Special res and Programs, the red as being on hospice.  Fare plan dated, 6/21/2022, The resident has a terminal resident has a terminal resident has a terminal resident has a terminal resident spiritual, 1, physical and social needs  Fated, 6/21/2022, rent admitted to (name of sis) - Alzheimer's. Call (name umber of hospice) with any or change in condition."  Faced failed to evidence resident from the hospice care  a.m. for the hospice care	F	656			

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F 656	(administrative staff r director. The fax informotes was dated 7/20 asked where these in stated he would have nursing) were he obtained from asked if the intervention and the in	were provided by ASM nember) #1, the executive mation on the tops of the 1/2022 at 4:55 p.m. When otes came from, ASM #1 to ask the DON (director of ained them from.  In p.m. an interview was (licensed practical nurse) # care plan states an intervention is not followed, is a care plan, LPN #2 stated,  If a.m. an interview was #2, the director of nursing. The above notes were the stated the hospice last night. When asked if eady been in the record, ASM asked the process for ince notes in the facility, ASM of fax the notes to medical y scan them in. When asked munication between the ty, ASM #2 stated the facility ille there are here, or we call to with the physician. ASM #2 sice staff come in they speak where the documentation of care	F6	56		

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F 656	scanned them, they them in the charts. A me their notes and I about (the name of the for R83, OSM #6 state any hospice notes. Oshe were talking on obtain those records.  ASM #1, the executive director of nursing, a clinical services, were concern on 7/21/202. No further information.  6. The facility staff factomprehensive care ordered for Resident. On the most recent is assessment, an annuassessment reference resident was not cook nurse's notes it is do refused to answer the Special Treatments, the resident was not. The comprehensive documented in part, therapy r/t (related to The "Interventions" of as ordered."	don't give me notes. I see All the doctor's email or fax scan them in." When asked he hospice company caring ted, she had never scanned DSM #6 stated the DON and working on a process to  We director, ASM #2, the nd ASM #3 the director of e made aware of the above 2 at 10:00 a.m.  In was provided prior to exit.  MDS (minimum data set) and assessment, with an active date of 7/7/2022, the ed for cognitive. In the cumented the resident e questions. In Section O-Procedures and Programs, coded as using oxygen.  Care plan dated 1/3/2020, "Focus: (R94) is on oxygen of all all assessments of the above 2 at 1/3/2020, "Focus: (R94) is on oxygen of all all all all all all all all all al	F 65	56		

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	ROVIDER OR SUPPLIER  WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		-
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F 656	approximately 12:00 pthe oxygen on via a nation concentrator was set ball sitting on the 1.5 on the 2.0 line.  A second observation 2:48 p.m. The oxygen cannula. The oxygen the top of the ball sitting for 2.0. LPN (licensed asked to read the oxygen was touching the 2.0 plan states to adminisit not being given perimplementing the care ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made as on 7/20/2022 at 5:23	le of R94 on 7/19/2022 at p.m. R94 was in the bed with asal cannula. The oxygen with the bottom of the black line and the top of the ball was made on 7/20/2022 at a was in use via nasal concentrator was set with any just under the black line at practical nurse) # 2, was gen concentrator, LPN #2 is set at 1.5. When asked en concentrator, LPN #2 be at the top of the ball line. When asked if the care ster oxygen as ordered and er the physician order, is that it is plan, LPN #2 stated, no.	F	656			
F 660 SS=D	Discharge Planning F CFR(s): 483.21(c)(1)( §483.21(c)(1) Dischar The facility must deve effective discharge pl	'rocess i)-(ix)	F	660			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING		C 07/21/2022	
NAME OF D	ROVIDER OR SUPPLIER	40001	1	STREET ADDRESS, CITY, STATE, ZIP CODE	071	21/2022
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ENVOY O	F WOODBRIDGE, LLC			14906 JEFFERSON DAVIS HIGHWAY		
				WOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660	transition them to pos reduction of factors le readmissions. The factors le resident are identified development of a discresident.  (ii) Include regular reidentify changes that it discharge plan. The dupdated, as needed, to updated, as needed, to lii) Involve the interdiscipt §483.21(b)(2)(ii), it developing the dischargive le discharge needs.  (v) Consider caregive and the resident's or operson(s) capacity an required care, as part discharge needs.  (v) Involve the resider representative in the odischarge plan and in resident representative (vi) Address the resident reatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities must up comprehensive care presents in the comprehen	ve partners and effectively t-discharge care, and the ading to preventable cility's discharge planning sistent with the discharge 15(b) as applicable and-charge needs of each and result in the charge plan for each evaluation of residents to require modification of the ischarge plan must be to reflect these changes. Sciplinary team, as defined in the ongoing process of rege plan.  Er/support person availability caregiver's/support dicapability to perform of the identification of the identification of the form the resident and the of the final plan. The ent's goals of care and so the community. The caresident has been asked receiving information the community. Cates an interest in returning facility must document any act agencies or other ade for this purpose.	F 6	1. The Plan of care was reviewed and for residents R32. Resident has decided discharge.  2. Residents who plan to discharge be community or another facility are at ris being impacted by the alleged deficient practice.  A quality review was conducted by the of those residents requesting discharge community to ensure discharge plannibeing coordinated.  3. The SSD will be re-educated by the ED/designee related to discharge plan expectations.  The IDT will discuss those residents we discharge in the AM meeting to ensure appropriate discharge planning in accounting the plan of care is completed.  4. The ED (Executive Director)/DCS/deto conduct quality monitoring of resider request discharge medical records to appropriate discharge planning in proceeding the properties of the second conduct quality monitoring of the second conduct quality and to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the RDCS (Republication of Clinical Services) / designed the plan of care is completed.	ed not to ck to the c for t  ED/SSD e to the ng is  ning shing to ordance signee ets that ensure ess e quality ity  I ith gional	9/1/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		495361	B. WING _		C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 660	appropriate entities. (C) If discharge to the to not be feasible, the made the determinati (viii) For residents wh SNF or who are discharced to avoid unnecessary discharge or transfer. This REQUIREMENT by:  Based on resident in clinical record review review, it was determ failed to actively assis survey sample with determination the control of the c	contact agencies or other community is determined facility must document who on and why. o are transferred to another larged to a HHA, IRF, or s and their resident ecting a post-acute care a that includes, but is not IRF, or LTCH standardized ata, data on quality on resource use to the extent The facility must ensure that tandardized patient a on quality measures, and is relevant and applicable to f care and treatment ete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the scussed with the resident or tive. All relevant resident incorporated into the litate its implementation and delays in the resident's	F 6	60		

PRINTED: 08/02/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING				21/ <b>2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	requested by R32 to the facility.  R32 was admitted to that included but were On the most recent M quarterly assessment reference date) of 5/2 15 out of 15 on the B mental status), indica cognitively intact for r Section G documente and having functional motion in both lower of On 7/19/2022 at 12:5 conducted with R32. paralyzed and used a day. R32 stated that discharge from the fa assistance from the fa assistance from the fa they were told that the family had to arrange wanted to leave. R32 worker had provided VA (veterans adminis for them to call and tr they had not been ab stated that they felt the have better access to than they did and shounders to call. R32 eventually like to discant apartment with an	I to actively participate when coordinate a discharge from the facility with diagnoses a not limited to paraplegia.  IDS (minimum data set), a with an ARD (assessment 20/2022, the resident scored IMS (brief interview for ting the resident was making daily decisions. and R32 using a wheelchair limitations in range of	F	660			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		<b>495361</b> B. W				C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP COL 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 660	that they had advised wanted to discharge they felt that they did term care facility. R3 asked the social world discharging them from that it was their job to send them out when off of them.  The comprehensive of documented in part, discharged to another machines that can as Initiated: 02/09/2021. Under "Interventions' "Establish a pre-discharging the progress and Date Initiated: 02/09/further documented, (activities of daily living deficit r/t (related to) Mobility, Limited RON Paraplegia. Date Initiated: 02/09/paraplegia. Date Initiated: 02/0	ed at the facility. R32 stated at the facility staff that they from the facility because not need to be in a long size stated that when they ker to assist them in the facility they were told be keep them there, not to they were "making money"  Care plan for R32  "[Name of R32 wishes to be refacility that has the rehabisist him walk again. Date Revision on: 04/13/2022."  "It documented in part, harge plan with the presentative/caregivers and derevise plan as needed. 2021" The care plan  "[Name of R32] has an ADL high self-care performance Impaired balance, Limited of (range of motion), siated: 01/20/2021"  Or R32 documented in part, 1:47 p.m.) Social Service to fe R32] wanting to be refacility that has specific the thinks will benefit him on all service again shared with refacilities do not have the esires."  1:09 p.m.) Social Service  1:10 Text: Resident was giving	F 66				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495361	B. WING	B. WING		C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 0111	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	call as well and left a intake specialist].  - "2/17/2022 09:52 (9 Progress Note. Note information again to ti [Name of VA Center]. lost the original sheet him prior to his recent was encouraged to mintake department for as well as rehab. Resto walk again with the equipment that most have but possibly the have."  - "2/23/2022 13:50 (1 Progress Note. Note if he got in touch with [Name of VA Center]. messages with admiscall back. Writer encotelephone operator to (public address) systems, "3/18/2022 12:21 (1) Progress Note. Note by the SSD (social set to reach the intake con VA Center]. He stated successful in reaching and has left message he never received and department and had the "4/7/2022 13:55 (1:5) Progress Note. Write to see if he has follow discharge from the far Administration Center.	hone number]. Writer did voicemail for [Name of	F	660			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 0112112022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 660	plan/IDT (interdisciple discuss residents plate [Name of R32] is aled place and time) and assist with ADL's He transfer to a VA facility Discussed residents facility and the require him regarding this transfer to a VA facility and the require him regarding this transfer to a Variety acknowledged under with the current plan - "4/22/2022 11:10 (1 Progress Note. Write to see if he has follow discharge from the fact Administration Center information of some scontact." - "6/8/2022 13:36 (1:: plan/IDT team met to of care, resident atteremain the same, he (discharge) plan is to Resident request for (due to) decline in fur submitted. Staff will cof care." - "7/14/2022 14:40 (2 Progress Note. Note resident to review ever transfer to a Veteran centers for some specimic want to go to a minary to go to a minary the therapy man has given resident so	calls." :19 p.m.) Note Text: Care inary team) team met to n of care, resident attended. It and oriented x3 (person, requires limited to extensive te is a full code, would like to the for therapy services desire to transfer to another ements and expectations of ansition, resident agreed and standing. Staff will continue of care."  1:10 a.m.) Social Service ter spoke with resident today of through on his request to acility into a Veterans r. Writer has given some facility that the resident can as of p.m.) Note Text: Care of discuss the residents plan anded Emergency contacts	F 66	50		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	I		STREET ADDRESS, CITY, STATE, ZIP ( 14906 JEFFERSON DAVIS HIGHWA' WOODBRIDGE, VA 22191	CODE	0172 172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 660	transfer process can resident some facility verify if they have the - "7/14/2022 15:15 (3) Progress Note. Note resident the below Ve and verify if they have looking for to help hir transfer process. VE CENTERS FOR [Nar phone numbers of fiv On 7/20/2022 at 3:43 conducted with OSM director of social serv R32 came from an as building and had unretheir recovery. OSM requested to be discribed by the commended the VA stated that the facility	s looking for before the start. Writer has given and contacts to call and machine he is looking for." :15 p.m.) Social Service Text: Writer has given eterans Health centers to call the therapy machine he is n walk again before the	F	660		
	numbers to them. On not want to transfer to facility because they they wanted and the to remain long term of the conducted with OSM PTA (physical therapy stated that R32 receivance)	p.m., an interview was #13, the director of rehab, y assistant). OSM #13 ved physical and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		495361	B. WING			C <b>7/21/2022</b>
