STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENVOY OF WILLIAMSBURG, LLC	**1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain an accurate clinical record for 2 residents (Resident #1 and Resident #3), in a sample size of 4 residents. The Findings included: 1. For Resident #1, there was incomplete documentation in the clinical record for a fall on 02/19/2020. On 03/03/2020, during the course of a closed record review for Resident #1, outside records provided by a local hospital for an emergency room visit on 02/25/2020, revealed a history of a previous emergency room visit to the same local hospital on [DATE]. Hospital records from 02/19/2020 were obtained and revealed Resident #1 was turning in bed at approximately 4:30 AM and rolled out onto the floor, landing on his knees. The facility sent Resident #1 to the Emergency department for evaluation. The emergency room physician determined that Resident #1 bruised his left knee and Resident #1 was sent back to the facility at approximately 8:00 AM the same morning. On 03/04/2020, a comprehensive review of Resident #1's clinical record was performed with particular attention given to Progress Notes and Care Plan. The Care Plan had been updated with new fall interventions initiated on 02/20/2020 to include check range of motion daily and monitor/document/report PRN (report as needed) x 72h (hours) to MD for s/sx (signs/symptoms): pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. The Progress Notes revealed no documentation of the actual fall event on 02/19/2020, no documentation of clinical assessments by facility staff, and no documentation of monitoring for 72 hours as per Care Plan and facility policy. Review of the facility policy and procedure entitled, Fall Management, revised 07/29/2019, subheading Post Fall Strategies, item #6 read, Initiate post fall documentation every shift for 72 hours. An interview was conducted with the Division Executive Director (Employee C) and the Director of Nursing (DON, Employee B). Both employees verified and agreed there was no documentation of the resident's fall at the time of occurrence and no documentation of follow up care. Both Employee B and C stated that it is their expectation for the actual fall event and follow up care to be documented in the Progress Notes to enable the healthcare team to make accurate treatment plans for the resident. No further information was provided. 2. For Resident #3, there was incomplete documentation in the clinical record for a fall on 02/19/2020. On 03/04/2020, in the course of a complaint investigation, a request was made for the facility staff to provide a list of all residents who experienced a fall on 02/19/2020. Resident #3 was on that list. However, a review of the clinical record for Resident #3 revealed no documentation of the actual fall event on 02/19/2020 in the Progress Notes. Employee C and Employee B were informed of these findings and verified the lack of documentation with regard to the fall experienced by Resident #3 on 02/19/2020. Employee C stated it is her expectation for falls to be documented in the clinical record to provide accurate detail for the healthcare team. No further information was provided.

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