FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com
www.jeffdowney.com

Envoy of Alexandria, LLC
900 Virginia Avenue
Alexandria, VA 22302

Facility Characteristics:

- Skills Nursing Facility with 111 beds
- Operational and Managerial Control is made up of CMC II LLC, Christopher Bryson, Daniel Dias, Todd Mehaffey, and Kenneth Ussery
- Website is https://centers.consulatehealthcare.com/ll/US/VA/Alexandria/900-Virginia-Ave_
- The For-profit corporation is owned by Envoy of Alexandria, LLC
- As of 2018 Regency Care of Arlington was evaluated as a one-star facility (much below average) on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:
Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing homes including Envoy of Alexandria, LLC. Periodically they do inspections as complaint surveys which should be public record. State law requires that all nursing facilities obtain a license to operate in Virginia. There are more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but fifteen nursing facilities are certified for

federal reimbursement under Medicare and Medicaid. In Virginia, nursing facilities and inspected every two years under the state licensure and on an average of 12 months under Medicare/Medicaid certification. When the Virginia Office of Licensure and Certification (OLC) conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the OLC or its employees from making reports under §63.2-1603 et. seq. of the Code of Virginia. (Ref. §32.1-127.1:03 of the Code of Virginia) You can register a complaint by mailing to Virginia Department of Health, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Henrico, VA 23233-1463 or via email at OLC-Complaints@vdh.virginia.gov.

Having already researched Envoy of Alexandria, LLC and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0154 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Tell the resident completely about his or her health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain the confidentiality of a resident's clinical record for one of 26 residents in the survey sample, Resident #11. Facility staff failed to maintain Resident # 11's personal and medical information in a confidential manner during a 6/24/16 podiatry consult that was not ordered by the physician. The findings include: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/16 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living. Review of the physician's orders [REDACTED]. Review of the clinical record documented that the resident was seen by the podiatrist on 6/24/16. An interview was conducted on 12/1/16 at 8:55 a.m. with LPN (licensed practical nurse) #3. When asked what staff did to maintain the resident's confidentiality, LPN #3 stated, We always close them (the resident's chart). No one is allowed to touch the chart at all. When asked who was allowed access to a resident's record, LPN #3 stated, Only who is responsible to look at them. It is the nurse or the doctor. When asked if any doctor could read a resident's chart, LPN #3 stated, If he announces himself to me and I know he's a doctor I let him look at the chart. When asked how she would know the doctor could look at the chart, LPN #3 stated, We check to see if there is an order (for the consultation). When asked why the resident's clinical information was kept confidential, LPN #3 stated, The HIPAA (1) law. When asked the process for obtaining a podiatry consult, LPN #3 stated, You see if the toenails are long. When asked if a doctor's order was needed, LPN #3 stated, Don't need an order. We put them on the list (for podiatry) and give it to (name of social worker). An interview was conducted on 12/1/16 at 9:05 a.m. with OSM (other staff member) #1, the social worker. When asked the process he followed in obtaining podiatry consults, OSM #1 stated, They would tally up a list for me. I would send a fax or email to him (the podiatrist) and he would email me back to let me know when he was coming. When asked if he needed doctor's order for a podiatry consult, OSM #1 stated, No. When asked if the facility had a standing physician order [REDACTED]. An interview was conducted on 12/1/16 at 9:10 a.m. with ASM (administrative staff member) #4, the divisional director of clinical services and ASM #5, the regional director of clinical services. ASM #4 stated that the order for the podiatry was included in the admission packet the resident signed. ASM #4 stated that Resident #11 had signed the section allowing for podiatry services. When asked if the admission packet was part of the clinical record, ASM #5 stated, No, we keep it in the business office. When asked how staff would know if the resident agreed to the services, ASM #5 stated, Don't know. Review of Resident #11's admission packet documented, NOTIFICATION & CONSENT FORM. 3. Vendors. I have been informed that the following vendors have been designated to provide services for this facility. I consent to these services, as ordered by my physician . The Resident signed the form on 5/10/16 and indicated that he would accept the vendor. On 12/1/16 at 10:00 a.m. ASM #2, the director of clinical services approached this surveyor and stated, We found out we need a doctor's order and we can't find it. On 12/1/16 at 12:45 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, Medical Care/Standards of Practice documented on page four, Written consent of the resident is required for release of medical information to persons not otherwise authorized to receive this information. Appropriate safeguards will be applied to protect confidential records and to minimize the possibility of loss and/or destructions. No further information was provided prior to exit. (1) HIPAA -- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is the first comprehensive Federal protection for the privacy of personal health information. This information was obtained from: <https://privacyruleandresearch.nih.gov/>
F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep each resident's personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain the confidentiality of a resident's clinical record for one of 26 residents in the survey sample, Resident #11. Facility staff failed to maintain Resident # 11's personal and medical information in a confidential manner during a 6/24/16 podiatry consult that was not ordered by the physician. The findings include: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/16 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living. Review of the physician's orders [REDACTED]. Review of the clinical record documented that the resident was seen by the podiatrist on 6/24/16. An interview was conducted on 12/1/16 at 8:55 a.m. with LPN (licensed practical nurse) #3. When asked what staff did to maintain the resident's confidentiality, LPN #3 stated, We always close them (the resident's chart). No one is allowed to touch the chart at all. When asked who was allowed access to a resident's record, LPN #3 stated, Only who is responsible to look at them. It is the nurse or the doctor. When asked if any doctor could read a resident's chart, LPN #3 stated, If he announces himself to me and I know he's a doctor I let him look at the chart. When asked how she would know the doctor could look at the chart, LPN #3 stated, We check to see if there is an order (for the consultation). When asked why the resident's clinical information was kept confidential, LPN #3 stated, The HIPAA (1) law. On 12/1/16 at 12:45 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, Medical Care/Standards of Practice documented on page four, Written consent of the resident is required for release of medical information to persons not otherwise authorized to receive this information.