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		772172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 660	realistic and that had them by the facility st #13 stated that they had they go to a spinal condischarged them when using a sliding board OSM #13 stated that to use the standing for they were unable to be stated that they attern R32 but did not feel they for paraplegia they had on 7/20/2022 at 4:22 conducted with OSM assistant and OSM # services. OSM #3 stated that they attern R32. OSM #3 stated fabricate things. OSM client wanted to leave ones who were to held OSM #3 stated that the R32 with additional with the phone numbers to call facility was collecting would they want to girl on 7/21/2022 at 7:50 conducted with ASM member) #1, the exertisted that as long as resident's request for was for the facility stated that they want they want they want they stated that as long as resident's request for was for the facility stated that they want they want they want they want they want to girl on 7/21/2022 at 7:50 conducted with ASM member) #1, the exertisted that as long as resident's request for was for the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that they want to girl on the facility stated that the facility stated that the facility stated the facility stated the facility stated that the facility stated the facility stated the	to walk again which was not been communicated to aff and the physician. OSM had suggested to R32 that rd specialist and they had en they were able to transfer with assistance from staff. initially they had attempted ame equipment with R32 but hear any weight. OSM #13 hipted the parallel bars with hat it was safe with the level d.  p.m., an interview was #12, social services 3, the director of social ated that they had reached diministration in January of rd back from them regarding that at times R32 would M #3 stated that when a exthe facility they were the p in finding the placement. his month they had provided beterans administration facility II. OSM #3 stated that the money from R32 and why we it away.	F 66			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495361	B. WING			07/	21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676 SS=D	11/30/2014, document evaluate the resident' formulate the best platesident. Discharge padmission. The process and family, Care Manand other members of the company of the c	scharge Planning" dated ated in part, "Policy: To shealth status and an of discharge for each planning begins the day of eas involves the resident agement/Social Services of the clinical team"  oximately 9:45 a.m., ASM member) #1, the executive director of nursing and ASM for of clinical services were encern.  In was presented prior to exit. (ADLs)/Mntn Abilities (b)(1)-(5)(i)-(iii)  the comprehensive dent and consistent with the choices, the facility must by care and services to the director of the silicities of consistent unless circumstances ical condition demonstrate was unavoidable. This		660	DEFICIENCY		
		of daily living. ide care and services in graph (a) for the following					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING		C 07/21/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07721	1/2022
				14906 JEFFERSON DAVIS HIGHWAY		
ENVOY O	F WOODBRIDGE, LLC			WOODBRIDGE, VA 22191		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			) BE	(X5) COMPLETION DATE
F 676	activities of daily living §483.24(b)(1) Hygien grooming, and oral ca §483.24(b)(2) Mobility including walking, §483.24(b)(3) Elimina	g: e -bathing, dressing, are, /-transfer and ambulation,	F 67	<ol> <li>Resident #25 was screened for ther 7/21/2022</li> <li>All residents have the potential to be affected.</li> <li>A quality monitoring audit will be compensure that all ordered therapy screen been completed as ordered.</li> <li>The IDT will be education by the ED/designee regarding carrying out screens/orders as indicated.</li> <li>IDT team will review and identify any rwith a change in functional status in the meeting. The MDS Coordinator will sullist of residents weekly to the nursing</li> </ol>	esidents	1/2022
	This REQUIREMENT by: Based on staff interv review, it was determ assess for a decline in	ommunication systems.  is not met as evidenced liew and clinical record lined the facility staff failed to an functional status for one of rvey sample, Resident #25	list of residents weekly to the nursing leadership team and therapy dept. for screening.  4. The ED (Executive Director)/DCS/design to conduct quality monitoring of residents screen orders to ensure appropriate follow weekly x 6 weeks. The findings of these quality in the execution of the execu			
	On the most recent M assessment, a quarte ARD (assessment ref the resident scored a (brief interview for me the resident was mod for making daily decis Functional Status, the requiring extensive as member physical ass bed, transfers, moving	resident was coded as				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER:  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495361	B. WING		C 07/21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		,	1 01/21/2022	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 676	one staff member ph  The MDS prior to the assessment, with an resident scored a 10 indicating the resider impaired for making a Functional Status, Findependent with set moving in the bed, transpired assistance of toileting. The activity occurred once with n The activity of moving the staff of the staff	e 86 as requiring supervision with sysical assistance for eating.  5/22/2022, an annual ARD of 2/10/2022, the out of 15 on the BIMS score, at was moderately cognitively daily decisions. In Section GR25 was coded as being up assistance only for ansfers, eating and personal at was coded as requiring one staff member for of moving on the unit, only o assistance from the staff. It is goff the unit, only occurred at up assistance from the	F 676		
	documented in part, supervision-limited a (activities of daily lividocumented in part, (occupational therapy ordered.  An interview was cornurse) #2, the MDS 3:25 p.m. RN #2 was MDS assessments drequested to look into survey team. RN #2 granddaughter was to closer to her and that thad caused a bit asked to explain why assessment was not	ssist for most ADLs ng)." The "Interventions" "PT (physical therapy) & OT y) evaluate and treat as  aducted with RN (registered coordinator, on 7/20/2022 at asked to review the two ocumented above. RN #2 o it and get back to the returned and stated that the rying to find placement t did not occur. RN #2 stated of depression. RN #2 was			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	•	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 676	was no therapy screes significant change as completed, RN #2 stathat. When asked if a assessment and a rebeen completed due resident's functional shelieve it was an oversignificant change as therapy screen should An interview was commember) #12, the dim 7/20/2022 at 4:19 p.m. for the therapy depart that are in need of the (RN #2) normally sensoreen when she compassessments. When the R25 since his 5/22/20 #12 stated she had be January of this year (therapy has worked wassessment, OSM #1 ASM (administrative executive director, AS nursing, and ASM #3 services were made as on 7/20/2022 at 5:23	provide any therapy ne in condition.  p.m. RN #2 stated there n done. When asked why a sessment was not ated she could not answer significant change ferral to therapy should have to the decline in the status, RN #2 stated, I resight. It should have been a sessment completed and a did have been completed.  ducted with OSM (other staff sector of therapy, on a when asked the process them to screen residents berapy, OSM #12 stated that disher a list of resident to appletes the MDS asked if she had screened to asked if she had screened to asked if with him since the MDS 2 stated, no.  staff member) #1, the SM #2, the director of the director of clinical aware of the above concerning.	F 6	76			
	•	1 a.m. ASM #1 stated the policy on addressing a unctional status.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP (14906 JEFFERSON DAVIS HIGHWA WOODBRIDGE, VA 22191		0112112022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 676	Continued From pag		F	676		
F 677 SS=D	ADL Care Provided f	n was obtained prior to exit. for Dependent Residents )	F	677		
	out activities of daily services to maintain personal and oral hy This REQUIREMEN' by:  Based on resident in clinical record review review, it was determ failed to provide ADL care to dependent refor 2 of 33 residents Resident #32 (R32) at The findings include:  1. The facility staff faresident choice/preferment of 15 on the most recent of quarterly assessment reference date) of 5/15 out of 15 on the Emental status), indicated cognitively intact for Section G document assistance of two or personal hygiene and one person for dress R32 being totally deposition.  On 7/19/2022 at 12:5	T is not met as evidenced  nterview, staff interview, and facility document nined that the facility staff (activities of daily living) esidents per resident choice in the survey sample, and Resident #22 (R22).				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495361	B. WING		C 07/21/2022		
NAME OF PROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP CODE	1 077.	21/2022	
ENVOY OF WOODBRIDGE LLC			14906 JEFFERSON DAVIS HIGHWAY			
ENVOY OF WOODBRIDGE, LLC			WOODBRIDGE, VA 22191			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL : IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
that they had purchased a mesh bottom for the sibeen used. R32 stated that they did not have a asked for a shower. R3 like to take a shower bethe same.  The comprehensive card documented in part, "[National Composition of Paraplegia and Paraplegi	s and that they were not they had not had a been readmitted to the . R32 stated that the assistants) gave them ffer a shower. R32 stated a special lift pad that had hower but it had never that the CNA's told them shower chair when they 2 stated that they would cause a bed bath was not epilon for R32 ame of R32] has an ADL self-care performance baired balance, Limited range of motion), ed: 01/20/2021" The ented, "The resident does (shower) r/t (related to) so to use shower sling 22." Under "Interventions" Allow the resident to make ent regime, to provide nitiated: 03/15/2022"  Ition for R32 dated umented in part, and Friday 3-11 shift (3:00 cumented a shower was 1022 and 5/10/2022.  Ition for R32 dated umented in part, and Friday 3-11 shift." It was not completed on	F 67	1. Shower assistance was immediately provided to residents #22 and #32. 2. All residents are at risk for being imp by the alleged deficient practice.  A quality monitoring audit of all shower to residents for the month of the July 2 was completed to identify residents shower/bathing status.  3. The ADON/designee will provide instonurses and certified nursing assistatensuring that residents are offered shoper their preference on their scheduled shower days. When residents refuse the showers, this will be documented in remedical record.  The IDT will review in the AM meeting shower/bathing documentation to ensus shower/baths are being offered and documented on as indicated.  4. The DCS/designee to conduct qualit monitoring of residents' shower/bathing documentation weekly x 6 weeks to er they are being offered and documente indicated. The findings of these quality monitoring's to be reported to the Quales Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the RDCS (ReDirector of Clinical Services) / designe	service nts in owers denicir sidents' ure  y g sure d on as y vith gional	9/1/2022	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191			1 ONLINEOLE	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pag	e 90	F 67	7			
	documentation of ref dates listed above.	or R32 failed to evidence usal of the showers on the					
	conducted with RN (stated that showers v						
	residents twice a week and per the residents choice. RN #4 stated that a schedule was kept at the nurses station for the CNA's to know which residents were to get showers each day on each shift. RN #4 stated that R32's showers were						
	shift. RN #4 stated t	ays and Fridays on the 3-11 hat they were not aware of owers or not getting showers					
	conducted with LPN LPN #1 stated that s twice a week per the	7 p.m., an interview was (licensed practical nurse) #1. howers were completed shower schedule kept at the					
	two shower rooms or was conducted with l on the unit. Both sho	#1 stated that there were the unit. An observation PN #1 of two shower rooms ower rooms were observed to wer stretcher, two shower					
	chairs and a shower and two shower chai	bench in one shower room rs in the other. LPN #1 not aware of any shortages					
	conducted with OSM the director of rehab, assistant). OSM #13 with R32 in the past. had discharged R32	o p.m., an interview was (other staff member) #13, PTA (physical therapy stated that they had worked OSM #13 stated that they when they were able to no board with assistance.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C 7/ <b>21/2022</b>	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		•	STREET ADDRESS, CITY, STATE, ZIP COD 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 677	worked with R32 to u were not stable enou assisted them to use out in the bottom. Os required one person had spasms in the leg a shower chair or a s that R32 had agreed they had ordered a sit the shower chair.  On 7/20/2022 at 4:39 conducted with CNA #7. CNA #7 stated the schedule in a book at showed them which reach day and each si received showers on that A beds had show B beds had show B beds had showers #7 stated that R32 us transfer with assistan CNA #7 stated that the a shower on the ever On 7/21/2022 at 8:47 conducted with CNA residents received showers wand they received shower on the ever were aware of. CNA assisted R32 to show and they are shown as sisted R32 to show as sisted R32 to s	se a shower bench but they gh to do this so they had a shower chair with a cut SM #13 stated that R32 to assist them because they gs and needed to use either hower bed. OSM #13 stated to use the shower chair so ing with a cut out to use with p.m., an interview was (certified nursing assistant) hat they had a shower the nurses station which residents received showers whift. CNA #7 stated that R32 the day shift. CNA #7 stated the day shift. CNA #7 stated the evening shift and on the evening shift. CNA sed a sliding board to be dead of the even of one staff member. They had never seen R32 take that howers twice a week. CNA orked with R32 on day shift owers then. CNA #2 stated them to chair. CNA #2 stated that when they wer they assisted them to chair. CNA #2 stated that	F 6	77			