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

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 AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Appropriate safeguards will be applied to protect confidential records and to minimize the possibility of loss and/or destructions. No further information was provided prior to exit. (1) HIPAA -- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule is the first comprehensive Federal protection for the privacy of personal health information. This information was obtained from: https://privacyruleandresearch.nih.gov/
F 0167 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Allow residents to easily view the results of the nursing home's most recent survey.** Based on observation, resident interview and staff interview, it was determined that facility staff failed to ensure survey results were readily accessible to residents residing in the facility. The survey results were not readily accessible to residents during the survey. The survey results were kept in a drawer behind the receptionist desk requiring residents to ask staff to examine the results and the survey results binder did not contain the last three years of survey results. The findings include: Upon entering the facility's lobby on 11/29/16 at 11:45 a.m. there was no evidence of the survey results or any signage regarding the location of the survey results. During the initial tour of the facility there was no evidence of the survey results. On one nursing unit there was a sign that documented, Survey results available at front desk. On 11/29/16 at 2:15 p.m. a resident meeting was conducted with eight residents. When asked if they knew about the facility's survey results the residents stated they did not. On 11/30/16 at 7:30 a.m. upon entering the facility there was no evidence of the survey results. An interview was conducted on 11/30/16 at 11:30 a.m. with OSM (other staff member) #6, the front desk receptionist. When asked where the survey results were kept, OSM #6 opened the bottom drawer of the desk and removed two binders before retrieving the survey results book. A review of the survey results book revealed the survey results binder did not contain the last three years of survey results. OSM #6 stated, Normally we put it on top (of the counter) so people could see it. When asked why it was not on the counter at that time, OSM #6 stated, We moved it just recently because of the things on the counter. OSM #6 pointed to seasonal decorations on the countertop. When asked if there was any signage regarding the location of the survey results, OSM #6 stated, No. An interview was conducted on 11/30/16 at 5:55 p.m. with ASM (administrative staff member) #1, the executive director. When asked where the survey book was located, ASM #1 stated, It's at the front desk. It's in a drawer now because it was knocking over the decorations. No further information was provided prior to exit.
F 0252 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide a safe, clean, comfortable and homelike environment.** Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a clean and comfortable environment for two of 58 resident rooms, room #123 and room #108. 1. In the bathroom of resident room #123 two ceiling tiles were observed during separate observations with large brown stains on them. 2. The facility staff failed to replace a cracked bathroom light fixture in resident's room #108 that had many dead bugs in it. The findings include: 1. During the initial tour of the facility on 11/29/16 at 11:45 a.m. two ceiling tiles in room 123 resident's bathroom were found to have large brown stains on them. Another observation of the resident's bathroom in room 123 was made on 11/30/16 at 11:10 a.m. the stained ceiling tiles were still present. A facility tour was conducted on 12/1/16 at 10:00 a.m. with ASM (administrative staff member) #3, administrator in training, OSM (other staff member) #3, the maintenance technician and OSM #4, the housekeeping account manager. An observation of the resident's bathroom in room 123 was made. The ceiling tiles had been replaced but there were two small stains on one of the new ceiling tiles. When asked if this was considered a clean and comfortable environment, ASM #3 stated, No. An interview was conducted on 12/1/16 at 10:30 a.m. with OSM #3. When asked who was responsible for maintaining the resident's rooms, OSM #3 stated, The nurses complain, they put it in the maintenance book. When asked if the staff performed preventative maintenance, OSM #3 stated, Yes. We make rounds every day. We get through all the rooms once a month. When asked what the staff looked for on the rounds, OSM #3 stated, Ceiling tiles, lights, the (floor) tile, the bed. Everything. When asked if stained ceiling tiles posed any risk to the resident, OSM #3 stated, Not good. Not safe. On 12/1/16 at 12:00 p.m. ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. 2. During the initial facility tour on 11/29/16 at 11:45 a.m., an observation of the bathroom in resident room #108 was made. The light fixture above the sink was observed to contain many dead bugs and the fixture was cracked along the top. A facility tour was conducted on 12/1/16 at 10:00 a.m. with ASM (administrative staff member) #3, administrator in training, OSM (other staff member) #3, the maintenance technician and OSM #4, the housekeeping account manager. An observation of the bathroom light fixture in resident room #108 was made. When asked if this was considered clean and homelike, ASM #3 stated, No, honestly no. An interview was conducted 12/1/16 at 10:35 a.m. with OSM #4, the housekeeping account manager. When asked if housekeeping staff checked the rooms when they cleaned them, OSM #4 stated, Yes. They come to me about it (if there are any problems). When asked if staff had told him about the light fixture, OSM #4 stated, No. An interview was conducted on 12/1/16 at 10:40 a.m. with OSM #7, the housekeeper who had just cleaned the room. OSM #7 does not speak English, OSM #3 translated her responses. When asked if she was aware of the broken and bug filled light fixture in the bathroom, OSM #7 stated she was. When asked why it had not been fixed, OSM #7 stated that she needed a step stool to reach the light and didn't have one. When asked why the broken fixture had not been reported, OSM #7 did not respond. On 12/1/16 at 12:00 p.m. ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, Maintenance documented, Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Procedure: All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form No further information was provided prior to exit.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for one of 26 residents in the survey sample, Resident #4. The facility staff failed to develop a comprehensive care plan to address the triggered area of [MEDICAL CONDITION] on the Care Area Assessment (CAA) Summary in section V of Resident #4's annual assessment with an ARD (assessment reference date) of 6/23/16. The findings include: Resident # 4 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident # 4's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 6/23/16 coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 being moderately impaired of cognition for daily decision making. Resident # 4 was coded as requiring extensive assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed, 01. [MEDICAL CONDITION] was coded as Addressed in Care Plan. Review of Resident # 4's comprehensive care plan dated 6/28/2016, failed to evidence a care plan to address Resident # 4's [MEDICAL CONDITION]. On 11/30/16 at 9:10 a.m., an interview was conducted with RN (registered nurse) # 3, MDS coordinator regarding the CAA area of [MEDICAL CONDITION] being identified for a care plan. After reviewing the annual MDS assessment with an ARD of 6/23/16 for Resident # 4 and the comprehensive care plan dated of 6/28/2016, RN # 3 stated, It's not on the care plan. A care plan should have been developed. On 11/30/16 at 10:55 a.m., RN # 3 provided this surveyor with a copy of a care plan for Resident # 4. The care documented, Focus: [MEDICAL CONDITION]. Revision on 11/30/2016. On 12/1/16 at 9:25 a.m., an interview was conducted with RN # 3, MDS coordinator. When asked to describe the process of developing a care plan for a triggered area from the CAA of a resident's MDS, RN # 3 stated, Whoever triggered the CAA is responsible for developing the care plan. When asked who was responsible for the area of [MEDICAL CONDITION], RN # stated, (OSM (other staff member) # 1), director of resident family services. On 12/1/16 at 11:35 a.m., an interview was conducted with OSM # 1, director of resident family services regarding the CAA area of [MEDICAL CONDITION] being identified for a care plan on the annual MDS assessment with an ARD of 6/23/16 for Resident # 4. OSM # 1 stated he was responsible for developing the care plan for [MEDICAL CONDITION]. When asked why the care plan for [MEDICAL CONDITION] was not developed, OSM # 1 stated, It was during the transition from paper to electronic and it didn't get to the electronic care plan. On 11/30/16 at 5:00 p.m. OSM # 3 provided this surveyor with a copy of an activity care plan for Resident # 2 dated 11/30/2016. The facility's policy Plans of Care documented, The facility will develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The facility's policy Plans of Care documented, The facility will develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, A written care plan serves as a communication tool among health care team members that helps ensure continuity of care .The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care .expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders . (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings. No further information was provided prior to exit. Reference: (1) the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing [MEDICATION NAME] damage. This information was obtained from the website: https://medlineplus.gov/ency/article/ 6.htm . (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) [MEDICAL CONDITION] (P.V.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. www.nhlbi.nih.gov/health/health-topics/topics/ <http://www.nhlbi.nih.gov/health/health-topics/topics/> (4) Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Diabetes&commit=Search (5) Depression (major [MEDICAL CONDITION] or [MEDICAL CONDITION]) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. https://www.nimh.nih.gov/health/topics/depression/index.shtml (6) [MEDICAL CONDITION] is a chronic, severe, and disabling mental disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness. <https://www.nimh.nih.gov/health/statistics/prevalence/[MEDICAL CONDITION].shtml> (7) [MEDICAL CONDITION] Peripheral [MEDICAL CONDITION] describes damage to the peripheral nervous system, which transmits information from the brain and spinal cord to every other part of the body. http://www.ninds.nih.gov/disorders/[MEDICAL CONDITION]/[MEDICAL CONDITION]. (8) [MEDICAL CONDITION] reflux disease (GERD) is an ongoing condition in which the contents of the stomach come back into the esophagus. www.ncbi.nlm.nih.gov/pubmedhealth/PMH 11/
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to review and revise the comprehensive care plan for six of 26 residents in the survey sample, Residents #3, #5, #2, #4, #10, and #1. 1. The facility staff failed to review and revise the comprehensive care plan after a pressure wound had healed for Resident #3. 2. The facility staff failed to review and revise the comprehensive care plan after a pressure wound had healed for Resident #5. 3. The facility staff failed to revise the interventions to prevent falls on Resident # 2's comprehensive care plan following a fall. 4. The facility staff failed to revise Resident 4's comprehensive care plan for cognition. 5. The facility staff failed to review and revise Resident #10's comprehensive care plan following a fall on 1/10/16. 6. a. Resident # 1's comprehensive care plan was not revised when the Resident's wounds healed. b. Resident # 1's comprehensive care plan contained interventions dated from a previous admission. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan after a pressure wound had healed for Resident #3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/5/16, coded the resident as being moderately impaired to make daily decisions. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The comprehensive care plan dated, 9/6/16, documented in part, Focus: Impaired skin integrity - right buttock - coccyx. The Pressure Ulcer Record documented, Right Buttock - 10/31/16 - Resolved. The Pressure Ulcer Record documented, Coccyx - 10/31/16 - Resolved. An interview was conducted with LPN (licensed practical nurse) #3 on 11/30/16 at 8:30 a.m. When asked if Resident #3 had any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) pressure ulcers, LPN #3 stated, She (Resident #3) had them but they healed a few weeks ago. An interview was conducted with LPN #3 on 11/30/16 at 2:40 p.m. When asked who is responsible for updating resident care plans, LPN #3 stated, The unit managers, MDS nurse, and social workers. When asked if the floor nurses update resident care plans, LPN #3 stated, No. When asked the purpose of the care plan, LPN #3 stated, It's the care we are to provide to the resident. An interview was conducted with LPN #2, the unit manager, on 11/30/16 at 2:46 p.m. When asked who updates the care plan, LPN #2 stated, The nurses on the floor, the unit managers and MDS nurse. When asked if a healed pressure ulcer should be removed from the care plan or documented that it was healed, LPN #2 stated, Absolutely. It can show it's healed and the resident is still at risk though. An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 11/30/16 at 2:49 p.m. When asked who is responsible for updating the care plan, RN #3 stated, MDS is responsible for the comprehensive care plan development. Unit manager can update the care plan also. When asked if floor nurses can update the care plan, RN #3 stated, Yes, they can make changes. When asked if a pressure ulcer is healed, should the care plan be updated, RN #3 stated, Yes. If you know of something that has changed, then you change it. Everyone can update the care plan. The facility policy, Plans of Care documented in part, The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, A written care plan serves as a communication tool among health care team members that helps ensure continuity of care .The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care .expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders . Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. (1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 274. 2. The facility staff failed to review and revise the comprehensive care plan after a pressure wound had healed for Resident #5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/16, coded the resident as being moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive to being dependent upon one or more staff members for all of her activities of daily living, except eating in which the resident was coded as requiring supervision of one staff member. The comprehensive care plan, dated 8/25/16, documented in part, Focus: Potential for impaired skin integrity r/t (related to): fragile skin, incontinence, opened area to right buttock, open area to left heel and opened area to right heel. The Pressure Ulcer Record documented, Right heel - 8/25/16 - Resolved. The Pressure Ulcer Record documented, Left heel - 10/31/16 - Resolved. An interview was conducted with LPN (licensed practical nurse) #3 on 11/30/16 at 8:30 a.m. When asked if Resident #3 had any pressure ulcers, LPN #3 stated, She has a healing one on her buttock. She had them on both of her heels but they are now healed. An interview was conducted with LPN #3 on 11/30/16 at 2:40 p.m. When asked who is responsible for updating the resident care plans, LPN #3 stated, The unit managers, MDS nurse, and social workers. When asked if the floor nurses update the resident care plans, LPN #3 stated, No. When asked the purpose of the care plan, LPN #3 stated, It's the care we are to provide to the resident. An interview was conducted with LPN #2, the unit manager, on 11/30/16 at 2:46 p.m. When asked who updates the resident care plans, LPN #2 stated, The nurses on the floor, the unit managers and MDS nurse. When asked if a healed pressure ulcer should be removed from the care plan or documented as healed, LPN #2 stated, Absolutely. It can show it's healed and the resident is still at risk though. An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 11/30/16 at 2:49 p.m. When asked who is responsible for updating the care plan, RN #3 stated, MDS is responsible for the comprehensive care plan development. Unit manager can update the care plan also. When asked if floor nurses can update the care plan, RN #3 stated, Yes, they can make changes. When asked if a pressure ulcer is healed, should the care plan be updated, RN #3 stated, Yes. If you know of something that has changed, then you change it. Everyone can update the care plan. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. (1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 286. (2) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 522 3. The facility staff failed to revise the interventions to prevent falls on Resident # 2's comprehensive care plan following a fall. Resident # 2 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident # 2's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 8/21/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff members for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. Under G0400 Functional Limitation in Range of Motion Resident # 2 was coded as Impaired on both sides for upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. Resident # 2's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 9/18/16 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff member for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. Under G0400 Functional Limitation in Range of Motion Resident # 2 was coded as Impaired on both sides for upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. The Interdisciplinary Progress Note dated 8/25/16 for Resident # 2 documented, 11p (11:00 p.m.) At 1015 p (10:15 p.m.) resident fell from bed to floor on his side during incontinence care by CNA (certified nursing assistant). As per CNA, he had positioned resident on his Rt (right) side during care on the bed. Resident rolled over, fell down on the floor on his side. Resident denies hitting head on the floor, CNA denies resident hitting head on the floor. ROM (range of motion) to all Xty (extremities) ok tolerated well. Resident assist (assisted) back to bed. VS (vital signs) T (temperature) 98, P (pulse) 74, R (respiration) 10, BP (blood pressure) 134/ (over) 76. (Name of Physician) notified. Family called x6 (six times) but no answer to phone. Staff educated on having x2 (two) CNAs during incontinence care. The comprehensive care plan for Resident # 2 with a revision date of 9/21/2016 documented, Focus: Potential for injury r/t (related to): Poor safety awareness. Psychoactive drug use. [DIAGNOSES REDACTED]. Under the heading Interventions it documented eight interventions for falls that further documented, Date Initiated: 9/21/2016 for each intervention. There was no documentation evidencing interventions the care plan was revised and interventions implemented after Resident #2's fall on 8/25/16. On 12/1/16 at 12:20 p.m. an interview was conducted with RN (registered nurse) # 1, assistant director of clinical services. After reviewing the comprehensive care plan for Resident # 2 with a revision date of 9/21/2016, RN # 1 was asked to identify which fall intervention was put into place following Resident # 2's fall on 8/25/16, RN # 1 was unable to identify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0280

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 4)
the intervention. RN # 1 stated, When the care plan is updated the program (the electronic health record) changes the dates of all the interventions to the review date. There is no way of knowing when each intervention was initiated.
The facility policy Plans of Care documented, The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.
References:
(1) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.
(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm.
(4) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or pins and needles and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html.
(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
(6) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
4. The facility staff failed to revise Resident 4's comprehensive care plan for cognition.
Resident # 4 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED].
Resident # 4's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 6/23/16 coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 being moderately impaired of cognition for daily decision making. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed, 02. Cognitive Loss/Dementia was coded as Addressed in Care Plan.
The comprehensive care plan for Resident # 4 dated 6/17/2016 documented, Focus. The resident has impaired cognition and/or impaired thought process r/t (related to):[MEDICAL CONDITION] with left [MEDICAL CONDITION]. [DIAGNOSES REDACTED].
The current comprehensive care plan for Resident # 4 dated 6/28/2016 failed to evidence documentation regarding cognition.
On 11/30/16 an interview was conducted with RN (registered nurse) # 3, MDS coordinator. When asked about the current comprehensive care plan for Resident # 4 dated 6/28/2016 that failed to evidence documentation regarding cognition, RN # 3 stated, It wasn't updated in the current care plan.
On 11/30/16 at 5:00 p.m. OSM # 3 provided this surveyor with a copy of a cognition care plan for Resident # 2 dated 11/30/2016.
On 12/1/16 at 9:25 a.m. an interview was conducted with RN # 3, MDS coordinator regarding the process of reviewing and revising the care plan. RN # 3 stated, During the care plan meetings the care plan is reviewed and we determine what areas need to be carried over to the revised care plan. When asked about the current comprehensive care plan dated 6/28/16 for Resident # 4 not revised being for the area of cognition, RN # 3 stated, It was overlooked.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.
Reference:
(1) the most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html.
(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.
(3) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing [MEDICATION NAME] damage. This information was obtained from the website: https://medlineplus.gov/ency/article/ 6.htm .
(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.
5. The facility staff failed to review and revise Resident #10's comprehensive care plan following a fall on 1/10/16.
Resident #10 was admitted to the facility on [DATE]. Resident #10's [DIAGNOSES REDACTED]. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/11/16, coded the resident as being cognitively intact. Section J documented Resident #10 had not sustained any falls since the prior assessment.
Review of Resident #10's clinical record revealed a nurse's note dated 1/10/16 that documented, Resident alert and verbally responsive get (sic) out of bed and slidded (sic) to the floor stated I was going to the bathroom, Resident assessed no apperent (sic) injury noted at present . A fall investigation dated 1/10/16 documented, Resolution/Intervention for minimizing future occurrences: Resident encouraged to used (sic) the call light to get assistance when needed.
Review of Resident #10's comprehensive care plan with an implementation date of 11/18/15 failed to reveal the care plan was reviewed or revised following the resident's fall on 1/10/16.
On 11/30/16 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1 (the assistant director of clinical services/former MDS coordinator). RN #1 was asked the facility process for implementing interventions and updating a resident's care plan following a fall. RN #1 stated an intervention based on the circumstances of the fall is implemented, orders are written, the information is documented in the nurses' notes and the fall/intervention is documented on the resident's care plan. At this time, RN #1 confirmed there was no documentation to evidence Resident #10's care plan was updated following the resident's fall on 1/10/16.
On 11/30/16 at 6:15 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern.
On 12/1/16 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated the unit manager was responsible for updating a resident's care plan following a fall.
On 12/1/16 at 10:22 a.m., an interview was conducted RN #2 (unit manager). RN #2 stated unit managers and the MDS coordinators were responsible for updating a resident's care plan following a fall. RN #2 stated the unit managers look to see if the MDS coordinators have updated a resident's care plan following a fall and if they have not, then they (the unit managers) update it.
The facility policy titled, Plans of Care documented in part, The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being .
No further information was presented prior to exit.
6 a. Resident # 1's comprehensive care plan was not revised when the Resident's wounds healed.
Resident # 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (minimum data
set), an admission assessment with an ARD (assessment reference date) of 11/6/16, coded the resident as scoring a 15 out of 15 on the brief interview for mental status, indicting the resident was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0280

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)
A review of Resident # 1's comprehensive care plan dated 11/9/16, revealed under Focus - SKIN: The resident has impaired skin integrity: The following list included: Left elbow, Left lateral leg, Left knee scab, Left under great toe, Right AKA (above the knee amputation) open wound, and Back - open blister. Review of the clinical record revealed that most of these areas were resolved but the care plan had not been updated to reflect that the area had healed.
During an interview on 11/30/16 at 5:30 p.m. with LPN (licensed practical nurse) # 1, LPN # 1 was asked who updates the resident care plans. LPN # 1 stated that everyone is responsible to update the care plan, whoever takes an order or notices a change can update the care plan. LPN # 1 stated that if staff receives an order, they will transcribe the order, fax the pharmacy, call the responsible party, go into PCC (point click care), the computer program and update the care plan, and write a nurse's note. The information would also go onto the 24 hour report and this report is reviewed at the morning meeting.
During an interview on 12/1/16 at 9:30 a.m. with RN (registered nurse) # 3, RN # 3 stated that revision of the care plan is a team effort; the IDT (interdisciplinary team) updates the care plan. If changes are noted in the morning meeting then changes (updates) are made at that time. RN # 3 was asked if the care plan would be revised if a resident's wound healed. RN # 3 stated that a revision would be done. RN # 3 stated that under Focus it would be documented that the wound was resolved.
During an interview on 12/1/16 at 11:35 a.m. with ASM (Administrative Staff Member) # 1, the executive director, ASM # 2, the director of clinical services, ASM # 3, the administrator in Training, ASM # 4, the divisional director of clinical services, ASM # 5, the regional director of clinical services, and RN # 1, the assistant director of clinical services, this concern was discussed.
Prior to exit on 12/1/16 an updated care plan for Skin was presented - this care plan indicated the Left lateral leg, left knee scab, and left under great toe wounds were resolved.
b. Resident # 1's care plan contained interventions dated from a previous admission.
Review of Resident # 1's care plan for the resident's current admission of 10/30/16 contained dates for interventions from a previous admission in April 2016.
During an interview on 11/30/16 at 5:35 p.m. with RN # 1, Resident # 1's care plan was reviewed. RN # 1 stated that when a new admission arrives the supervisor puts the information into the computer. There is a basic care plan in the computer and this program allows the new care plan to pull everything in the computer for an individual resident.
During an interview on 12/1/16 at 9:30 a.m. with RN (registered nurse) # 3, the current care plan for Resident # 1 was reviewed. The dates for interventions were reviewed and RN # 3 stated that the dates for the interventions should have been updated for the current admission.
During an interview on 12/1/16 at 10:00 a.m. with RN # 1 Resident # 1's care plan was again discussed. RN # 1 stated that the reason dates from the previous care plan were on the current care plan is that Resident # 1's previous care plan was still in the computer system. The previous care plan should have been resolved out - it was not resolved out and the computer continued with the previous care plan information.
During an interview on 12/1/16 at 11:35 a.m. with ASM (Administrative Staff Member) # 1, the executive director, ASM # 2, the director of clinical services, ASM # 3, the administrator in Training, ASM # 4, the divisional director of clinical services, ASM # 5, the regional director of clinical services, and RN # 1, the assistant director of clinical services, this concern was discussed.
No further information was provided prior to exit.
References:
(1) [MEDICAL CONDITION] (CAD) is the most common type of [MEDICAL CONDITION]. It is the leading cause of death in the United
States in both men and women. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=cad&commit=Search
(2) [MEDICAL CONDITION] (P.V.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. www.nhlbi.nih.gov/health/health-topics/topics/ <http://www.nhlbi.nih.gov/health/health-topics/topics/>
(3) Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Diabetes&commit=Search
(4) Depression (major [MEDICAL CONDITION] or [MEDICAL CONDITION]) is a common but serious mood disorder. It causes severe
symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. https://www.nimh.nih.gov/health/topics/depression/index.shtml
(5) [MEDICAL CONDITION] is a chronic, severe, and disabling mental disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness.<https://www.nimh.nih.gov/health/statistics/prevalence/[MEDICAL CONDITION].shtml>
(6) [MEDICAL CONDITION] Peripheral [MEDICAL CONDITION] describes damage to the peripheral nervous system, which transmits
information from the brain and spinal cord to every other part of the body. http://www.ninds.nih.gov/disorders/[MEDICAL CONDITION]/[MEDICAL CONDITION].
(7) [MEDICAL CONDITION] reflux disease (GERD) is an ongoing condition in which the contents of the stomach come back into the esophagus. www.ncbi.nlm.nih.gov/pubmedhealth/PMH 11/

F 0282

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care by qualified persons according to each resident's written plan of care.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, staff interview, clinical record review and facility document review it was determined that facility staff failed to provide services in accordance with the written plan of care for one of 26 residents in the survey sample, Resident # 2.
1a. The facility staff failed to administer oxygen as ordered by the physician and as documented in the comprehensive care plan for Resident # 2.
1b. The facility staff failed to put Resident # 2's bed in its lowest position as documented in the comprehensive care plan.
The findings include:
1a. The facility staff failed to administer oxygen as documented in the comprehensive care plan for Resident # 2.
Resident # 2 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED].
Resident # 2's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 9/18/16 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff members for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. A review of Section O Special Treatments, Procedures and Programs of Resident # 2's annual MDS assessment with an ARD of 9/18/16 coded Resident # 2 with Oxygen therapy.
An observation on 11/29/16 at approximately 3:00 p.m. revealed Resident # 2, sitting up in bed watching television receiving oxygen by nasal cannula (7). Further observation of Resident # 2's oxygen concentrator (8) revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/29/16 at approximately 4:30 p.m. revealed Resident # 2, sitting up in bed watching television receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/30/16 at approximately 8:30 a.m. revealed Resident # 2, lying in bed awake receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/30/16 at approximately 2:45 a.m. revealed Resident # 2, lying in bed watching television receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
The physician's orders [REDACTED].# 2 documented, Oxygen at 2L/MIN (two liters per minute) via (by) nasal cannula continuous for [MEDICAL CONDITION] ([MEDICAL CONDITION] (6)). Date 9/28/16.
The care plan for Resident # 2 with a revision dated of 9/21/2016 documented, Focus: Potential for ineffective breathing pattern r/t (related to): [MEDICAL CONDITION] reflux disease (2), H/O (History of) asthma, H/O pneumonia, [DIAGNOSES REDACTED]. Under Interventions/Tasks it documented, Oxygen via nasal cannula per order. Date initiated 09/21/2016.
On 11/30/16 at 2:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 8. When asked what the oxygen flow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0282

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 6)
rate should be set at for Resident # 2, LPN #8 stated, Two liters per minute. When asked how the oxygen flow rate is read on an oxygen concentrator, LPN # 8 stated, The line of the flow rate should pass through the middle of the float ball. LPN # 8 was then asked to accompany this surveyor into Resident # 2's room and read the flow rate on the oxygen concentrator for Resident # 2. LPN # 8 read the oxygen flow rate and stated, It's at one and a half liters. After reviewing the physician orders [REDACTED].# 2, LPN # 8 stated, If it's on the care plan it should be followed.
On 11/30/16 at 4:15 p.m. an interview was conducted with LPN # 2, unit manager. When asked about the purpose of the care plan, LPN # 2 stated, To properly take care of the resident. Nursing refers to it for resident care and changes are made according to changes in the resident.
The facility policy Plan of Care documented, Direct care staff should be aware, understand and follow their resident's plan of care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary.
According to Mosby's Textbook for Long-Term Care Assistants, fourth edition, 2003. Page 144, Safety is a basic need. Nursing center residents are at great risk for falls and other accidents You need to know the factors that increase a person's risk of accidents and injury. You also need to follow the person's care plan.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.
References:
(1) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.
(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm.
(4) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or pins and needles and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html.
(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
(6) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
(7) A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. This information was obtained from the website: http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes.
(8) An oxygen concentrator (also sometimes called oxygen generator) is a medical device used to deliver oxygen to those who require it. People may require it if they have a condition that causes or results in low levels of oxygen in their blood. Oxygen concentrators are powered by plugging in to an electrical outlet or by battery. If the concentrator is powered by an electric battery, that battery will need to be charged by plugging into an outlet. Several parts make up a concentrator, including a compressor, sieve bed filter, and circuit boards. This information was obtained from the website: http://www.inogen.com/resources/oxygen-concentrators/how-does-an-oxygen-concentrator-work/.
1b. The facility staff failed to put Resident # 2's bed in its lowest position as documented in the comprehensive care plan.
An observation on 11/29/16 at approximately 3:00 p.m. revealed Resident # 2, sitting up in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 17 (seventeen) inches from the floor.
An observation on 11/29/16 at approximately 4:30 p.m. revealed Resident # 2, sitting up in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 17 (seventeen) inches from the floor.
An observation on 11/30/16 at approximately 8:30 a.m. revealed Resident # 2, lying in bed awake. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 14 (fourteen) inches from the floor.
An observation on 11/30/16 at approximately 2:45 a.m. revealed Resident # 2, lying in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 14 (fourteen) inches from the floor.
The physician's orders [REDACTED].# 2 documented, Treatment. Bed in lowest position at all times when in bed every shift. Date 5/16/16.
The comprehensive care plan for Resident # 2 with a revision date of 9/21/2016 documented,Focus: Potential for injury r/t (related to): Poor safety awareness. Psychoactive drug use. [DIAGNOSES REDACTED]. Under the headingInterventions it documented,Bed in lowest position when resident is in bed. Date Initiated: 9/21/2016.
On 11/30/16 at 2:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 8. LPN # 8 was then asked to accompany this surveyor into Resident # 2's room and look at the height of Resident # 2's bed. Using a wooden folding ruler provided by this surveyor LPN # 8 read the measurement of the bed from the bottom of the frame to the floor being 14 inches. LPN # 8 stated,It's not all the way down. After reviewing the care plan for Resident # 2 LPN # 8 stated,If it's on the care plan it should be followed.
On 11/30/16 at 3:05 p.m. an examination and measurement of Resident # 2's bed was conducted with ASM (administrative staff member) # 2, director of clinical services, and ASM # 4, divisional director of clinical services. ASM # 2 and ASM # 4 stated that the bed's lowest point was 11 inches from the floor. Using a wooden folding ruler provided by this surveyor to measure the bed from the bottom of the frame to the floor, ASM # 2 and ASM # 4 acknowledged that it was above the 11 inches and was not in the lowest position.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.