	because they were a with assistance of on	ble to transfer themselves e person. CNA #2 stated when in shower chair and					

DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495361	B. WING			C <b>07/21/2022</b>	
OVIDER OR SUPPLIER WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	I	07/21/2022	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
was able to assist in CNA #2 reviewed R for 5/1/2022-5/31/20 and stated that the documented a show stated that there she shower was not given The facility policy "E 11/30/2014 documented at least two provided at least two needed) to cleanse resident shall be as a frequency scheduwill take precedence PRN cleansing. The preferences for batted quarterly during car (administrative staff director, ASM #2, the #3, the regional director aware of the No further information. The facility staff resident choice/preferences for the Control of the most recent quarterly assessments.	an the showering process. 232's shower documentation 222 and 6/1/2022-6/30/2022 dates listed above wer was not given. CNA #2 ould be a note saying why a en.  Bathing/showering" dated ented in part, "Policy: owering and bathing will be rice a week and PRN (as and refresh the resident. The sked on admission to establish alle for bathing. This schedule e over the twice a week and e resident's frequency and hing will be reviewed at least re conference"  proximately 9:45 a.m., ASM f member) #1, the executive ne director of nursing and ASM extor of clinical services were concern.  on was presented prior to exit.  failed to provide showers per ference to R22.  MDS (minimum data set), a ent with an ARD (assessment	F 67	7			
	SUMMARY:  (EACH DEFICIENT REGULATORY OF THE REGU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 was able to assist in the showering process. CNA #2 reviewed R32's shower documentation for 5/1/2022-5/31/2022 and 6/1/2022-6/30/2022 and stated that the dates listed above documented a shower was not given. CNA #2 stated that there should be a note saying why a shower was not given.  The facility policy "Bathing/showering" dated 11/30/2014 documented in part, "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference"  On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern.  No further information was presented prior to exit.  2. The facility staff failed to provide showers per resident choice/preference to R22.  On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	WOODBRIDGE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92  was able to assist in the showering process.  CNA #2 reviewed R32's shower documentation for 5/1/2022-5/31/2022 and 6/1/2022-6/30/2022 and stated that the dates listed above documented a shower was not given. CNA #2 stated that there should be a note saying why a shower was not given.  The facility policy "Bathing/showering" dated 11/30/2014 documented in part, "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference"  On 7/21/2022 at approximately 9:45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern.  No further information was presented prior to exit.  2. The facility staff failed to provide showers per resident choice/preference to R22.  On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	Divider or supplier  WOODBRIDGE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92 was able to assist in the showering process. CNA #2 reviewed R32's shower documentation for 5/1/2022-5/31/2022 and 6/1/2022-6/30/2022 and stated that the dates listed above documented a shower was not given.  The facility policy "Bathing/showering" dated 11/30/2014 documented in part, "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN (deministrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern.  No further information was presented prior to exit.  2. The facility staff failed to provide showers per resident Choice/preference to R22.  On the most recent MDS (minimum data set), a	DYIDER OR SUPPLIER  WOODBRIDGE, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 92  was able to assist in the showering process. CNA #2 reviewed R32's shower documentation for 51/1/2022-3nd 61/1/2022-6/30/2022 and 61/1/2022-6/30/2022 and stated that the dates listed above documented in part, "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice as week and PRN (as needed) to cleanse and refresh the resident. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference"  On 7/21/2022 at approximately 9.45 a.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services were made aware of the concern.  No further information was presented prior to exit.  2. The facility staff failed to provide showers per resident choice/preference to R22.  On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment)	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED		PLE CONSTRUCTION  G	' '	COMPLETED		
		495361	B. WING			C 07/21/2022		
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	07/21/2022			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 677	physical help in part On 7/19/2022 at 1:5 conducted with R22 observed in R22's re had purchased the s use because the cha small for them. R22 their insurance case that they were not re week as scheduled. received a shower of average and would led stated that their shore every Wednesday a offered or given. R2 staff were great and make sure that they did not care.  The comprehensive documented in part, cooperate with care Personal choice Date Initiated: 04/20 it documented in part decisions about treat sense of control. Da "Provide resident with during care provision The care plan furthe R22] is supervision in living) selfcare perfor 05/02/2022." Under documented in part, Provide sponge bath	documented R22 requiring of bathing from one person.  7 p.m., an interview was A shower chair was bom. R22 stated that they shower chair for their personal airs at the facility were too stated that they had called manager last week to report eceiving their showers twice a R22 stated that they noce every three weeks on ike them more often. R22 wers were supposed to be not Saturday but were not the expectation of the would take extra steps to got their shower but some  care plan for R22  "The resident does not (shower) r/t (related to)  /2022." Under "Interventions" t, "Allow the resident to make them tregime [sic], to provide the Initiated: 04/20/2022" and the opportunities for choice in. Date Initiated: 04/20/2022." Indemented, "[Name of with ADL (activities of daily rmance Date Initiated: "Interventions" it "BATHING/SHOWERING: in when a full bath or shower Per resident requested	F 6	77				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		RIPLE CONSTRUCTION  NG	(X3) DATE SURVEY  COMPLETED	
		495361	B. WING _			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		•	STREET ADDRESS, CITY, STATE, ZIP CO 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 677	(3:00 p.m11:00 p.m. not completed on 5/7  The shower documer 6/1/2022-6/30/2022 or "Showers on Wednes shift." It documented 6/8/2022 and 6/11/20 6/22/2022 and 6/25/2 for showering was ob The shower documer 7/1/2022-7/31/2022 or "Showers on Wednes shift." It documented 7/6/2022, 7/9/2022 at The progress notes for documentation of shoulisted above.  On 7/20/2022 at 2:47 conducted with LPN (LPN #1 stated that shiftwice a week per the nurses station. LPN is two shower rooms on that R22 had their ow LPN #1 stated that C refused their shower resident to see if they	ntation for R22 dated locumented in part, sday and Saturday 3-11 shift )." It documented a shower /2022 and 5/11/2022.  Intation for R22 dated locumented in part, sday and Saturday 3-11 a shower not completed on 22. On 6/18/2022, 022 the documentation area served to be blank.  Intation for R22 dated locumented in part, sday and Saturday 3-11 a shower not completed on not 7/13/2022.  Deep R22 failed to evidence lower refusals on the dates of the were shower schedule kept at the #1 stated that there were the unit. LPN #1 stated on shower chair they used. NA's reported if a resident and they talked to the still refused. LPN #1 stated used the shower it was	F	677		

PRINTED: 08/02/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C <b>07/21/2022</b>	
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	conducted with CNA #2. CNA #2 stated the showers twice a week did not work with R22 showers were given a schedule and docume #2 stated that if a resist they informed the nur medical record. CNA documentation for 5/16/1/2022-6/30/2022 a R22 and stated that the documented a shower stated that they should shower was given and shower was given if the blank. CNA #2 stated saying why a shower On 7/21/2022 at appreciation (administrative staff in director, ASM #2, the #3, the regional direct made aware of the converse CFR(s): 483.25	a.m., an interview was (certified nursing assistant) at residents received k. CNA #2 stated that they 2. CNA #2 stated that according to the shower ented in the computer. CNA ident refused their shower se and documented it in the a #2 reviewed the shower 1/2022-5/31/2022, and 7/1/2022-7/31/2022 for the dates listed above ar was not given. CNA #2 Id only document when a documentation was at that there should be a note was not given.  In was presented prior to exit.		677			
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with professions.	nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			l	C <b>21/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	011	21/2022	
					906 JEFFERSON DAVIS HIGHWAY			
ENVOY O	F WOODBRIDGE, LLC				OODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	by: Based on staff intervand clinical record reto provide care and sprofessional standard comprehensive care the survey sample, R#19.  The findings include:  1. The facility staff fair (R82) daily weights p  On the most recent M quarterly assessment reference date) of 6/3 out of 15 on the BIMS status), indicating the cognitively impaired f  R82's comprehensive documented, "(R82) ineffective breathing is status due to: CHF (of failure)weights as oclinical record reveale 6/3/22 for daily weight clinical record only refollowing dates: 6/7/2  On 7/20/22 at 3:24 p. conducted with LPN (LPN #4 stated the puweights is to monitor weight, residents who	sidents' choices.  is not met as evidenced  iew, facility document review view, the facility staff failed ervices in accordance with its of practice and plan for 4 of 33 residents in esidents #82, #88, #83 and  led to obtain Resident's #82 er the physician's orders.  IDS (minimum data set), a twith an ARD (assessment 80/22, the resident scored 9 is (brief interview for mental eresident was moderately for making daily decisions.  In care plan dated 10/2/18 is at risk for alteration patterns and cardiovascular congestive heart fordered" A review of R82's ed a physician's order dated tts. Further review of R82's vealed weights for the 2, 7/6/22 and 7/16/22.	F 6		1.Residents # 88 and #82 were immedia weighed per physician orders and weigh recorded under the weight tab in point of care.  Hospice note was uploaded for Resider (R83) and #19 on 8/2/2022  2.All residents are at risk for being imparaby the alleged deficient practice.  The DON/designee will complete a qual monitoring audit of all residents being with daily, Care Plans and needed hospice resure that physician orders are being followed.  3.The ADON/designee will provide educt to all certified nursing assistants and lice nurses in ensuring that residents who have ordered for daily weights are completed a ordered.  DON will counsel hospice staff to to ensure that Hospice notes are provided timely the IDT will review daily weight documentation and care plans in the All meeting to ensure compliance with documentation.  4.The DCS/designee to conduct quality monitoring of 25% of residents with daily weight orders weekly x 6 weeks to ensure accuracy of setting. The findings of these quality monitoring is to be reported to the Quality Assurance/Performance Improv Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regi Director of Clinical Services) / designee	nts click  at #83  acted  lity reighed notes to  cation ensed ave as  sure	9/1/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495361	B. WING			C <b>07/21/2022</b>		
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC	1		STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191	'	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 684	on the MAR (medica TAR (treatment adm stated the CNAs (ce obtain daily weights the weights on the M No weights were doo 2022 or July 2022 M On 7/20/22 at 5:37 p staff member) #1 (th ASM #2 (the director aware of the above of the physician, PA (pl (advanced registered his/her verbal confirm transcribed to all appelectronic health reconstruction of the physician, PA (pl (advanced registered his/her verbal confirm transcribed to all appelectronic health reconstruction of the physician, PA (pl (advanced registered his/her verbal confirm transcribed to all appelectronic health reconstruction of the physician of the facility stopation of the physician of the provide the facility stopation of the physician of the provide the facility stopation of the physician of the	daily weights should appear tion administration record) or inistration record). LPN #4 rtified nursing assistants) then the nurses document IAR or TAR.  cumented on R82's June ARs or TARs.  c.m., ASM (administrative e executive director) and of nursing) were made concern.  ed, "Physician Orders" reder will be repeated back to hysician assistant) or ARNP dinurse practitioner) for mation. The order is propriate areas of the	F 68	4				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	, ,	COMPLETED		
		495361	B. WING			C <b>07/21/2022</b>	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191		, 0		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	ge 98	F 68	34			
	quarterly assessment reference date) of 7, out of 15 on the BIM status), indicating the cognitively impaired. A review of R88's cliphysician's order date for CHF (congestive comprehensive care documented, "The refailuredaily weughter of the properties of the pr	esident has Congestive Heart nt (sic)" Further review of only revealed weights for the					
	conducted with LPN LPN #4 stated the p weights is to monito weight, residents who weight and residents stated the order for on the MAR (medical TAR (treatment admistated the CNAs (ce	o.m., an interview was (licensed practical nurse) #4. urpose of obtaining daily r residents who are losing to are gaining too much s who have CHF. LPN #4 daily weights should appear ation administration record) or inistration record). LPN #4 rtified nursing assistants) then the nurses document MAR or TAR.					
	2022 or July 2022 M On 7/20/22 at 5:37 p staff member) #1 (th	o.m., ASM (administrative ne executive director) and r of nursing) were made					
	No further information	on was presented prior to exit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING				24/2022
NAME OF PI	ROVIDER OR SUPPLIER	40001	1		STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY	<u>  U//</u>	21/2022
ENVOY O	F WOODBRIDGE, LLC		WOODBRIDGE, VA 22191				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	99	F	684	1		
	_	led to evidence coordination ith the facility for Resident					
	assessment, a signific with an assessment of the resident scored a (brief interview for me the resident was sever making daily decision Treatments, Procedur resident was not code.  The physician order of documented, "Reside hospice) DX (diagnos of hospice) (phone not questions, concerns of the clinical documentation or not company.  The comprehensive of the comprehensive of the resident was not code.	nt admitted to (name of is) - Alzheimer's. Call (name imber of hospice) with any or change n condition."					
	prognosis r/t (related hospice) DX: Alzheim documented in part, "hospice team to ensu emotional, intellectual are met."  A request was made approximately 11:00 a notes.	to) admission to (name of ers." The "Interventions" Work cooperatively with re the resident's spiritual, l, physical and social needs on 7/20/2022 at a.m. for the hospice care					
	On 7/21/2022 at 7:46	a.m. copies of "Client					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING		07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		•	STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		
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F 684	(administrative staff in director. The fax informotes was dated 7/20 asked where these in stated he would have nursing) were he obtained from, ASM when asked where the obtained from, ASM emailed them to him they should have alrewalled them to him they should have alrewalled the hospicarecords and then the should there be comhospice and the facil staff "catch" them whithem, and they speas stated when the hospicare, ASM #2 failed for these conversation care, ASM #2 failed from the medical records the medical records and them, they show hospice note are OSM #6 stated, "To I scanned them, they them in the charts. As the stated in the charts. As the stated in the charts.	eport" for 6/22/2022, 222 were provided by ASM member) #1, the executive rmation on the tops of the 2/2022 at 4:55 p.m. When otes came from, ASM #1 e to ask the DON (director of ained them from.  3 a.m. an interview was #2, the director of nursing. he above notes were #2 stated the hospice last night. When asked if eady been in the record, ASM n asked the process for ice notes in the facility, ASM e fax the notes to medical y scan them in. When asked munication between the ity, ASM #2 stated the facility will there are here, or we call k with the physician. ASM #2 pice staff come in they speak where is the documentation as and the coordination of	F 68	34		
	about (the name of the for R83, OSM #6 sta	ne hospice company caring ted, she had never scanned DSM #6 stated the DON and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP COD 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		0112112022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page 101		F 6	884		
	she were talking on voltain those records	working on a process to				
	part, "To ensure cont center and the hospin Nursing will designat interdisciplinary team included the following plan process betwee Communication with hospice medical dire attending physician to care. Ensure the follobtained from the hoplan of careThe ce includes the most curand the center's plan patient/resident's hig mental and psychosomolecular patient of nursing, a clinical services, were concern on 7/21/202.  No further information 4. The facility staff facil	spice: most recent hospice nter will ensure the care plan rrent hospice plan of care to attain or maintain the hest practicable physical, ocial well-being."  we director, ASM #2, the nd ASM #3 the director of e made aware of the above				
	assessment, a quarter assessment reference resident scored a zero (brief interview for methe resident was sevo	MDS (minimum data set) erly assessment, with an ee date of 5/6/2022, the ro out of 15 on the BIMS ental status) score, indicating erely cognitively impaired for ns. In Section O - Special				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED		
		495361	B. WING _			C 07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		0112112022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	resident was coded a services.  The physician order documented, "Admit home care with term degeneration of the land phone number) or change in condition.  Review of the clinical documentation or no company.  The comprehensive documented in part, prognosis r/t (related of hospice company).  A request was made approximately 11:00 notes.  On 7/21/2022 at 7:46 Coordination Note R 6/30/2022, 7/7/2022 by ASM (administrative executive director. Tops of the notes was p.m. When asked whas #1 stated he would rector of nursing).  On 7/21/2022 at 7:56 conducted with ASM When asked where to obtained from, ASM	dated 8/18/2021, to (name of hospice) routine inal diagnosis of senile brain. Call (name of hospice for any questions, concerns in."  I record failed to evidence tes from the hospice care plan dated, 2/15/2022, "Focus: (R19) has a terminal to) declining health - (Name i."  on 7/20/2022 at a.m. for the hospice care	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP COI 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	DE	0112112022
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F 684	#2 stated, yes. When maintaining the hospice records and then the should there be cominospice and the facilistaff "catch" them who them, and they speal stated when the hospice with us. When asked these conversations is, ASM #2 failed to a conducted with OSM the medical records show hospice note are OSM #6 stated, "To be scanned them, they of them in the charts. A me their notes and I sabout (the name of the for R83, OSM #6 stated any hospice notes. Osh ewere talking on woobtain those records from hospice were for was on hospice since "They are not in her I ASM #1, the executive director of nursing, a	eady been in the record, ASM asked the process for ice notes in the facility, ASM asked the notes to medically scan them in. When asked munication between the ity, ASM #2 stated the facility ille there are here, or we call k with the physician. ASM #2 bice staff come in they speak where the documentation of and the coordination of care answer.  Ya.m. an interview was (other staff member) # 6, staff member. When asked as put in the clinical record, be honest, I have never don't give me notes. I see all the doctor's email or fax scan them in." When asked he hospice company caring ted, she had never scanned asked where notes to when asked where notes ar R19 were as the resident as 8/2022, OSM #6 stated, hard chart."  Ye director, ASM #2, the and ASM #3 the director of the made aware of the above	F	584		
F 690 SS=D		n was provided prior to exit. tinence, Catheter, UTI	F	690		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495361	B. WING			07/2	21/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	F WOODBRIDGE, LLC			1	4906 JEFFERSON DAVIS HIGHWAY		
ENVOIO	r WOODBRIDGE, LLC			٧	VOODBRIDGE, VA 22191		
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F 690	admission receives somaintain continence to condition is or become not possible to maintain \$483.25(e)(2)For a reincontinence, based of comprehensive assessed in the comprehensive assessed somaintain the comprehensive assessed in the continence of the continence of the continence of the continence of the comprehensive aspossible unless the demonstrates that can and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the extension of the comprehensive assessed in the comprehensive assessed in the continence of the comprehensive assessed in the continence of the extension of the comprehensive assessed in the continence of the extension of the continence of the extension of the continence of the comprehensive assessed in the continence of the extension of the continence of the continence of the extension of the continence of the con	cility must ensure that the tent of bladder and bowel on the ervices and assistance to unless his or her clinical the estate with urinary on the resident's assment, the facility must the facility without an not catheterized unless the dition demonstrates that the ecessary; the facility with an subsequently receives one are resident's clinical condition the terization is necessary; incontinent of bladder the treatment and services to infections and to restore the ent possible.  The sident with fecal on the resident's estate the facility must the f	F	690			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	<u> </u>	(X3) DATE	
		495361	B. WING _			07/2	21/2022
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		1 0111	112022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 690	facility document revicomplaint investigation facility staff failed to purinary incontinence as 33 residents, Resider.  The findings include:  Resident #350 was an 11/29/21 with diagnost limited to: atrial fibrillicoronary artery diseat longer resided at the.  The most recent MDS assessment, a 5 day an ARD (assessment, a 5 day an ARD (assessment coded the resident as the BIMS (brief intervindicating the resident impaired. A review of G-functional status correquiring extensive as transfer, dressing and eating and total depeth: coded resident as and bowel. Foley cat Section H.  A review of the compinal factor of th	ew and in the course of a on, it was determined the provide care and services for and catheter care for one of an #350.  Idmitted to the facility on sis that included but were not action, hypertension and se. Resident #350 no facility.  Is (minimum data set) Medicare assessment, with reference date) of 12/6/21, as scoring a 10 out of 15 on iew for mental status) score, it was moderately cognitively the MDS Section	F	facility.  2.All residents with being impacted by practice.  The DON/designer monitoring audit of catheters to ensure completed.  3.The ADON/des to all nurses in processidents.  The IDT will reviet documentation in compliance with of the design monitoring of catheters we accuracy of setting quality monitoring Quality Assurance. Committee months schedule modified guarterly monitoring quality monitoring duality monitoring duality monitoring quality monitoring duality monitoring quarterly monitoring practices.	th catheters are at risk by the alleged deficient ee will complete a quality of residents with urinary are catheter care is being signee will provide eductiviting catheter care to each the AM meeting to ensure expectations.  Innee to conduct quality heter care of 25% of residents x 6 weeks to ensure expectations of these of the experience of the experi	for  ity y ng cation o sure sidents ire e e e ement	9/1/2022

` /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191			
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F 690	wound care and refuse repositioned by staff. the resident to make regime to provide a samegotiate a time for A participates in the de A review of the physicevealed, "Catheter coneeded."  A review of the nursing 12/31/21 at 2:21 PM, party) would try and callow staff to provide medication. Informed continue to try and at meet resident's needer resident."  A review of Resident administration record every shift and as near revealed no missing however January 202 missing documentation. A review of Resident December 2021 day/10 of 31 day shifts medocumentation and Jerus documentation and Jerus documentation per Cassistant) #1.	sed medication prior to ses to be turned and INTERVENTIONS: Allow decisions about treatment ense of control. If possible, IDLs so that the resident cision making process."  cian orders dated 12/16/21 are every shift and as  ng progress note dated revealed, "RP (responsible encourage her mother to care and administer d RP that staff would tempt to provide care and to s as allowed by the  #350's TAR (treatment ) included: "catheter care eded." December 2021 documentation of care, 22 reveals 7 of 35 shifts was on of care.  #350's ADL record for evening/night shift revealed dissing toilet use anuary 2022 of trevealed 6 of 11 day shifts cumentation. Incontinence under toilet use	F	690			