F 0323

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement fall safety interventions for one of 26 residents in the survey sample, Resident # 2.
The facility staff failed to implement fall interventions for Resident # 2, per a physician's orders [REDACTED].
The findings include:
Resident # 2 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED].
Resident # 2's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 8/21/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff member for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. Under G0400 Functional Limitation in Range of Motion Resident # 2 was coded as Impaired on both sides for upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities.
Resident # 2's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 9/18/16 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff member for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. Under G0400 Functional Limitation in Range of Motion Resident # 2 was coded as Impaired on both sides for upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. An observation on 11/29/16 at approximately 3:00 p.m. revealed Resident # 2, sitting up in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 17 (seventeen) inches from the floor. An observation on 11/29/16 at approximately 4:30 p.m. revealed Resident # 2, sitting up in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 17 (seventeen) inches from the floor. An observation on 11/30/16 at approximately 8:30 a.m. revealed Resident # 2, lying in bed awake. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 14 (fourteen) inches from the floor. An observation on 11/30/16 at approximately 2:45 a.m. revealed Resident # 2, lying in bed watching television. A measurement of Resident # 2's bed, using a wooden folding ruler provided by this surveyor, from the bottom of the frame to the floor revealed it was 14 (fourteen) inches from the floor. The Interdisciplinary Progress Note dated 8/25/16 for Resident # 2 documented, 11p (11:00 p.m.) At 1015 p (10:15 p.m.) resident fell from bed to floor on his side during incontinence care by CNA (certified nursing assistant). As per CNA , he had positioned resident on his Rt (right) side during care on the bed. Resident rolled over, fell down on the floor on his side. Resident denies hitting head on the floor, CNA denies resident hitting head on the floor. ROM (range of motion) to all Xty (extremities) ok tolerated well. Resident assist (assisted) back to bed. VS (vital signs) T (temperature) 98, P (pulse) 74, R (respiration) 10, BP (blood pressure) 134/ (over) 76. (Name of Physician) notified. Family called x6 (six times) but no answer to phone. Staff educated on having x2 (two) CNAs during incontinence care. The physician's orders [REDACTED].# 2 documented, Treatment. Bed in lowest position at all times when in bed every shift. Date 5/16/16. The ADL (activities of daily living) care plan with a target date of 3/16 (March 2016) documented, Resident is dependent on 2 (two) (specify # (number) of staff) regarding bathing, dressing, grooming, hygiene, bed mobility, and toileting. The comprehensive care plan for Resident # 2 with a revision date of 9/21/2016 documented, Focus: Potential for injury r/t (related to): Poor safety awareness. Psychoactive drug use. [DIAGNOSES REDACTED]. Under the heading Interventions it documented eight interventions for falls that that further documented, Date Initiated: 9/21/2016 for each intervention. The current ADL care plan dated 9/21/16 for Resident # 2 failed to specify the number of staff required to assist Resident # 2 for bathing, dressing, grooming, hygiene, bed mobility, and toileting. The facility's Kardex for Resident # 2 documented, Elimination. Under Elimination the level of assistance was left blank. Further review of the Kardex documented, Bed Mobility: assist of 2 (two), Transfers: assist of 2. Review of the clinical record for Resident # 2 revealed that he did not have any other fall since 8/25/16. On 11/30/16 at 2:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 8. LPN # 8 was then asked to accompany this surveyor into Resident # 2's room and look at the height of Resident # 2's bed. Using a wooden folding ruler provided by this surveyor LPN # 8 read the measurement of the bed from the bottom of the frame to the floor being 14 inches. LPN # 8 stated,It's not all the down. After reviewing the care plan for Resident # 2 LPN # 8 stated, If it's on the care plan it should be followed. On 11/30/16 at 3:05 p.m. an examination and measurement of Resident # 2's bed was conducted with ASM (administrative staff member) # 2, director of clinical services, and ASM # 4, divisional director of clinical services. ASM # 2 and ASM # 4 stated that the bed's lowest point was 11 inches from the floor. Using a wooden folding ruler provided by this surveyor to measure the bed from the bottom of the frame to the floor, ASM # 2 and ASM # 4 acknowledged that it was above the 11 inches and was not in the lowest position. On 11/30/16 at 3:15 p.m. an interview was conducted with CNA (certified nursing assistant) # 8. When asked how she determines the level of assistance a resident requires during care CNA # 8 stated, I look on the kardex at the nurse's station. On 12/1/16 at 8:35 a.m. an interview was conducted with RN (registered nurse) # 1, assistant director of clinical services. When asked what a CNA (certified nursing assistant) would reference on the Kardex to determine the level of assistance for incontinence care RN # 1 referred to the kardex for Resident # 2 and identified the heading, Elimination. When it was pointed out that the level of assistance under Elimination was left blank RN # 1 stated, Since the level of assistance was blank under elimination the CNA could refer to the level of assistance under bed mobility. On 12/1/16 at 12:20 p.m. an interview was conducted with RN (registered nurse) # 1, assistant director of clinical services. After reviewing the comprehensive care plan for Resident # 2 with a revision date of 9/21/2016 RN # 1 was asked to identify which fall intervention was put into place following Resident # 2's fall on 8/25/16 RN # 1 was unable to identify the intervention. RN # 1 stated, When the care plan is updated the program (the electronic health record) changes the dates of all the interventions to the review date. There is no way of knowing when each intervention was initiated. During the days of the survey attempts were made to interview the staff members who were present at the time of Resident # 2's fall on 8/25/16. The staff members were not available during the days of the survey. On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings. No further information was provided prior to exit. References: (1) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html. (2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm. (4) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or pins and needles and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. (5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. (6) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
F 0328 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide specialty services per the physician's orders [REDACTED].#11 and Resident #2. 1. The facility staff failed to obtain a physician's orders [REDACTED].#11 that was completed on 6/24/16. 2a. The facility staff failed to administer oxygen according to the physician's orders [REDACTED]. b. The facility staff failed to obtain a podiatry consult according to the physician's orders [REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**	STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0328

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 8)
The findings include:
1. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/16 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living.
Review of the resident's care plan initiated on 5/12/16 and revised on 11/14/16 did not evidence documentation related to a podiatry consultation.
Review of the clinical record documented that the resident was seen by the podiatrist on 6/24/16.
Review of the physician's orders [REDACTED].
An interview was conducted on 12/1/16 at 8:55 a.m. with LPN (licensed practical nurse) #3. When asked the process for obtaining a podiatry consult, LPN #3 stated, You see if the toenails are long. When asked if a doctor's order was needed, LPN #3 stated, Don't need an order. We put them on the list (for podiatry) and give it to (name of social worker).
An interview was conducted on 12/1/16 at 9:05 a.m. with OSM (other staff member) #1, the social worker. When asked the process he followed in obtaining podiatry consults, OSM #1 stated, They would tally up a list for me. I would send a fax or email to him (the podiatrist) and he would email me back to let me know when he was coming. When asked if he needed doctor's order for a podiatry consult, OSM #1 stated, No. When asked if the facility had a standing physician order [REDACTED].
An interview was conducted on 12/1/16 at 9:10 a.m. with ASM (administrative staff member) #4, the divisional director of clinical services and ASM #5, the regional director of clinical services. ASM #4 stated that the order for the podiatry was included in the admission packet the resident signed. ASM #4 stated that Resident #11 had signed the section allowing for podiatry services. When asked if the admission packet was part of the clinical record, ASM #5 stated, No, we keep it in the business office. When asked how staff would know if the resident agreed to the services, ASM #5 stated, Don't know.
Review of Resident #11's admission packet documented, NOTIFICATION & CONSENT FORM. 3. Vendors. I have been informed that the
following vendors have been designated to provide services for this facility. I consent to these services, as ordered by my physician . The Resident signed the form on 5/10/16 and indicated that he would accept the vendor.
On 12/1/16 at 10:00 a.m. ASM #2, the director of clinical services approached this surveyor and stated, We found out we need a doctor's order and we can't find it.
On 12/1/16 at 12:45 p.m. ASM #1, the executive director and ASM #2 were made aware of the findings.
Review of the facility's policy titled, Medical Consolations (sic) documented, Policy: Members of the medical staff will request a medical consultation when appropriate.
No further information was provided prior to exit.
2a. The facility staff failed to administer oxygen according to the physician's orders [REDACTED].
Resident # 2 was admitted to the facility on [DATE] and a readmitted on [DATE] with [DIAGNOSES REDACTED].
Resident # 2's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 9/18/16 coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 2 was coded as requiring extensive assistance to being totally dependent of one to two staff members for activities of daily living. Resident # 2 was coded as requiring extensive assistance of two staff members for bed mobility and total assistance of two staff members for transfers. A review of Section O Special Treatments, Procedures and Programs of Resident # 2's annual MDS assessment with an ARD of 9/18/16 coded Resident # 2 with Oxygen therapy.
An observation on 11/29/16 at approximately 3:00 p.m. revealed Resident # 2, sitting up in bed watching television receiving oxygen by nasal cannula (7). Further observation of Resident # 2's oxygen concentrator (8) revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/29/16 at approximately 4:30 p.m. revealed Resident # 2, sitting up in bed watching television receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/30/16 at approximately 8:30 a.m. revealed Resident # 2, lying in bed awake receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
An observation on 11/30/16 at approximately 2:45 a.m. revealed Resident # 2, lying in bed watching television receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator was set between one and one and a half liters per minute.
The physician's orders [REDACTED].# 2 documented, Oxygen at 2L/MIN (two liters per minute) via (by) nasal cannula continuous for [MEDICAL CONDITION] ([MEDICAL CONDITION] (6)). Date 9/28/16.
The MAR (medication administration record) dated for November 2016 for Resident # 2 documented, Oxygen at 2L/MIN via nasal cannula continuous for [MEDICAL CONDITION]. Date 9/28/16. Further review of the MAR indicated [REDACTED]. m. shift, the 7:00 a.m.-3:00 p.m. shift and the 3:00 p.m-11:00 p.m. shift.
The care plan for Resident # 2 with a revision dated of 9/21/2016 documented, Focus: Potential for ineffective breathing pattern r/t (related to): [MEDICAL CONDITION] reflux disease (2), H/O (History of) asthma, H/O pneumonia, [DIAGNOSES REDACTED]. Under Interventions/Tasks it documented, Oxygen via nasal cannula per order. Date initiated 09/21/2016.
On 11/30/16 at 2:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 8. When asked what the oxygen flow rate should have be for Resident # 2, LPN #8 stated, Two liters per minute. When asked how the oxygen flow rate is read on an oxygen concentrator, LPN # 8 stated, The line of the flow rate should pass through the middle of the float ball. LPN # 8 was then asked to accompany this surveyor into Resident # 2's room and read the flow rate on the oxygen concentrator for Resident # 2. LPN # 8 read the oxygen flow rate and stated, It's at one and a half liters.
According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's order [REDACTED]. The six rights of medication administration also pertain to oxygen administration.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.
References:
(1) Low blood pressure. This information was taken from the website: https://medlineplus.gov/lowbloodpressure.html.
(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 4.htm.
(4) A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or pins and needles and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html.
(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
(6) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html.
(7) A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. This information was obtained from the website: http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes.
(8) An oxygen concentrator (also sometimes called oxygen generator) is a medical device used to deliver oxygen to those who require it. People may require it if they have a condition that causes or results in low levels of oxygen in their blood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0328

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 9)
Oxygen concentrators are powered by plugging in to an electrical outlet or by battery. If the concentrator is powered by an electric battery, that battery will need to be charged by plugging into an outlet. Several parts make up a concentrator, including a compressor, sieve bed filter, and circuit boards. This information was obtained from the website: http://www.inogen.com/resources/oxygen-concentrators/how-does-an-oxygen-concentrator-work/.
b. The facility staff failed to obtain a podiatry consult according to the physician's orders [REDACTED].
The Physician's Telephone Order dated 10/4/16 for Resident # 2 documented, Podiatry Consult.
Review Resident # 2's clinical record failed to evidence a podiatry consult.
Review of the comprehensive care plan failed to evidence documentation regarding podiatry services for Resident #2.
On 11/30/16 at 10:35 a.m. an interview was conducted with ASM (administrative staff member) # 4, divisional director of clinical services, regarding the podiatry consult for Resident # 2. ASM # 2 stated, There's no note for the podiatry visit. We called the podiatrist's office and they stated that (Resident # 2) was seen but there is no documentation. ASM # 4 further stated that the podiatrist's office informed her that the podiatrist had retired on 11/29/16.
On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.

F 0329

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure resident drug regimens were free of unnecessary medications for two of 26 residents in the survey sample, Residents #6 and #9.
1. The facility staff failed to ensure adequate monitoring for the administration of [MEDICATION NAME] ([MEDICATION NAME] acid) to Resident #6. The facility staff failed to obtain a physician ordered [MEDICATION NAME] acid level from Resident #6 on 10/25/16. The laboratory test was used to monitor the resident's medication [MEDICATION NAME] ([MEDICATION NAME] acid).
2. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed [MEDICATION NAME] to Resident #9 seven out of seven times from October 2016 through November 2016.
The findings include:
1. The facility staff failed to ensure adequate monitoring for the administration of [MEDICATION NAME] ([MEDICATION NAME] acid) to Resident #6. The facility staff failed to obtain a physician ordered [MEDICATION NAME] acid level from Resident #6 on 10/25/16. The laboratory test was used to monitor the resident's medication [MEDICATION NAME] ([MEDICATION NAME] acid).
Resident #6 was admitted to the facility on [DATE]. Resident #6's [DIAGNOSES REDACTED]. Resident #6's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/8/16, coded the resident's cognition as being moderately impaired.
Review of Resident #6's clinical record revealed readmission physician's orders [REDACTED].
Laboratory (lab) test results collected on 10/18/16 documented a low [MEDICATION NAME] acid level of 25.9 (with a normal reference range of 50.0 to 100.0).
A physician's telephone order dated 10/18/16 documented orders for [MEDICATION NAME] 250 mg- one tablet by mouth every day in the morning and a [MEDICATION NAME] acid level on 10/25/16.
Further review of Resident #6's clinical record failed to reveal results of a [MEDICATION NAME] acid level obtained on 10/25/16.
Resident #6's comprehensive care plan initiated on 3/17/16 documented,
Psychoactive Medication Use: Depression, [MEDICAL CONDITIONS]
- Anti-Depressant
-Antipsychotic
Interventions: Evaluate medication use and resident's response quarterly .
On 11/30/16 at 4:30 p.m., RN (registered nurse) #1 confirmed the [MEDICATION NAME] acid level ordered to be obtained from Resident #6 on 10/25/16 was not done. RN #1 stated the physician had been notified and ordered the lab be obtained STAT (immediately).
On 11/30/16 at 6:15 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern.
A [MEDICATION NAME] acid level obtained on 11/30/16 documented a low [MEDICATION NAME] acid level of 45.8. Handwritten
documentation on the results documented, (Name of physician) made aware. New orders given. D/C (Discontinue) previous [MEDICATION NAME] (also known as [MEDICATION NAME] and also known as [MEDICATION NAME] acid) orders. Start [MEDICATION
NAME] 500 mg Bid (twice a day) daily.
On 12/1/16 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked the process for obtaining labs per physician's orders [REDACTED].#7 stated an employee from the lab comes to the facility to obtain labs every Tuesday and Thursday. LPN #7 stated the physician will tell the nurses whether to obtain a lab on the next lab day or STAT. LPN #7 stated the nurses should write the order, transcribe the order to the TAR (treatment administration record) and enter the order on the lab log. LPN #7 stated the 11:00 p.m. to 7:00 a.m. shift is responsible for ensuring the labs are obtained.
The facility policy titled, Laboratory Procedure documented, Policy: To provide a means to check a resident's specimen as ordered by the physician and to maintain a record of the results .Procedure: Obtain a physician's orders [REDACTED]. When the blood is drawn, the nurse or phlebotomist will document in the lab log or in the clinical record. If deemed necessary, the facility may keep a special log for laboratory tests being ordered. The results are checked by the Clinical Nurse and the physician is notified of the results. This notification may be written on the Lab Results form. All lab results are kept in a designated place until seen and signed by the physician. The lab results are filed in the patient's chart under the Laboratory section.
No further information was presented prior to exit.
(1) [MEDICATION NAME] ([MEDICATION NAME] acid) is used alone or with other medications to treat certain types of [MEDICAL
CONDITION]. [MEDICATION NAME] acid is also used to [MEDICAL CONDITION](episodes of frenzied, abnormally excited mood) in
people with [MEDICAL CONDITION] disorder (manic-[MEDICAL CONDITION]; a disease that causes episodes of depression, episodes
of mania, and other abnormal moods) . This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a 2.html
(2) [MEDICAL CONDITION] disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, up, and active to very sad and hopeless, down, and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html
2. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed [MEDICATION NAME] (1) to Resident #9 seven out of seven times from October 2016 through November 2016.
Resident #9 was admitted to the facility on [DATE]. Resident #9's [DIAGNOSES REDACTED]. Resident #9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/26/16, coded the resident's cognition as being moderately impaired. Section N documented Resident #9 had received anti-anxiety medication one out of the last seven days.
Review of Resident #9's clinical record revealed a physician's orders [REDACTED].
Review of Resident #9's October 2016 and November 2016 MARs (medication administration records) revealed the resident was administered as needed [MEDICATION NAME] seven times. Further review of Resident #9's clinical record (including MARs and nurses' notes) failed to reveal non-pharmacological interventions were attempted prior to the administration of as needed Ativen seven out of seven times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) Resident #9's comprehensive care plan initiated on 5/19/16 documented, [MEDICAL CONDITION] Drug Use .[MEDICATION NAME] (Anxiety) . The care plan failed to document information regarding non-pharmacological interventions. On 12/1/16 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked what should be done prior to the administration of as needed [MEDICATION NAME]. LPN #7 stated staff should try to calm the patient, offer fluids and one on one conversation. LPN #7 was asked where nurses should document that these non-pharmacological interventions were attempted. LPN #7 stated the [MEDICATION NAME] administration and reassessment of the resident should be documented on the MAR and the attempted interventions should be documented in the nurses' notes. At this time, LPN #7 was asked why non-pharmacological interventions were not documented for Resident #9 prior to the administration of as needed [MEDICATION NAME]. LPN #7 stated the resident tells staff she wants [MEDICATION NAME]. When asked if non-pharmacological interventions were still attempted with Resident #9, LPN #9 stated, We still talk to her. What's going on? What do you need? Do you need to be repositioned in bed? Turn TV on? LPN #7 confirmed attempted non-pharmacological interventions should be documented in residents' clinical records. On 12/1/16 at 12:10 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern. The facility policy titled, Psychoactive Medications documented in part, 2. The facility supports the goals of determining the underlying cause of resident behavioral symptoms to determine the appropriate treatment of [REDACTED]. Non-pharmacological Interventions will be used to avoid using psycho-pharmacologic drugs to the extent possible . No further information was presented prior to exit. (1) [MEDICATION NAME] is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a 3.html
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Store, cook, and serve food in a safe and clean way** Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and prepare food in a sanitary manner. The findings include: Observation of the kitchen was conducted on 11/29/16 at approximately 12:00 p.m. with OSM (other staff member) # 9, director of dining services. The following was observed: Observation of the food preparation table revealed a meat slicer. When asked if the meat slicer was cleaned and ready for use OSM # 9 stated, Yes. Observation of the meat slicer revealed the carriage had food debris on it. OSM # 9 agreed with the findings and had it disassemble and washed by the kitchen staff. Observation of the dry food storage room revealed a plastic bin containing flour. Further observation of the flour bin revealed the plastic lid was not correctly placed on the bin, leaving a gap around the edge exposing the flour to contamination. OSM # 9 removed the lid to the flour bin and repositioned it so it sealed the bin. Observation of the dry storage rack revealed nine 12 inch wide by 20 long and two inch deep pans and one 4 inch deep by 12 inches wide and 20 inches long pan ready for use. Further observation of the pans revealed the bottoms of the inside of the pans had food debris on them. OSM # 9 observed each of the pans and agreed with the findings. OSM # 9 had the pans removed from the rack and rewashed. The facility's policy Equipment documented, It is the center policy that all food service equipment is clean, sanitary and in proper working order. The policy Food Storage-dry Goods documented, 3. The Food Service Director or designee ensures that all packaged and canned food items shall be kept clean, dry, and properly sealed. On 11/30/16 at approximately 5:55 p.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings. No further information was provided prior to exit.
F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure timely physician visits for six of 26 residents in the survey sample, Residents #3, #5, #12, #6, #10, and #11. 1. For Resident #3, the physician did not see the resident from [DATE] until the time of the survey, [DATE], a period of 142 days. 2. For Resident #5, the physician did not see the resident from [DATE] until [DATE], a period of 91 days. 3. The physician was required to see Resident # 12 every 60 days. The clinical record failed to document a visit by the physician or nurse practitioner between [DATE] to [DATE], (122 days). 4. The facility staff failed to ensure Resident #6 was seen by the physician from [DATE] through [DATE], a period of 179 days. 5. The facility staff failed to ensure Resident #10 was seen by the physician from [DATE] through [DATE], a period of 155 days. 6. Facility staff failed to ensure that Resident #11 was seen by the physician after [DATE] to present. A total of 174 days without a physician visit. The findings include: 1. Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of [DATE], coded the residents as being moderately impaired to make daily decisions. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The physician progress notes [REDACTED]. There were no further physician progress notes [REDACTED]. A request was made for any physician progress notes [REDACTED]. On [DATE] at 1:18 p.m. LPN (licensed practical nurse) #1, informed this surveyor that there were no other physician progress notes [REDACTED]. An interview was conducted with ASM (administrative staff member) #4, the divisional director of clinical services, on [DATE] at 1:19 p.m. When asked who is responsible for tracking physician visits, ASM #4 stated, Medical Record. An interview was conducted with ASM #1, the executive director; on [DATE] at 1:20 p.m. ASM #1 explained the medical records staff member has only been with the facility for one week. We have a physician's log book but we can't find it with the previous logs. When asked if the medical director was aware of (Resident #3's attending physician) not coming, ASM #1 stated, I'm sure he's not. An interview was conducted with ASM #5, an attending physician, on [DATE] at 3:45 p.m. When asked how he is notified of when a resident is due to be seen, ASM #5 stated, The medical records person or someone emails or text me to let me know. The facility policy, Physician's Visit Monitoring documented in part, Policy: The facility will make every effort to assure that physician's visits to residents conform to applicable State and Federal laws, i.e., every 30 days for the first 90 days and at least every 60 days thereafter, regardless of the resident's level of care. Signing of the physician orders [REDACTED]. Procedure: 1. The Medical Record Designee will monitor physician visits for timeliness by: a. Using the Physician's Visit Log; b. Completing one Physician's Visit Log for every resident in house; c. Determining visit date due by consulting with the Director of Clinical Services. The visit date due may vary from applicable State/Federal regulation, but will not exceed acceptable parameters. For example, The Director of Clinical Services may wish for a skilled resident to be seen every 30 days after the first 90 because of acuity of services provided or severity of illness incurred. Document this in the space provided on the log form; d. File the individual log forms by physician in Physician's Visit Notebook, For example, if Dr. X visits 10 residents, file all 10 logs behind a divider labeled, Dr. X. File physicians alphabetically for ease of information retrieval; e. Perform visit monitoring monthly at the beginning of each month. f. Place a telephone call to each physician at least 7 days prior to visit due date. Because physicians will probably only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0387