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	'	0172172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 690	When asked to descr #1 stated it is done eveneeded and they star here. When asked who documented, CNA #1 under toileting. When documentation for incomplete the care was not proven the care was not proven the care was not proven an interview was con AM, with RN (register who provides the cath RN #3 stated, the nur and document it on the administration record means if there is no care every shift, RN # was not done. If it is done."  On 7/20/22 at 7:39 Almember) #2 stated, "Perry and Potter 9th and Potter, "Providing preventing catheter reinterventions to reduct urinary tract infections."  On 7/21/22 at approx (administrator, ASM # ASM #3, the regional were made aware of No further information."	ed nursing assistant) #1. ibe incontinence care, CNA very two hours and as it rounds as soon as they get here incontinence care was stated it is documented hasked what missing continence care meant, CNA hissing documentation then vided.  ducted on 7/21/22 at 8:40 here red nurse) #3. When asked here care for the residents, heres do the catheter care here TAR (treatment here in the catheter has stated, "It means that it hours documented it is not  M, ASM (administrative staff The standard of practice is heredition." According to Perry has gregular perineal hygiene, helated trauma are important here risk of catheter associated has."  himately 9:45 AM, ASM hember) #1, the hember) #1, the hember in the catheter of nursing and hereditions. has provided prior to exit.	F 6			
F 695 SS=D	CFR(s): 483.25(i)	stomy Care and Suctioning	F 6	33 33		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING				C <b>21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	REET ADDRESS, CITY, STATE, ZIP CODE 1906 JEFFERSON DAVIS HIGHWAY 1000BRIDGE, VA 22191	1 011	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 695	§ 483.25(i) Respirator tracheostomy care and The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the compreherand 483.65 of this sufficient and 483.65 of this sufficie	ry care, including d tracheal suctioning. In that a resident who e, including tracheostomy tioning, is provided such professional standards of tensive person-centered tts' goals and preferences, opart. In is not met as evidenced to its in the professional standards of tensive person-centered tts' goals and preferences, opart. In its not met as evidenced to its in the professional standards of tensive person-centered the professional standards of tensive person-centered the professional standards of the professi	F 6		1.Resident #94's oxygen was immediate at 2L/min as prescribed by the physiciar 2.All residents that receive oxygen are a for being impacted by the alleged deficie practice.  A quality monitoring audit of all residents oxygen was completed on 07/21/2022 to ensure that the correct number of liters being administered per physician order that the dial was set correctly.  3.The ADON/designee will provide educt to all nurses to ensure that they know he correctly set the oxygen dial on all concentrators.  The Quality monitoring teams will audit that assignment and report in the AM meeting any issues with oxygen settings outside order range.  4.The DCS/designee to conduct quality monitoring of oxygen settings of 10 residently and the complete to the Quality monitoring's to be reported to the Quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring with quarterly monitoring by the RDCS (Region Director of Clinical Services) / designee.	at risk ent s on owas and eation ow to their of dents  y the onal	9/1/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 077	21/2022
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F 695	the top of the ball sitti for 2.0. LPN (licensed asked to read the oxy stated the oxygen wa how to read the oxygen was to read the oxygen was to read the line should LPN #2 reset the oxygen was touching the 2.0.  The physician order of documented, "Oxygen minute) via nasal can the comprehensive of documented in part, "therapy r/t (related to). The "Interventions" do as ordered."  The manufacturer's in concentrator, documented in part, "therapy r/t (related to). The "Interventions" do as ordered."  The manufacturer's in concentrator, documented in part, "therapy r/t (related to). The "Interventions" do as ordered."  The facility policy documented in part, as ordered. The facility policy documented in part, as ordered	concentrator was set with ng just under the black line if practical nurse) # 2, was agen concentrator, LPN #2 is set at 1.5. When asked en concentrator, LPN #2 is be at the top of the ball. In gen so the top of the ball line.  Idated 9/10/2020, in at 2 LPM (liters per nula continuously."  Is are plan dated 1/3/2020, if Focus: (R94) is on oxygen of altered respiratory status."  In pocumented in part, "Oxygen in part, "Oxygen in part, "NOTE: To a a continuously in the prescribed in part, "Review in the prescribed."  Is a truction of the oxygen in part, "Review in the prescribed."  Is a truction of the line. Now, center in the prescribed. In part, "Review in the prescribed in part, "Review in the prescribed liter flow or in the	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495361	B. WING			07/	21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14906 JE	ADDRESS, CITY, STATE, ZIP CODE EFFERSON DAVIS HIGHWAY BRIDGE, VA 22191			
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F 695	verify that the client is oxygen concentration medication administration administration."  ASM (administrative sexecutive director, AS nursing, and ASM #3 services were made as on 7/20/2022 at 5:23	k the physician's orders to a receiving the prescribed. The six rights of ation also pertain to oxygen staff member) #1, the SM #2, the director of the director of clinical aware of the above concern		695 698				
SS=E	require dialysis receive with professional stand comprehensive personal the residents' goals at This REQUIREMENT by:  Based on staff intervice clinical record reviewereview, it was determed provide dialysis care at residents in the surveous The findings include:  The facility failed to produce the facility failed to provide dialysis facility for 7 or 13 visits in May 2022, and 3 of 5 visits in Juliana.	iew, resident interview, and facility document ined the facility staff failed to and services for one of 33 y sample, Resident #37.  rovide communication to the f 13 visits in April 2022, 8 of , 3 of 10 visits in June 2022						

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NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	WOODBRIDGE, LLC				4906 JEFFERSON DAVIS HIGHWAY		
	,			٧	VOODBRIDGE, VA 22191		
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F 698	5/16/16 with diagnosis limited to: end stage in mellitus, heart failure  The most recent MDS assessment, a quarte ARD (assessment reficial coded the resident as the BIMS (brief intervindicating the resident review of the MDS Secoded the resident as assistance for bed monthly indicating the resident as as as a single for	s that included but were not renal disease, diabetes and encephalopathy.  6 (minimum data set) rly assessment, with an reference date) of 5/21/22, scoring a 14 out of 15 on rew for mental status) score, the was cognitively intact. A requiring extensive obility, transfer, dressing, supervision for locomotion reating. Section O-special is coded the resident as  rehensive care plan dated of DCUS: The resident is on arterial-venous Fistula Renal Disease. Transferred did AV shunt 6/27/22. Communicate with dialysis alysis 3 times/week:  Saturday.  orders, dated 10/21/20, grid in the properties of the prop	F	398	The facility recognizes that it was unab provide complete dialysis communication requested. The resident continues on cand her communication book is accompler to visits.  1. All residents on dialysis are at risk to impacted by the alleged deficient practice. The DON/designee will complete a qual monitoring audit of the dialysis communication gaudit of the dialysis communication for all dialysis resident within the vensure that communication is received dialysis.  2. The ADON/designee will provide in-set to all nurses to ensure that they are get communication from the dialysis center each resident dialysis day.  The IDT will review dialysis communicate the AM meeting following visits to ensure communication forms are present.  3. The DCS/designee to conduct quality monitoring of residents on dialysis wee weeks to ensure bed hold was provided included in the medical record. The find these quality monitoring's to be reported Quality Assurance/Performance Improv Committee monthly. Quality Monitoring schedule modified based on findings wire quarterly monitoring by the RDCS (Reg Director of Clinical Services) / designee	on as lialysis panying on as lialysis panying on ce ce. lity ication week to from ervice ting on tion in the liand ings of d to the ement the ional	9/1/2022
		ducted on 7/20/22 at 9:15 7. When asked if she takes					

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	· · · · ·	3172 172022		
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F 698	dialysis center, Resthe book with me."  An interview was condam with LPN (licental asked what informate facility when a resident little w	inication book with her to the sident #37 stated, "Yes, I take onducted on 7/20/22 at 9:30 sed practical nurse) #3. When tion is provided to the dialysis lent is sent for hemodialysis, show we communicate with and their condition. The labs, bruit, thrill and all basic ts."  Legis contract on 7/20/22 at the following, "Review of acility shall ensure that all I, social, administrative and ecompany all designated the of transfer to the center. It is all include but is not limited to, the following: The ent's name, address, DOB thone number of next of kin ical records including history, including labs and x-ray that is condition, change of	F 69	98				
	On 7/20/22 at appro (administrative staff administrator, ASM	oximately 5:30 PM, ASM						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495361	B. WING				C <b>21/2022</b>
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14906 J	ADDRESS, CITY, STATE, ZIP CODE  EFFERSON DAVIS HIGHWAY  BRIDGE, VA 22191	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	nursing, confirmed the communication forms:  A review of the facility Hemodialysis Service the following, "Reside ESRD facility will have the facility. There will the facility. There will the facility and the ES resident. The facility of Agreement/Arrangement residents requiring Diagreement shall incluate to be managed.  Procedure:  1. The Dialysis Communitiated by the facility ESRD center for hem 2. Nursing will collect information regarding ESRD Center."  No further information Provision of Medically CFR(s): 483.40(d)  §483.40(d) The facility medically-related socimaintain the highest pand psychosocial well This REQUIREMENT by:  Based on resident inclinical record review	the findings.  M, ASM #2, the director of at no additional dialysis were found.  It's "Coordination of as" dated 11/2014, revealed ants requiring an outside a services coordinated by be communication between SRD facility regarding the will establish a Dialysis ant if there are any alysis Services. The de how the residents care is an unication form will be for any resident going to an odialysis.  and complete the the resident to send to the an was provided prior to exit. A Related Social Service  by must provide a service attain or coracticable physical, mental labeing of each resident.  The is not met as evidenced atterview, staff interview, and facility document		745			
	review, it was determ	ined that the facility staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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		495361	B. WING _		07/	/21/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	-	
				14906 JEFFERSON DAVIS HIGHWAY			
ENVOY O	F WOODBRIDGE, LLC			WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 745	-		F 7		ad and ravised		
	failed to provide medically related social services to one of 33 residents in the survey sample, Resident #32 (R32).			<ol> <li>The Plan of care was reviewe for residents R32. Resident has discharge.</li> <li>All residents are at risk to be the alleged deficient practice.</li> </ol>	decided not to impacted by	9/1/2022	
	The findings include: The facility staff failed			A quality review was conducted of those residents requesting discommunity to ensure discharge being coordinated.	scharge to the		
	The facility staff failed to actively assist R32 in coordinating a resident requested discharge from the facility.			The SSD will be re-educated ED/designee related to providing related social services.	by the g medically		
	R32 was admitted to the facility with diagnoses that included but were not limited to paraplegia.		The IDT will discuss those resid discharge in the AM meeting to	ensure			
		MDS (minimum data set), a t with an ARD (assessment		appropriate discharge planning with the plan of care is complete	ed.		