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 11)
want to visit the facility once per month due to busy schedules elsewhere, it is prudent to group their residents together and estimate the best time of the month to visit so that acceptable time frames are maintained to meet State and Federal regulation; g. Document date of call in the Date of Pre-call column on each resident; h. Document date due in the Date Due column on each resident; i. Review records after due date has expired to see if physician visited. j. Notify Director of Clinical Services if physician is past due. Director of Clinical Services will send the physician written notification. Enter information into DATE Director of Clinical Services letter column. k. If physician continues to be past due, the Director of Clinical Services is to notify the Executive Director. The Executive Director will send the physician written notification and enter information in DATE Exec. (Executive) Dir (Director) Letter column. l. Notify facility Medical Director if physician continues to be past due. The Executive Director will notify the Medical Director via a letter of physician's visits past due and enter information in Date Med (medical) Dir (director) notified. m. The Medical Director will call the physician regarding past due visits. The Medical Director will inform the facility of the date the call was made. Enter information in Director Phone Call Information. n. The facility will notify the resident/legal guardian of physician's past due visits requesting selection of a new attending physician or possible discharge.
Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on [DATE] at 6:05 p.m.
No further information was provided prior to exit.
(1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 274.
2. For Resident #5, the physician did not see the resident from [DATE] until [DATE], a period of 91 days.
Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of [DATE], coded the resident as being moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive to being dependent upon one or more staff members for all of her activities of daily living except eating, which coded Resident #5 as requiring supervision of one staff member.
The review of the clinical record revealed a physician progress notes [REDACTED].
A request was made for any physician progress notes [REDACTED].
On [DATE] at 1:18 p.m. LPN (licensed practical nurse) #1, informed this surveyor that there were no other physician progress notes [REDACTED].
An interview was conducted with ASM (administrative staff member) #4, the divisional director of clinical services, on [DATE] at 1:19 p.m. When asked who is responsible for tracking physician visits, ASM #4 stated, Medical Record.
An interview was conducted with ASM #1, the executive director; on [DATE] at 1:20 p.m. ASM #1 explained the medical records staff member has only been with the facility for one week. We have a physician's log book but we can't find it with the previous logs. When asked if the medical director was aware of (Resident #3's attending physician) not coming, ASM #1 stated, I'm sure he's not.
An interview was conducted with ASM (administrative staff member) #4, the divisional director of clinical services, on [DATE] at 1:19 p.m. When asked who is responsible for tracking physician visits, ASM #4 stated, Medical Record.
An interview was conducted with ASM #5, Resident #5's attending physician, on [DATE] at 3:45 p.m. When asked how he is notified of when a resident is due to be seen, ASM #5 stated, The medical records person or someone emails or text me to let me know. Resident #5's chart was reviewed with ASM #5. He stated he thought he had seen her between the dates listed and stated he would check at his office to check on the billing.
Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on [DATE] at 6:05 p.m.
No further information was provided prior to exit.
(1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 286.
(2) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 522
3. The physician was required to see Resident # 12 every 60 days. The clinical record failed to document a visit by the physician or nurse practitioner between [DATE] to [DATE], (240 days).
Resident # 12 was admitted to the facility on [DATE] and a readmission of [DATE] with [DIAGNOSES REDACTED].
Resident # 12's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE] coded the resident as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 being moderately impaired of cognition for daily decision making. Resident # 12 was coded as being totally dependent of one staff member for activities of daily living.
Review of Resident # 12's clinical record revealed there were no visits by the physician from [DATE] through [DATE] for a total of 240 days.
An interview was conducted with ASM #1, the executive director; on [DATE] at 1:20 p.m. ASM #1 explained the medical records staff member has only been with the facility for one week. We have a physician ' s log book but we can't find it with the previous logs. When asked if the medical director was aware of (Resident #12's attending physician) not coming, ASM #1 stated, I'm sure he's not.
An interview was conducted with ASM #4, the divisional director of clinical services; at approximately 9:30 a.m. ASM # 4 stated that they were unable to locate the missing notes regarding the physician ' s visits for Resident # 12.
On [DATE] at approximately 11:37 a.m. ASM (administrative staff member) # 1 the executive director, ASM # 2, director of clinical services, and ASM # 3, administrator-in-training and ASM # 4, divisional director of clinical services, were made aware of the findings.
No further information was provided prior to exit.
References
(1) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.
(2) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website: https://medlineplus.gov/ency/article/ 0.htm.
(3) Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/ 9.htm.
4. The facility staff failed to ensure Resident #6 was seen by the physician from [DATE] through [DATE], a period of 179 days.
Resident #6 was admitted to the facility on [DATE]. Resident #6's [DIAGNOSES REDACTED]. Resident #6's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of [DATE], coded the resident's cognition as being moderately impaired.
Review of Resident #6's clinical record failed to reveal a physician's note to evidence the resident was seen by the physician from [DATE] through [DATE], a period of 179 days.
Resident #6's comprehensive care plan initiated on [DATE] failed to document information regarding timely physician visits.
On [DATE] at 1:20 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the medical records employee (the person responsible for tracking physician visits) had only been employed at the facility for one week. ASM #1 stated the facility had a physician's log book but couldn't find the previous logs.
On [DATE] at 6:15 p.m., ASM #1, ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern.
No further information was presented prior to exit.
(1) [MEDICAL CONDITION] disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, up, and active to very sad and hopeless, down, and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html
5. The facility staff failed to ensure Resident #10 was seen by the physician from [DATE] through [DATE], a period of 155 days.
Resident #10 was admitted to the facility on [DATE]. Resident #10's [DIAGNOSES REDACTED]. Resident #10's most recent MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 12) (minimum data set), an annual assessment with an ARD (assessment reference date) of [DATE], coded the resident as being cognitively intact. Review of Resident #10's clinical record failed to reveal a physician's note to evidence the resident was seen by the physician from [DATE] through [DATE], a period of 155 days. Resident #10's comprehensive care plan initiated on [DATE] failed to document information regarding timely physician visits. On [DATE] at 1:20 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated the medical records employee (the person responsible for tracking physician visits) had only been employed at the facility for one week. ASM #1 stated the facility had a physician's log book but couldn't find the previous logs. On [DATE] at 6:15 p.m., ASM #1, ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern. No further information was presented prior to exit. 6. The facility staff failed to ensure that Resident #11 was seen by the physician after [DATE] to present. A total of 174 days without a physician visit. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of [DATE] coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living. Review of Resident #11's physician notes documented a physician note on [DATE]. Further review of the clinical record did not evidence documentation of any other physician visits from that date to present. A request was made on [DATE] at 9:00 a.m. to ASM (administrative staff member) #2, the director of clinical services, for all physician visits for Resident #11 since [DATE]. An interview was conducted on [DATE] at 1:20 p.m. with ASM (administrative staff member) #1, the executive director. When asked who was responsible for tracking physician visits, ASM #1 stated, It's medical records. ASM #1 stated the medical records manager had just started that week. When asked how visits were tracked, ASM #1 stated, We have a log book but we can't find it. When asked if staff were aware that Resident #11 had not had a physician visit since [DATE], ASM #1 stated, Apparently not. We were not aware that he had missed visits. On [DATE] at 10:55 a.m. ASM #2 returned and stated, We looked in medical records and couldn't locate it (any physician visit notes). An interview was conducted on [DATE] at 1:30 p.m. with LPN (licensed practical nurse) #2, the unit manager. When asked how they ensured that the physician visits the residents as required, LPN #2 stated, When I know the physician is here I notify the nurses so they can speak to him. On [DATE] at 12:00 p.m. ASM #1 and ASM #2 were made aware of the findings. No further information was provided prior to exit.
F 0456 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep all essential equipment working safely.** Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure medical supplies were not expired in two of five medication rooms and failed to maintain equipment in safe operating condition for one of three dryers. 1. The facility staff failed to discard expired respiratory equipment supplies in two of five medication rooms. 2. Facility staff failed to remove the lint build up in one of three dryers. The findings include: 1. Observation was made of the Terrace Medication Room on 11/30/16 at 2:38 p.m. accompanied by LPN (licensed practical nurse) #3. A Suction Catheter Kit had an expiration date of 10/2015. When asked if the kit was available for use, LPN #3 stated, It should have been thrown away. It shouldn't be in here if it is expired. Observation was made of the Medication room on MSU 2. A kit labeled, Kim Vent Suction Swab Pack with hydrogen peroxide in it, was dated as expired on 09/2016. An interview was conducted with LPN #4 on 10/30/16 at 3:17 p.m. When asked if the kit was available for use, LPN #4 stated, We don't even carry this, it must have come from the hospital. When asked if it was available for use, Yes, if it's in the medication room. The facility policy, Equipment Storage documented in part, All stock is to be inventoried and inspected during the Field Representative facility site visit. This inspection will include checking for damaged or expired supplies and equipment. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. 2. The facility staff failed to remove lint in one of three dryers. A facility tour was conducted on 12/1/16 at 10:00 a.m. with ASM (administrative staff member) #3, the administrator in training, OSM (other staff member) #3, maintenance technician and OSM #4, the housekeeping account manager. An observation of the laundry room was made on 12/1/16 at 10:13 a.m. A request was made for OSM #4 to open the lint compartments for each dryer. In the first dryer on the right a veil of lint was hanging from one side of the filter to the other and was approximately four inches from the floor. There was also lint on the surface of the filter. OSM #4 immediately swept the lint up. The lint filled a dustpan. The other dryer's lint compartments were clean. When asked how often the lint was removed from the dryers, OSM #4 stated, Once an hour. An interview was conducted on 12/1/16 at 10:14 a.m. with OSM #4 and OSM #8, the laundry aide. When asked the last time the lint compartment had been cleaned, OSM #8 stated, It was cleaned at 10 (10:00 a.m.). When asked if there was any risk to having that amount of lint in the dryer compartment, OSM #4 stated, If it's not clean it could cause a fire. When OSM #4 was asked if it was possible to have that amount of lint build up in 14 minutes, OSM #4 stated it was possible. A request was made for a similar load of items be dried in the dryer so the lint compartment could be checked. On 12/1/16 at 11:05 a.m. an observation of the lint compartment of the dryer was made with ASM #3, OSM #3 and OSM #4 after a load of linens were dried in the dryer. There was a small amount of lint on the lint filter. A request for the manufacturer's operating instructions was requested at that time. The instructions were not received. On 12/1/16 at 12:00 p.m. ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, General Laundry Policies documented, Equipment Care and General Cleaning .2. Lint traps are to be cleaned daily. Review of the facility's document titled, Healthcare Services Group, Inc. Laundry In-Service documented, LINT SCREEEN (sic) CLEANING: As dryers run, lint will accumulate inside the dryers. To keep lint from traveling up to the top of the dryers, near the flame, the dryers are equipped with a screen to catch lint and hold it away from the flame. These screens will eventually be covered with lint and must be cleaned. If not cleaned, the screens will prevent air from circulating through dryers and is a definite fire hazard. After every load or roughly once per hour: Shut off the dryer. Remove lint screen from bottom of dryer No further information was provided prior to exit.