	15 out of 15 on the B	20/2022, the resident scored IMS (brief interview for ating the resident was		4.The ED (Executive Director)/D to conduct quality monitoring of request discharge medical record	residents that rds to ensure		
	cognitively intact for r Section G documente	making daily decisions. ed R32 using a wheelchair		appropriate discharge planning weekly x 6 weeks. The findings monitoring's to be reported to the Assurance/Performance Improvi	of these quality e Quality		
	and having functiona motion in both lower	I limitations in range of extremities.		Committee monthly. Quality Mor schedule modified based on find quarterly monitoring by the RDC	nitoring dings with SS (Regional		
	conducted with R32.	59 p.m., an interview was R32 stated that they were		Director of Clinical Services) / de	esignee.		
	1 -	a manual wheelchair every they had been trying to					
	_	acility but were not getting					
		acility staff. R32 stated that					
	_	e resident or the residents					
		e for a discharge if they 2 stated that the social					
		them phone numbers to the					
		stration) facilities in the area					
		ry to get transferred to but					
		ble to speak to anyone. R32					
		nat the facility staff would					
		reach the other facilities					
		ould not just give them					

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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 01/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 745	eventually like to disan apartment with a getting more special what they had receit that they had advisor wanted to discharge they felt that they diterm care facility. Fasked the social word discharging them for that it was their job send them out when off of them.  The comprehensive documented in part discharged to anoth machines that can a Initiated: 02/09/202 Under "Intervention" "Establish a pre-dis resident/resident's revaluate progress a Date Initiated: 02/09/202 The progress Note. [Na transferred to anoth rehab equipment the equipment that his spinal cord. Social metal to discharge the conditions of the condit	32 stated that they would scharge to the community into an aide to help them after dized rehab services than ived at the facility. R32 stated ed the facility staff that they erform the facility because id not need to be in a long R32 stated that when they worker to assist them in form the facility they were told to keep them there, not to in they were "making money"  The care plan for R32, "[Name of R32 wishes to be ner facility that has the rehab easist him walk again. Date 1. Revision on: 04/13/2022." s" it documented in part, charge plan with the representative/caregivers and and revise plan as needed. 19/2021"  To R32 documented in part, (2:47 p.m.) Social Service me of R32] wanting to be the facility that has specific at he thinks will benefit him on the care facilities do not have the	F 74	5	
	Progress Note. No the telephone numb Veteran's Administr	te Text: Resident was giving per and contact at the ation- [Name of VA Center]. [Phone number]. Writer did			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495361	B. WING		07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	1 01/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 745	call as well and left a intake specialist].  - "2/17/2022 09:52 (9 Progress Note. Note information again to [Name of VA Center] lost the original shee him prior to his recer was encouraged to n intake department fo as well as rehab. Reto walk again with the equipment that most have but possibly the have."  - "2/23/2022 13:50 (1 Progress Note. Note if he got in touch with [Name of VA Center] messages with admicall back. Writer encotelephone operator to (public address) syst.  - "3/18/2022 12:21 (1 Progress Note. Note by the SSD (social set or reach the intake of VA Center]. He state successful in reachin and has left message he never received and department and had.  - "4/7/2022 13:55 (1: Progress Note. Write to see if he has follow discharge from the fand Administration Center).	voicemail for [Name of 2:52 a.m.) Social Service a Text: Resident was given the Veterans Administration. The reason is because he to f paper that was given to at hospitalization. Resident make to call and speak to the rong term care admission sident continues want to try assistance of special LTC (long term care) do not a Veterans Administration.  2:50 p.m.) Social Service a Text: Writer asked resident to the Va. Administration - 1. He stated that he has left assions but did not receive a buraged him to ask the page the contact on the PA em instead."  2:21 p.m.) Social Service a Text: Resident was asked ervice director) if he was able bordinator of the [Name of did that he has not been granyone in that department as for a return call, in which and the service are spoke with resident today of through on his request to accility into a Veterans r. He stated that he is persons that he is contacting	F 74		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495361	D. WING			07/	21/2022	
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ENVOY O	F WOODBRIDGE, LLC				4906 JEFFERSON DAVIS HIGHWAY			
				۷	VOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 745	- "4/11/2022 13:19 (1:1) plan/IDT (interdiscipling discuss residents plant [Name of R32] is aler place and time) and reassist with ADL's He transfer to a VA facility Discussed residents of facility and the require him regarding this transfer to a very limit of acknowledged unders with the current plant of "4/22/2022 11:10 (1:1) Progress Note. Write to see if he has follow discharge from the factor Administration Center information of some factor of care, resident atter remain the same, he (discharge) plan is to Resident request for the (due to) decline in fur submitted. Staff will conficate."  - "7/14/2022 14:40 (2) Progress Note. Note resident to review ever transfer to a Veteran centers for some spechim walk again. Resident want to go to a numbave the therapy machas given resident so which he can verify if	entry team) Note Text: Care nary team) team met to not care, resident attended. It and oriented x3 (person, equires limited to extensive to is a full code, would like to y for therapy services desire to transfer to another ements and expectations of nsition, resident agreed and standing. Staff will continue of care."  1:10 a.m.) Social Service through on his request to cility into a Veterans r. Writer has given some acility that the resident can ded Emergency contacts is a full code, d/c transfer to another facility therapy eval (evaluation) d/t notional status, referral ontinue with the current plan (40 p.m.) Social Service Text: Social Service met erything in pertaining his	F	745				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	·	3172 172022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 745	transfer process car resident some facilit verify if they have the "7/14/2022 15:15 (Progress Note. Not resident the below hand verify if they had looking for to help hand transfer process. VCENTERS FOR [Naphone numbers of fill on 7/20/2022 at 3:4 conducted with OSM director of social set R32 came from an abuilding and had untheir recovery. OSM requested to be disc specialized equipment walk. OSM #3 state type of equipment a recommended the histated that the facilit who wanted to leave themselves but they numbers to them to did not want to transfacility because they they wanted and the to remain long term.  On 7/20/2022 at 4:0 conducted with OSM PTA (physical therap admitted to the facility admitted to the facility admitted to the facility occupational therap admitted to the facility admitted to the facility the facility occupational therap admitted to the facility the facility occupational therap admitted to the facility the facility occupational therap admitted to the facility the facility that the facility the facility that the facility	n start. Writer has given y and contacts to call and e machine he is looking for." 3:15 p.m.) Social Service e Text: Writer has given //eterans Health centers to call we the therapy machine he is im walk again before the ETERANS HEALTH ame of R32] [Name and ve Veterans Centers]."  3 p.m., an interview was // (other staff member) #3, the rvices. OSM #3 stated that assisted living facility to the realistic expectations about // #3 stated that R32 had charged to a facility with ent that would help them to ed that they did not have that the facility and they had //A systems for R32. OSM #3 ry policy was that a resident e would find placement had been providing phone call. OSM #3 stated that R32 after to another long term care of did not have the equipment e plan currently was for them care.  5 p.m., an interview was // #13, the director of rehab, roy assistant). OSM #13	F 74	5				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING				21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 077	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745	them by the facility st #13 stated that they if they go to a spinal co discharged them whe using a sliding board OSM #13 stated that to use the standing from they were unable to be stated that they attern R32 but did not feel they for paraplegia they had the paraplegia they had on 7/20/2022 at 4:22 conducted with OSM assistant and OSM # services. OSM #3 stated fabricate things. OSM client wanted to leave ones who were to held OSM #3 stated that the R32 with additional with the phone numbers to cate facility was collecting would they want to gion 7/21/2022 at 7:50 conducted with ASM member) #1, the executated that as long as resident's request for was for the facility stated that the resident to arrange the stated that the tresident th	been communicated to aff and the physician. OSM had suggested to R32 that ard specialist and they had en they were able to transfer with assistance from staff. initially they had attempted ame equipment with R32 but bear any weight. OSM #13 apted the parallel bars with that it was safe with the level d.  p.m., an interview was #12, social services 3, the director of social ated that they had reached diministration in January of ard back from them regarding that at times R32 would of the facility they were the pin finding the placement. This month they had provided beterans administration facility II. OSM #3 stated that the money from R32 and why we it away.	F	745			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	<u> </u>	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 745	Responsibilities6. P work services as indicendeds12. Act as a and the community'  The facility policy, "Di 11/30/2014, document evaluate the resident' formulate the best platesident. Discharge padmission. The proceand family, Care Manand other members of the facility policy, "So 11/30/2014, document Medically-related socto attain or maintain the mental, and psychosor residentSocial Servithe medically related of residents and their those needs by:g. It to support a resident's preferencesk. Finding physical and emotion On 7/21/2022 at appropriate (administrative staff in director, ASM #2, the #3, the regional direct made aware of the communication"	d in part, "Duties and rovide/arrange for social cated by resident/family liaison between the facility scharge Planning" dated ated in part, "Policy: To shealth status and an of discharge for each blanning begins the day of eas involves the resident agement/Social Services of the clinical team"  Docial Services" dated ated in part, "Policy: ital services will be provided the highest practical physical, ital services will identify social and emotional needs families and provide for identifying and seeking ways individual needs and ing options that meet the all needs of each resident"  Doximately 9:45 a.m., ASM member) #1, the executive director of nursing and ASM tor of clinical services were oncern.	F	745			
F 802 SS=E	No further information Sufficient Dietary Sup CFR(s): 483.60(a)(3)		F	802			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495361	B. WING		C 07/21/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 802	§483.60(a) Staffing The facility must emp appropriate competer out the functions of th taking into considerat individual plans of cal and diagnoses of the in accordance with th required at §483.70(e) §483.60(a)(3) Support The facility must prov personnel to safely ar functions of the food at §483.60(b) A member Services staff must painterdisciplinary team (2)(ii). This REQUIREMENT by: Based on observation document review, it w staff failed to maintain meet the needs of the on 7/19/22 in one of of was insufficient staff f working at lunch on 7 residents' not receiving compatible with common resulting in residents dishes.  The findings include: On 7/19/22 at 11:24 at	loy sufficient staff with the noies and skills sets to carry be food and nutrition service, ion resident assessments, are and the number, acuity facility's resident population be facility assessment be.  In the sufficient support and effectively carry out the land nutrition service.  In of the Food and Nutrition larticipate on the las required in § 483.21(b)  In is not met as evidenced and the facility was determined the facility and sufficient dietary staff to be residents at the lunch meal one facility kitchens. There from the dietary department and land the facility in sufficient dietary department and land the facility in sufficient dietary department and land the facility in sufficient dietary department and land the dietary standards, and being served on disposable a.m., initial observation of the M (other staff member) #1, washing dishes from	F 802	1.The facility recognizes that dietary stars been less than sufficient. The Diet Manager is to notify the ED immediate any staffing concerns so that emergen staffing can be implemented.  2.All residents have the potential to be impacted by the alleged deficient pract. A quality review will be conducted by the Executive Director/Human Resource Coordinator of dietary staff for the upon week beginning 8/18/2022 to ensure staff dietary support personnel scheduled.  3.Dietary manager will be re-educated Executive Director/Human Resource Coordinator related to providing sufficitientary staffing.  The Dietary manager will report in the meeting staffing patterns for the upcon week to discuss any staffing concerns plans for addressing.  The Executive Director will report to the Regional Administrator any anticipated concerns following AM meeting or upon discovery.  4.The Executive Director/Human Resource Coordinator to conduct quality monitor dietary staffing, weekly x 6 weeks. The findings of these quality monitoring's to reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings we quarterly monitoring by the Regional Dof Clinical Services/designee.	ary ly with cy  9/1/2022  tice. he oming ufficient  by the ent  AM ning with e d staffing in ource ing of e o be

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC		•	14906 JEFFE	RESS, CITY, STATE, ZIP CODE ERSON DAVIS HIGHWAY DGE, VA 22191		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 802	manager from a sisted kitchen, and was end asked if lunch was be time compatible to who be served lunch in the "No there's a delay." what time lunch woul was due to lack of stawas "having to do it a breakfast meal had bhad to prep, cook, se stated OSM #1 then the lunch meal. Two present in the kitcher the floors. They did not serving of the food.  On 7/19/22 at 1:25 p. resident lunches from only kitchen. OSM #1 disposable Styrofoam placed on one side of side of the container cover. Two stacks of observed in a dish case of the container cover. Two stacks of observed the lunch transfer interviewed. She state Styrofoam "because stated if the facility st disposable dishware, ever be able to turn the oget the dinner means."	p.m., OSM #2, the dietary or facility, had arrived in the couraging OSM #1. When being served on time, and at a then residents would normally be community, she stated: She stated she was not sure distart. She stated the delay affing. She stated OSM #1 all today." She stated the there is a stated to preply cook, and serve dietary assistants were in waiting to take the trays to not assist in preparation or in the facility's it served all the meals on a in container. The food was folded over to create a facility dishware were art adjacent to the tray line.  I.m., OSM #2, who had also may line service, was seed OSM #1 was serving on they are short staffed." She	F	302			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495361	B. WING			C 07/21/2022	
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	:	0172	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 802	staff member) #1, the the director of nursing director of clinical ser these concerns.  A review of the facility Staffing," revealed, in department will emploappropriate competer out the functions of for a manner that is safe staffing will be provide palatable, attractive, rat proper temperature to support proper san utilized."	m., ASM (administrative executive director, ASM #2, g, and ASM #3, the regional vices, were informed of policy, "Department part: "The Dining Services by sufficient staff with noies and skill sets to carry and and nutrition services in and effectiveAdequate end to prepare and serve nutritionally adequate meals, es, at appropriate times, and itary techniques being	F	802			
F 804 SS=D	Nutritive Value/Appear CFR(s): 483.60(d)(1)(1)(1)(1)(1)(2)(1)(2)(1)(2)(2)(2)(2)(3)(2)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	drink es and the facility provides- repared by methods that ue, flavor, and appearance; nd drink that is palatable,	F	804			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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		495361	B. WING		07	/21/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FNVOY O	WOODBRIDGE, LLC			14906 JEFFERSON DAVIS HIGHWAY		
21110101	WOODBINDOL, LLO			WOODBRIDGE, VA 22191		
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F 804	oonanaa maa	ple, Residents #49 (R49), #28 (R28), #41		1. Food Service Manager educat staff to ensure they are using pla maintain food temperature and to including seasoning.	te warmer to	9/1/2022
	The facility staff failed taste and temperature	to serve food at a palatable at lunch on 7/19/22.		2.All the residents that receive a at risk to be impacted by the alleg practice.	meal tray are ged deficient	
	The findings include:  1. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/10/22, R49 was coded as being cognitively intact for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). On 7/19/22 at 1:01 p.m., an interview was conducted with R49. The resident stated the facility food was lousy, cold, and not good.  2. On the most recent MDS, an annual assessment with an ARD of 5/12/22, R28 was coded as being cognitively intact for making daily decisions, having scored 13 of 15 on the BIMS. On 7/19/22 at 11:45 a.m., R28 stated the food was not good, both in taste and temperature.			3.Food Services Manager will ed staff on the use of plate warmer i maintain the food temperature, at palatability including seasoning a An audit will be done by the Food Manager to ensure timely deliver trays with acceptable temperature temperatures are maintained. Quality monitoring will be done by Services Manager to ensure propalatability/taste.  4.Food Services Manager/food stassistant will audit 5 trays each weeks then monthly for 2 months proper food temperature/palatabil maintained. Findings will be repo QAPI Committee monthly and Quantonitoring Review schedule will based on findings.	n order to s well as food nd taste. If Services y of meal es-that y the Food per services week for 4 to ensure lity is rted to the uality	
	coded as cognitively in decisions, having scored BIMS. On 7/20/2022 was conducted with Final Served was normally and it did not taste very con 7/19/22 at 1:25 p.1 member) #1, the dieta holding temperature of temperature was 173	aRD of 5/30/2022, R41 was nearly for making daily red 15 out of 15 on the at 8:45 a.m. an interview r41. R41 stated that the food cold when they received it, ry good.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495361	B. WING _			C 07/21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 804	the cart at 2:22 p.m. tested for taste and to after the final tray had The temperatures of Fahrenheit): pureed to bread 117, mashed p pasta 118, baked ziti pureed bread had a prot taste like bread. Vergular baked pasta, warmth to be palatab manager from a siste food temperatures artray, stated: "I think it lunch. And that does explained that this quifacility's norm. She experience.  On 7/20/22 at 5:17 p. staff member) #1, the the director of nursing director of clinical ser these concerns.  A review of the facility Temperatures," reveal temperatures are mo points to ensure safe.	e tray service line.  m., a test tray was was made and left the unit on The food on the tray was emperature at 2:30 p.m., d been served to residents. the food were as follows (all vegetables 116, pureed otatoes 121, pureed baked 150, and broccoli 115. The baste-like texture, and did With the exception of the all the food lacked the le. OSM #2, the dietary or facility, who had taken the red tasted the food on the latity of food is not the explained that the facility has urnover, is short staffed, and of have a great deal of  m., ASM (administrative executive director, ASM #2, g, and ASM #3, the regional vices, were informed of  y policy, "Food aled, in part: "Food nitored at critical control	F8			
F 809 SS=E	Frequency of Meals/S	Snacks at Bedtime	F 8	09		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495361	B. WING			C 07/21/2022	
	ROVIDER OR SUPPLIER  F WOODBRIDGE, LLC			14	TREET ADDRESS, CITY, STATE, ZIP CODE 1906 JEFFERSON DAVIS HIGHWAY OODBRIDGE, VA 22191	1 011	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 809	facility must provide a regular times compart the community or in a needs, preferences, r §483.60(f)(2)There m hours between a substreakfast the following nourishing snack is so hours may elapse betweel and breakfast the group agrees to this r §483.60(f)(3) Suitable meals and snacks must who want to eat at no of scheduled meal se the resident plan of carrow the facility staff failed to so compatible with commone facility kitchens. Degin to serve the lund 1:25 p.m. The final redistributed until 2:30 p.  The findings include:  On 7/19/22 at 11:24 at kitchen revealed OSM the dietary manager,	of Meals sident must receive and the t least three meals daily, at able to normal mealtimes in occordance with resident equests, and plan of care.  Sust be no more than 14 stantial evening meal and g day, except when a erved at bedtime, up to 16 ween a substantial evening e following day if a resident neal span.  It, nourishing alternative est be provided to residents in-traditional times or outside ervice times, consistent with are.  It is not met as evidenced that interview, and facility as determined that the erve a meal at a time munity standards in one of the facility staff did not ch meal on 7/19/22 until sident tray was not o.m.	F	809	<ol> <li>It is the intended practice of this facensure the frequency of meals and should be followed in accordance with the regula Meals delayed that day due to short a staff in the Kitchen. The Dietary depairs now fully staffed. The Dietary Manarecruiting and training staff to assist with mealtimes.</li> <li>All residents needing and/or wanting snacks are at risk to be impacted by the talleged deficient practice.</li> <li>Staff will also be informed that whe unexpected incidents or resident need result in a need for additional staff in the talleged deficient practice.</li> <li>Staff will also be informed that whe unexpected incidents or resident need result in a need for additional staff in the dining room, they are to inform the DON/Sup, or E.D, who will assist them by obtaining other staff members who trained or licensed to assist in the dining room.</li> <li>E.D and/or designee will complete trained and audits of resident meals servitensure residents are eating during scheduled meal times. These audits we done weekly x 6 weeks. These results be forwarded to the QAPI committee in review. The committee will determine need for further audits and/or action</li> </ol>	nacks is nation. ge of the order is not only the order is not only the order is not order in the	9/1/2022

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3	OMPLETED
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	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	433301		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		07/21/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 809	On 7/19/22 at 12:49 was made of the kit manager from a sis kitchen, and was er worked to prepare b broccoli, salad, brea When asked if lunch and at a time componormally be served #2 stated: "No there was not sure what t stated the delay was tated OSM #1 was She stated the brea because OSM #1 hclean it up. She stated cook, and serve the assistants were pre	were visible in the ovens, steamer.  It p.m., a follow up observation chen. OSM #2, the dietary ter facility, had arrived in the accuraging OSM #1 as he baked pasta, steamed ad, and pureed food for lunch. In was being served on time, atible to when residents would lunch in the community, OSM as a delay." She stated she ime lunch would start. She is due to lack of staffing. She "having to do it all today." kfast meal had been late and to prep, cook, serve, and sed OSM #1 then had to prep, lunch meal. Two dietary sent in the kitchen waiting to a floors. They did not assist in	F 8	09		