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, staff interview and facility document review, it was determined that the facility staff failed to provide a safe and sanitary environment on two of three floors in the facility. Facility staff failed to replace two stained ceiling tiles across from the nurse's station on the second floor and a stained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0465 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 13) ceiling tile in the hallway on the basement level leading to a nursing unit. The findings include: An initial tour of the facility was made on 11/29/16 at 11:45 a.m. On the second floor across from the nurse's station there were two ceiling tiles with large brown stains that covered approximately two thirds of the tiles. On 11/30/16 at 11:10 a.m. an observation of the ceiling tiles was made. The ceiling tiles remained stained. A facility tour was conducted on 12/1/16 at 10:00 a.m. with ASM (administrative staff member) #3, administrator in training, OSM (other staff member) #3, the maintenance technician and OSM #4, the housekeeping account manager. The ceiling tiles on the second floor across from the nurse's station were observed to have been replaced. During the tour of the basement hallway leading to a nursing unit a large ceiling tile across from the laundry room was noted to be completely brown stained. An interview was conducted on 12/1/16 at 10:30 a.m. with OSM #3. When asked if she had been aware of the stained ceiling tiles, OSM #3 stated she was and that the tiles had been replaced the previous evening. When asked who was responsible for changing the ceiling tiles, OSM #3 stated, Maintenance. When asked if the maintenance staff performed preventative maintenance, OSM #3 stated, Yes. We make rounds everyday. When asked what the staff looked for on the rounds, OSM #3 stated, Ceiling tiles, lights, the (floor) tiles, the bed. Everything. When asked if stained ceiling tiles posed any risk to the resident, OSM #3 stated, Not good. Not safe. On 12/1/16 at 12:00 p.m. ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, Maintenance documented, Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Procedure: All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form No further information was provided prior to exit.
F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain a laboratory test per physician's orders [REDACTED].#6. The facility staff failed to obtain a physician ordered [MEDICATION NAME] acid (1) level from Resident #6 on 10/25/16. The findings include: Resident #6 was admitted to the facility on [DATE]. Resident #6's [DIAGNOSES REDACTED]. Resident #6's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/8/16, coded the resident's cognition as being moderately impaired. Review of Resident #6's clinical record revealed readmission physician's orders [REDACTED]. Laboratory (lab) test results collected on 10/18/16 documented a low [MEDICATION NAME] acid level of 25.9 (with a normal reference range of 50.0 to 100.0). A physician's telephone order dated 10/18/16 documented orders for [MEDICATION NAME] 250 mg- one tablet by mouth every day in the morning and a [MEDICATION NAME] acid level on 10/25/16. Further review of Resident #6's clinical record failed to reveal results of a [MEDICATION NAME] acid level obtained on 10/25/16. Resident #6's comprehensive care plan initiated on 3/17/16 documented, Psychoactive Medication Use: Depression, [MEDICAL CONDITIONS] - Anti-Depressant -Antipsychotic Interventions: Evaluate medication use and resident's response quarterly . On 11/30/16 at 4:30 p.m., RN (registered nurse) #1 confirmed the [MEDICATION NAME] acid level ordered to be obtained from Resident #6 on 10/25/16 was not done. RN #1 stated the physician had been notified and ordered the lab be obtained STAT (immediately). On 11/30/16 at 6:15 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern. A [MEDICATION NAME] acid level obtained on 11/30/16 documented a low [MEDICATION NAME] acid level of 45.8. Handwritten documentation on the results documented, (Name of physician) made aware. New orders given. D/C (Discontinue) previous [MEDICATION NAME] (also known as [MEDICATION NAME] and also known as [MEDICATION NAME] acid) orders. Start [MEDICATION NAME] 500 mg Bid (twice a day) daily. On 12/1/16 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked the process for obtaining labs per physician's orders [REDACTED].#7 stated an employee from the lab comes to the facility to obtain labs every Tuesday and Thursday. LPN #7 stated the physician will tell the nurses whether to obtain a lab on the next lab day or STAT. LPN #7 stated the nurses should write the order, transcribe the order to the TAR (treatment administration record) and enter the order on the lab log. LPN #7 stated the 11:00 p.m. to 7:00 a.m. shift is responsible for ensuring the labs are obtained. The facility policy titled, Laboratory Procedure documented, Policy: To provide a means to check a resident's specimen as ordered by the physician and to maintain a record of the results .Procedure: Obtain a physician's orders [REDACTED]. When the blood is drawn, the nurse or phlebotomist will document in the lab log or in the clinical record. If deemed necessary, the facility may keep a special log for laboratory tests being ordered. The results are checked by the Clinical Nurse and the physician is notified of the results. This notification may be written on the Lab Results form. All lab results are kept in a designated place until seen and signed by the physician. The lab results are filed in the patient's chart under the Laboratory section. No further information was presented prior to exit. (1) [MEDICATION NAME] ([MEDICATION NAME] acid) is used alone or with other medications to treat certain types of [MEDICAL CONDITION]. [MEDICATION NAME] acid is also used to [MEDICAL CONDITION](episodes of frenzied, abnormally excited mood) in people with [MEDICAL CONDITION] disorder (manic-[MEDICAL CONDITION]; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) . This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a 2.html (2) [MEDICAL CONDITION] disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, up, and active to very sad and hopeless, down, and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html
F 0503 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Ensure lab services, blood blanks and transfusion services provided on site meet requirements for certified laboratories; or 2) Have an agreement to obtain services from an offsite laboratory, that meets the same requirements.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility staff failed to ensure laboratory supplies were not expiring in one of five medication rooms. Seven blood drawing tubes were expired in one of five medication rooms, MSU2. The findings include: Observation was made on [DATE] at 3:12 p.m. of the MSU2 medication room. The following laboratory tubes were expired: [MEDICATION NAME] top tubes: 3 ML (milliliter) - one expired on ,[DATE] - one expired on ,[DATE] Blue top tubes: 2.7 ML - One expired on ,[DATE] - two expired on ,[DATE]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0503 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 14) Yellow/gold tubes: 4.0 ML - two expired on ,[DATE] - one expired on ,[DATE] An interview was conducted on [DATE] at 3:16 p.m. with ASM (administrative staff member) #4, the divisional director of clinical services. When asked who draws blood, ASM #4 stated, The Lab (laboratory) staff draws the blood, the nurses don't draw in this building. An interview was conducted on [DATE] at 3:17 p.m. with LPN (licensed practical nurse) 4. When asked if she draws blood, LPN #4 stated, No, the phlebotomist draw here. An interview was conducted with RN (registered nurse) #4 on [DATE] at 3:44 p.m. When asked if the nurses draw blood, RN #4 stated, Sometimes we draw STAT (Immediate) labs (labratory tests) and the RNs draw blood from the PICC * lines. When asked why it is important to check the expiration dates of the tubes, RN #4 stated, For some of the tubes, it can affect the results. *According to the glossary in Lippincott, Williams & Wilkins, Fundamental of Nursing, 5th edition, 2007, page 1423, the definition is Peripherally inserted central catheter is a long-line catheter made of soft silicone or [MEDICATION NAME] material that is placed peripherally but delivers medications and solutions centrally. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on [DATE] at 6:05 p.m. A copy of the policy on storing laboratory supplies was requested. No further information was provided prior to exit. According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies. (4) d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.
F 0513 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep signed and dated reports of x-rays and other diagnostic services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to file x-ray results in the clinical record for one of 26 residents in the survey sample, Resident #5. Resident #5 had two x-rays ordered; neither result was located in the clinical record. The findings include: Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/16, coded the resident as being moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive to being dependent upon one or more staff members for all of her activities of daily living except eating which coded Resident #5 as requiring supervision of one staff member. The physician order [REDACTED]. The physician order [REDACTED]. Review of the clinical record did not reveal the results of the above ordered x-rays. A request was made for the copy of the results on 11/30/16 at 10:00 a.m. On 11/30/16 at 1:22 p.m. ASM (administrative staff member) #4, the divisional director of clinical services, stated, The x-ray results were not in the clinical record, I got them from (name of portable x-ray company). An interview was conducted with LPN (licensed practical nurse) #3, on 11/30/16 at 2:40 p.m. When asked how the x-ray results get into the clinical record, LPN #3 stated, It depends on when they come back. If they come back on my shift, I call the doctor and then I put them in the chart. Basically, it's whoever is here when the results come in; they should call the doctor and put them in the record. An interview was conducted with LPN #2, the unit manager, on 11/30/16 at 2:46 p.m. When asked how the x-ray results get into the medical record, LPN #2 stated, The nurse who gets the results calls the doctor. Once the doctor is notified the nurse puts it (the results) into the chart. The facility policy, X-ray or Diagnostic Report, Telephone/Verbal documented, Policy: The report of a resident's x-ray or other Diagnostic test may be received by a licensed nurse by phone when there is an abnormality or when requested, prior to receiving a written report. Procedure: Document in the medical record receiving the diagnostic or X-ray report along with the following: Notify the physician or provide of the results and document notification along with any new orders. Include date and time of notification. Indicate the date of the x-ray/diagnostic was obtained. Indicate the date the results are verbally received. Document the type of x-ray/diagnostic test taken. Document the findings as communicated by the provider of the service. Sign and date the entry. Complete telephone orders if new orders received. File report in medical record. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. (1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 286. (2) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 522
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for eight of 26 residents in the survey sample, Residents #6, #9, #10, #1, #7, #11, #3 and #5. 1. The facility staff failed to ensure the podiatry consult note filed in Resident #6's clinical record was legible. 2. The facility staff failed to ensure the podiatry consult note filed in Resident #9's clinical record was legible. 3. The facility staff failed to ensure the podiatry consult note filed in Resident #10's clinical record was legible. 4. Resident # 1's face sheet contained an incorrect diagnosis - the face sheet documented that the resident has a [DIAGNOSES REDACTED].# 1 is female and does not have a prostate. 5. Facility staff failed to file the 7/19/16 ENT (ear nose and throat) consult in Resident #7's clinical record. 6. Facility staff failed to ensure that Resident #11's 6/24/16 podiatry consult was legible. 7. The facility staff failed to ensure that physician progress notes [REDACTED].#3. 8. The facility staff failed to ensure that physician progress notes [REDACTED].#5. The findings include: 1. The facility staff failed to ensure the podiatry consult note filed in Resident #6's clinical record was legible. Resident #6 was admitted to the facility on [DATE]. Resident #6's [DIAGNOSES REDACTED]. Resident #6's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/8/16, coded the resident's cognition as being moderately impaired. Review of Resident #6's clinical record revealed an illegible podiatry consult note dated 10/30/16. On 12/1/16 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated the podiatrist's notes were hard to read. LPN #7 was asked how she utilized the podiatrist's notes and if she used the notes to check for physician's orders [REDACTED].#7 stated she checks the podiatrist's orders for any new order because it's hard to read the notes. On 12/1/16 at 12:10 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 (the divisional director of clinical services) were made aware of the above concern. The facility policy titled, Clinical/Medical Records documented in part, Supervisory and support personnel are employed by the center to ensure clinical records are maintained as required .Clinical records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care .The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**