	temperature of the beautiful (120 degrees Fahre standards. The pass At 1:07 p.m. and at repeated with the satemperature of the beautiful beautiful (120 degrees) transport cart, and we last resident lunch to the control of the beautiful (120 degrees) transport cart, and we last resident lunch to the control of the beautiful (120 degrees) transport cart, and we last resident lunch to the control of the control	is p.m., OSM #1 took the baked pasta. The temperature enheit) did not meet safety that was returned to the oven. 1:23 p.m., this process was ame result. At 1:25 p.m., the baked pasta was 173, and in. At 2:22 p.m., the last erved and placed on the was delivered to the unit. The ray was served at 2:30 p.m.  p.m., ASM (administrative the executive director, ASM #2, and, and ASM #3, the regional				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X*)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		495361	B. WING _		•	7/21/2022	
	F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 809	these concerns.  A review of the policy revealed, in part: "At I	vices, were informed of , "Frequency of Meals," east three daily meals will ar times comparable to	F 8	09			
F 812 SS=E	Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision doe facilities from using progradens, subject to consider safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accordant standards for food set This REQUIREMENT by:  Based on observation document review, it we facility staff failed to set food in a sanitary man	y requirements.  re food from sources ed satisfactory by federal, es. re food items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility rompliance with applicable d-handling practices. es not preclude residents is not procured by the facility.  prepare, distribute and nce with professional	F8	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	COMF	(X3) DATE SURVEY COMPLETED	
		495361	B. WING _			C /21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			STREET ADDRESS, CITY, STATE, ZIP COI 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 812	oven were dirty. OSM the dietary manager, temperatures of hot, lines prior to serving individual resident medietary staff member to dry all of them.  The findings include:  On 7/19/22 at 11:24 a kitchen revealed OSM the dietary manager, breakfast in the facilit observation of the kittop. The stove contain debris on the stove to burners. Some of the some of the debris was composed some of the debris was convection oven burned-on grease, and the convection oven oparticles of food and stated both the stove were available for use contained a square pand unlabeled.  On 7/19/22 at 12:49 pmanager from a siste kitchen. On 7/19/22 at the temperature of the temperature of the temperature (120 degmeet safety standard)	stove top and convection  I (other staff member) #1, failed to take the holding perishable foods on the tray them on 7/19/22. Trays for eals were wet nesting, and a used the same drying towel  a.m., initial observation of the II (other staff member) #1, washing dishes from y dish room. Initial chen revealed a dirty stove ned heavy amounts of op and in the wells of the debris was burned on; as greasy; some of the d of particles of old food; as the consistency of ash. doors contained caked-on, nd the walls and bottom of contained debris including baked-on grease. OSM #1 top and the convection oven e. The cook's refrigerator an of grape jelly and a ple tidbits that were open	F 8	1. Root Cause Analysis was the Dietary Manager and Nu Administrator to determine the responsible for these alleged Upon completion, it was detestaffing changes, lack of audieducation all contributed to toutcomes  2. All residents are at risk to the alleged deficient practice Regional Dietary Manager redietary staff on  * Holding Temperatures  * Dishes air drying  * Food storage, labeling and discarding food per manufact recommendation and facility  3. A quality review was cond Dietary Manager and Unit Menourishment room/ refrigerate that there were no expired it facility food policy.  Newly hired dietary employed the above training as approprindividual job duties. The Diewill provide the H.R with provided the H.R wit	rsing Home ne system failure deficiencies. ermined that liting and staff he undesired  be impacted by e-educating  d monitoring and tural policy  ucted by the anager on all the ors to ensure ems per the  es will receive riate for their etary Manager of that the opriate training tency prior to the ently.  of nourishment orage and o expired items d twice weekly by or designee for a thly. During this ininistrator or al random audit	9/1/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495361	B. WING _				C / <b>21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			1490	EET ADDRESS, CITY, STATE, ZIP CODE 06 JEFFERSON DAVIS HIGHWAY ODBRIDGE, VA 22191	<u>,                                    </u>	112022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 812	OSM #2 stated she was thermometer in the far p.m. and at 1:23 p.m. with the same result. had taken temperature that morning without OSM #1 admitted he of the breakfast food arrived in the kitchen the temperature of the lunch service began, temperatures of any the tray line, including rice, pureed vegetable pureed baked pasta, trays including each As the lunch service unidentified member observed wiping water resident's tray before line. The trays were wased the same white  On 7/19/22 at 1:46 probserved the lunch tray interviewed. She stated the temperaturatems on the steam to overwhelmed he mustated the stove and should have been cleastated the trays should have been cleastated the trays should have been cleastated the trays should have been cleastated the tray line. She to the position of diet been employed since	vas returned to the oven. vould have a working acility kitchen "soon." At 1:07 ., this process was repeated OSM #1 was asked how he res of the breakfast foods a working thermometer. had not taken temperatures . The new thermometer at 1:24 p.m. At 1:25 p.m., e baked pasta was 173, and OSM #1 did not take holding other hot, perishable food on g steamed broccoli, white es, pureed bread, and OSM #1 served resident of the hot foods listed above. continued, OSM #10, an of the dietary staff, was er from each individual placing the tray on the tray wet nested, and OSM #10 towel to dry all the wet trays.	F	312	DON or Designee will conduct Qua Monitoring Review of nourishment room refrigerators for food storage expiration dates to ensure no expiritems are present weekly x 6 weeks ensure compliance.  All findings will be reported to the Committee monthly and Quality Monitoring Review schedule will be modified based on findings.	and ed s, to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		495361	B. WING			C <b>07/21/2022</b>
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC	1111		STREET ADDRESS, CITY, STATE, ZIP CODE 14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191		0112112022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	attrition," and clearly and support.  On 7/20/22 at 5:17 staff member) #1, the director of clinical set these concerns.  A review of the facil Temperatures," revet temperatures are monitoring to ensure saft cook is responsible temperatures when oven, prior to the behours after removal Director of Dining Smonitoring temperatures to ensure safter removal Director of Dining Smonitoring temperatures when oven, prior to the behours after removal Director of Dining Smonitoring temperatures when oven, prior to the behours after removal Director of Dining Smonitoring temperatures when oven, prior to the behours after removal Director of Dining Smonitoring temperatures when oven, prior to the behours after removal Director of Dining Smonitoring temperatures and service and service in the facil revealed, in part: "A review of the facil Production/Prepara" Ground or pureed to degrees after preparatures a	p.m., ASM (administrative ne executive director, ASM #2, ng, and ASM #3, the regional ervices, were informed of ealed, in part: "Food onitored at all critical control fety and acceptabilityThe for checking food items are removed from the eginning of service, and 6 from the steam tableThe ervices is responsible for tures to ensure foods are er internal temperature, held correct temperatureHot foods as Fahrenheit or above when areaTemperatures on the aken by the cook inutes before the start of tray ity policy, "Warewashing," all dishware, serviceware, and ned and sanitized after each will be air dried and properly ity policy, "Food tion," revealed, in part: food must be reheated to 165	F 8	12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495361	B. WING			·	21/2022
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WOODBRIDGE, LLC				1	TREET ADDRESS, CITY, STATE, ZIP CODE 4906 JEFFERSON DAVIS HIGHWAY VOODBRIDGE, VA 22191	1 0111	21/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	allowed to cool before A review of the facility Foods," revealed, in p wrapped or in covered dated, and arranged i contamination."  No further information	es, and steam tables are		812 947			
	CFR(s): 483.95(g)(1)- §483.95(g) Required aides. In-service training mu §483.95(g)(1) Be suff continuing competence be no less than 12 ho §483.95(g)(2) Include training and resident af §483.95(g)(3) Address determined in nurse af	in-service training for nurse stat- icient to ensure the se of nurse aides, but must burs per year. dementia management abuse prevention training. s areas of weakness as aides' performance reviews int at § 483.70(e) and may eeds of residents as		941			
	§483.95(g)(4) For nur to individuals with cog address the care of the This REQUIREMENT by: Based on staff intervireview, it was determined to individuals with the cognition of the company of the cognition of th	rse aides providing services gnitive impairments, also ne cognitively impaired.  is not met as evidenced liew and facility document ined that the facility staff uired annual continuing					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495361	B. WING _			1	21/2022
	ROVIDER OR SUPPLIER F WOODBRIDGE, LLC			14	REET ADDRESS, CITY, STATE, ZIP CODE 1906 JEFFERSON DAVIS HIGHWAY OODBRIDGE, VA 22191	1 011	172022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 947	(certified nursing assi CNAs #2, #3, #4, #5, For CNAs #2, #3, #4, no evidence of demersion of continuing edition of continuing edition evidence of says and at that time, she documentation of continuing edition and at that time, she documentation of continuing edition of continuing edition evidence of any and she stated she began and at that time, she documentation of continuing edition ended that the computer-based initial but many of the facility know how to access it process of getting all to the computer-base getting employees up	hours for five of five CNA stant) records reviewed, and #6.  and #5, the facility provided intia training in the past year.  ty provided no evidence of aining in the past year.  m., OSM (other staff from the past year)  m., OSM #5 provided from the past year  m., OSM #5 provided from the provide any transcripts for year  m., OSM #5 provided from the provide any transcripts for year  m., OSM #5 stated she are waiver which relieved the past year  m., OSM #5 stated she are waiver which relieved the past year  m., OSM #5 provided from the past year.	FS	947	<ol> <li>Dementia and Abuse in-services wimmediately initiated with CNA's #2,# and #6 to ensure the continuing comportation of Nurses Aides.         All Affected Certified Nurses Aides tracking records were/will be updated reflect their in-services after completion.         <ol> <li>All Residents have the ability to be affected by this deficient practice.</li> <li>All Certified Nurses Aides will be in-serviced 2x a month then monthly thereafter to complete all Dementia and Abuse in-services.</li> </ol> </li> <li>All tracking records of in-services will updated at the time of the in-services checked weekly by the DON /Nurse Manager for 3 months and monthly thereafter to ensure completion/comp</li> <li>The DON and Administrator will retain the findings of these audits and present them to the Quarterly QA committee the determine frequency of future audits.</li> </ol>	be and liance.	9/1/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495361	B. WING			C <b>07/21/2022</b>	
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WOODBRIDGE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE  14906 JEFFERSON DAVIS HIGHWAY  WOODBRIDGE, VA 22191			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
staff the o direct these A re - Ge prov an a of C for a educ educ requ loca docc	director of nursing ctor of clinical service concerns.  view of the facility eneral," revealed, inded in-service trainnual basisThe linical Services/Deassigning, coordination and in-servicationmay including the coordination of the coordinat	executive director, ASM #2, , and ASM #3, the regional vices, were informed of  policy, "In-Service Training n part: "Employees will be aining on required topics on Executive Director, Director esignee will be responsible ating, and monitoring ice trainingRequired de a combination of n Federal, State and/or service Training will be	F	947			