NAME OF PROVIDER OF SUPPLIER **ENVOY OF ALEXANDRIA, LLC**		STREET ADDRESS, CITY, STATE, ZIP **900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 15)
purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care .
No further information was presented prior to exit.
According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 237, Clearly documented information on the client record communicates the plan of care and the client's progress to all members of the healthcare team. Team members who interact with the client at different times and in different ways get a clear picture of what took place in their absence. This communication ensures continuity of care and provides essential data for revision or continuation of care.
2. The facility staff failed to ensure the podiatry consult note filed in Resident #9's clinical record was legible.
Resident #9 was admitted to the facility on [DATE]. Resident #9's [DIAGNOSES REDACTED]. Resident #9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/26/16, coded the resident's cognition as being moderately impaired.
Review of Resident #9's clinical record revealed an illegible podiatry consult note dated 9/18/16.
On 11/30/16 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was shown the 9/18/16 podiatry note. RN #1 confirmed the note was illegible and stated there were only two or three legible words. RN #1 was asked if the note should be legible. RN #1 stated the note should be legible because it could contain new orders and new diagnoses. RN #1 stated if the note can't be read then the physician should be asked for clarification.
On 11/30/16 at 6:15 p.m., ASM #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 were made aware of the above concern.
No further information was presented prior to exit.
3. The facility staff failed to ensure the podiatry consult note filed in Resident #10's clinical record was legible.
Resident #10 was admitted to the facility on [DATE]. Resident #10's [DIAGNOSES REDACTED]. Resident #10's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/11/16, coded the resident as being cognitively intact.
Review of Resident #10's clinical record revealed an illegible podiatry consult note dated 10/30/16.
On 11/30/16 at approximately 11:15 a.m., ASM (administrative staff member) #4 (the divisional director of clinical services) confirmed she could not read the podiatry consult note dated 10/30/16.
On 11/30/16 at 4:30 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated she could not read the podiatry consult note dated 10/30/16. RN #1 stated the note was less than 50 percent legible and she could only read, Patient seen today and treated and history of diabetes. RN #1 was asked if the note should be legible. RN #1 stated the note should be legible because it could contain new orders and new diagnoses. RN #1 stated if the note can't be read then the physician should be asked for clarification.
On 11/30/16 at 6:15 p.m., ASM #1 (the executive director), ASM #2 (the director of clinical services), ASM #3 (the administrator in training) and ASM #4 were made aware of the above concern.
No further information was presented prior to exit.
4. Resident # 1's face sheet contained an incorrect diagnosis - the face sheet documented that the resident has a [DIAGNOSES REDACTED].# 1 is female and does not have a prostate.
Resident # 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (minimum data
set), an admission assessment with an ARD (assessment reference date) of 11/6/16, coded the resident as scoring a 15 out of 15 on the brief interview for mental status, indicting the resident was cognitively intact.
During an interview on 11/30/16 at 3:25 p.m. with RN (registered nurse) # 3, the [DIAGNOSES REDACTED]. RN # 3 stated that she would check to see where the [DIAGNOSES REDACTED].
During an interview on 11/30/16 at approximately 3:50 p.m. with RN # 3, RN # 3 stated that she did not know where the [DIAGNOSES REDACTED]. RN # 3 stated that she received an order to discontinue the [DIAGNOSES REDACTED].# 3) noted the order
transcribed the order and faxed the order to the pharmacy, updated the fact sheet and modified the MDS.
During an interview on 11/30/16 at 5:55 p.m. with ASM (Administrative Staff Member) # 1, the Executive Director, ASM # 2, the Director of Clinical Services, ASM # 3, the Administrator in Training, ASM # 4, the Divisional Director of Clinical Services, and RN # 1, the Assistant Director of Clinical Services, this concern was discussed.
During an interview on 12/1/16 at approximately 11:00 a.m. with RN # 3, RN # 3 stated that she did not know where the [DIAGNOSES REDACTED].
During an interview on 12/1/16 at 11:35 a.m. with ASM # 1, ASM # 2, ASM # 3, ASM # 4, ASM # 5, the Regional Director of Clinical Services, and RN # 1, this concern was again reviewed.
No further information was provided prior to exit.
References:
(1) [MEDICAL CONDITION]--also called [MEDICAL CONDITION]--is a condition in men in which the prostate gland is enlarged and
[MEDICAL CONDITION]. [MEDICAL CONDITION] is also called [MEDICAL CONDITION] or benign prostatic obstruction. https://www.niddk.nih.gov/health-information/health-topics/urologic-disease/benign-prostatic-[MEDICAL CONDITION]-[MEDICAL
CONDITION]/Pages/facts.aspx#1
(2) [MEDICAL CONDITION] (CAD) is the most common type of [MEDICAL CONDITION]. It is the leading cause of death in the United
States in both men and women. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=cad&commit=Search
(3) [MEDICAL CONDITION] (P.V.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. www.nhlbi.nih.gov/health/health-topics/topics/ <http://www.nhlbi.nih.gov/health/health-topics/topics/>
(4) Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Diabetes&commit=Search
(5) Depression (major [MEDICAL CONDITION] or [MEDICAL CONDITION]) is a common but serious mood disorder. It causes severe
symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. https://www.nimh.nih.gov/health/topics/depression/index.shtml
(6) [MEDICAL CONDITION] is a chronic, severe, and disabling mental disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness.<https://www.nimh.nih.gov/health/statistics/prevalence/[MEDICAL CONDITION].shtml>
(7) [MEDICAL CONDITION] Peripheral [MEDICAL CONDITION] describes damage to the peripheral nervous system, which transmits
information from the brain and spinal cord to every other part of the body. http://www.ninds.nih.gov/disorders/[MEDICAL CONDITION]/[MEDICAL CONDITION].
(8) [MEDICAL CONDITION] reflux disease (GERD) is an ongoing condition in which the contents of the stomach come back into the esophagus. www.ncbi.nlm.nih.gov/pubmedhealth/PMH 11/
5. The facility staff failed to file the 7/19/16 ENT (ear nose and throat) consult in Resident #7's clinical record.
Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED].
The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 10/8/16 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident required assistance from staff for activities of daily living except for eating, which the resident could achieve independently after the tray was prepared.
Review of the physician's orders [REDACTED]. (appointment) (speech) on July 19th 2016 at 2 (2:00) p.m. at 415 (4:15 p.m.) (speech pathologist for prosthesis change).
Review of Resident #7's care plan initiated on 10/11/16 documented, Focus. Potential for an infection r/t (related to): .Stoma to tracheal area. Interventions. Treatments as ordered.
Review of the clinical record did not evidence documentation of the ENT consult.
An interview was conducted on 11/30/16 at 1:30 p.m. with LPN (licensed practical nurse) #2, the unit manager. When asked if it was necessary to have a copy of a consultant's report on the resident's record, LPN #2 stated, Definitely because again, depending on what they went out for. We want to know if there's any follow up necessary and make the necessary changes that helps with the care of the resident.
On 11/30/16 at 5:55 p.m. a request was made to ASM (administrative staff member) #2, the director of clinical services for the 7/19/16 ENT consultation report for Resident #7
On 12/1/16 at 10:55 a.m. a copy of the consultation was given to this surveyor from ASM #2. At the top of the report it was documented [DATE] . the date the facility received the report from the ENT physician. When asked if the consultation report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **495203**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/01/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 16) had been on the resident's record, ASM #2 stated, No and there are some things we need to follow up on (based on the recommendations on the report). Review of the facility's policy titled, Medical Consolations (sic) documented, The consultant physician will complete the Report section of the Request For Consultation or its equivalent. Finding: Information gathered from examination. Diagnosis: [REDACTED].Upon completion of the consultation the charge nurse will notify the attending physician that the consult is complete and obtain any changes in plan of care or medications recommended by the consulting physician. No further information was provided prior to exit. 6. The facility staff failed to ensure that Resident #11's 6/24/16 podiatry consult was legible. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/10/16 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living. Review of the resident's care plan initiated on 5/12/16 and revised on 11/14/16 did not evidence documentation related to a podiatry consultation. Review of the physician's progress notes documented a handwritten note on 6/24/16. The note was illegible. An interview was conducted on 11/30/16 at 1:30 p.m. with LPN (licensed practical nurse) #2, the unit manager. When asked who the note was written by, LPN #2 stated, The podiatrist. When asked to read the note, LPN #2 stated, I'm having trouble reading that. When asked if it was important for staff to be able to read a physician's noted, LPN #2 stated, Yes it is, so we know what to implement if the doctor has given instructions. An interview was conducted on 11/30/16 at 2:35 p.m. with LPN #3, the resident's nurse. When asked what the note said, LPN #3 stated, I cannot read this one. When asked if it was important to be able to read a physician's notes, LPN #3 stated, Sure. If they write clearly I know what I can do. On 11/30/16 at 5:55 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. Review of the facility's policy titled, Medical care/Standards of Practice documented, All clinical entries in the resident's medical record shall be accurately dated and authenticated. The medical record must be clean, concise, complete and current. No further information was provided prior to exit. 7. The facility staff failed to ensure that physician progress notes [REDACTED].#3. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/5/16, coded the residents as being moderately impaired to make daily decisions. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. Review of the clinical record revealed a physician progress notes [REDACTED]. An interview was conducted with LPN (licensed practical nurse) #2, the unit manager, on 11/30/16 at approximately 11:00 a.m. When asked if he could read the progress note, LPN #2 stated, No I can't. When asked who wrote the note, LPN #2 stated, I don't know. LPN #2 went off to ask another staff member who wrote the note. At 11:40 a.m. LPN #2 returned and stated the note had been written by the podiatrist. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. (1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 274. 8. The facility staff failed to ensure that physician progress notes [REDACTED].#5. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/16, coded the resident as being moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive to being dependent upon one or more staff members for all of her activities of daily living except eating in which required supervision of one staff member. Review of the clinical record revealed a physician progress notes [REDACTED]. An interview was conducted with ASM (administrative staff member) #5, Resident #5's attending physician; on 11/30/16 at 4:00 p.m. ASM #5 was shown the progress note dated 11/24/16. When asked if he could read it, ASM #5 stated, No, I have no idea what it says. That's illegible. Administrative staff member (ASM) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the administrator in training, ASM #4, the divisional director of clinical services were made aware of the above findings on 11/30/16 at 6:05 p.m. No further information was provided prior to exit. (1) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 286. (2) Barron's Dictionary for Medical Terms for the Non - Medical Reader; Rothenberg and Chapman, page 522

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495203	A. BUILDING ______ B. WING _____	11/15/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF ALEXANDRIA, LLC	**900 VIRGINIA AVENUE ALEXANDRIA, VA 22302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0372 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Dispose of garbage and refuse properly.** Deficiency Text Not Available
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** Deficiency Text Not Available

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

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.