PRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES					OMB N	10. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCT			DATE SURVEY COMPLETED
		495327	B. WING					R 08/ <b>10/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STRE	EETADDRE	SS, CITY, STATE, ZIP COD	and the second s	
ENVOY C	F WESTOVER HILLS	5				HILL AVENUE VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH	OVIDER'S PLAN OF CORRE I CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 000} {F 280} SS=D	revisit to the standar conducted 8/8/17 the survey was conducted 8/8/17 the survey was conducted 8/8/17 the survey was conducted following 42 CFR For Care requirements identified on the CI were investigated of the consisted of 15 curtified at the time of the consisted of 15 curtified 15 cur	Medicare/Medicaid second and survey ending 5/19/17 was hrough 8/10/17. The first revisit oted 7/10/17 through 7/12/17. Quired for compliance with the Part 483 Federal Long-Term Corrected deficiencies are MS-2567B. No complaints	; {F 2		2.	On 8/17/17, the MD Mix Coordinator revithe care plan for Resto ineffective breath include, administratiphysician order. Respoygen at liter flow a physician.  On 8/17/17, facility I initiated a quality immonitoring of reside administration to enplan has been review reflect administratio physician order. DC/completed a quality residents on oxygen being administered a physician orders. The discrepancies identif	iewed and sident #20 ing proble ion of oxy sident #20 as ordered Executive provements with consure residued and renofoxyge Monitor of to ensure at liter flowere were	al Case d revised 08 related em to gen as per 08 receives d by  Director nt 0xygen dent's care evised to en per e of current e oxygen is w per
	(iv) The right to re	ceive the services and/or items						

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

included in the plan of care.

Any deficiency statement anding 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

(X6) DATE

PRINTED: 08/17/2017

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•	FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING			(X3) DATE SURVEY COMPLETED
		495327	B. WING			R 08/10/2017
NAME OF F	PROVIDER OR SUPPLIER		S <sup>*</sup>	TREETAD	DRESS, CITY, STATE, ZIP CODE	
ENVOV	OF WESTOVER HILLS	3	44	103 FORE	EST HILL AVENUE	
ENVOT	OF WESTOVER THEE	3	R	ICHMON	ND, VA 23225	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E CR(	PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULE DSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
{F 280}	right to sign after sign of care.  (c)(3) The facility sight to participate	the care plan, including the ignificant changes to the plan thall inform the resident of the in his or her treatment and esident in this right. The	{F 280}		By 8/17/17, the MDS/Region Coordinator reeducated the review and revision of care residents on oxygen to enshave updated care plans the resident's medical, nursing psychosocial needs.	e IDT on the e plans for sure residents nat meet the s, mental, and
	(i) Facilitate the incresident representa	lusion of the resident and/or ative.		4.	The DCS/Nurse Manager/N Coordinator to conduct Qu Improvement Monitoring of to ensure that the resident	ality of care plans

strengths and needs.

(ii) Include an assessment of the resident's

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

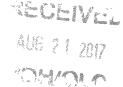
483.21

- (b) Comprehensive Care Plans
- (2) A comprehensive care plan must be-
- (i) Developed within 7 days after completion of the comprehensive assessment.
- (ii) Prepared by an interdisciplinary team, that includes but is not limited to--
- (A) The attending physician.
- (B) A registered nurse with responsibility for the resident.
- (C) A nurse aide with responsibility for the resident.

to ensure that the resident's oxygen is updated on the resident's care plan 2 x weekly for 3 months, then 1 x weekly for 4 weeks then monthly utilizing a sample size of 10 residents. The DCS and Unit Managers to complete a quality monitor of residents on oxygen for residents being administered per physician orders daily, Monday through Friday times 4 weeks then weekly times

> 4 weeks then monthly. Quality Improvement Monitoring results to be reported to the facility QAPI Team during regularly scheduled monthly QAPI Meetings.

5. Allegation of Compliance: August 19, 2017



# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/17/2017 FORM APPROVED

CENTERS	FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	į 1 ,	E SURVEY MPLETED
		495327				08	R / <b>10</b> /2017
NAME OF PRO	VIDER OR SUPPLIER		L		ET ADDRESS, CITY, STATE, ZIP COD	E	
ENVOY OF	WESTOVER HILLS	5			FOREST HILL AVENUE HMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
•	ontinued From pa )) A member of fo	age 2 ood and nutrition services staff.	{F 2	280}			
th A m ai	ne resident and the nexplanation mun nedical record if the ned their resident record if the new their resident and the resident and	racticable, the participation of e resident's representative(s). st be included in a resident's ne participation of the resident representative is determined the development of the n.					
ď		ate staff or professionals in rmined by the resident's needs the resident.					
te c a T b f d t!	eam after each as omprehensive an ssessments. This REQUIREME by: Based on observation revine facility staff fail (208) of 15 reside	revised by the interdisciplinary sessment, including both the d quarterly review  ENT is not met as evidenced ation, staff interview, facility riew, and clinical record review, and for one resident (Resident nts in the survey sample to hensive care plan timely.					
r		208, the facility staff failed to the Care Plan for ineffective since 7/7/16.					
6 C	admitted to the fac diagnoses include	s a 70 year old who was cility on 1/4/10. Resident #208's d Heart Failure, Chronic e, and Unspecified	3				

FORM CMS-2567(02-99) Previous Versions Obsolete

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date

Event ID: 1FXQ13

Facility ID: VA0085

If continuation sheet Page 3 of 9



FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			<u>JMB NO. 0938-039 (</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	495327	B WING_		R 08/10/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4403 FOREST HILL AVENUE	
ENVOY OF WESTOVER HILLS			RICHMOND, VA 23225	
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
Brief Interview of Mindicating severely  On 8/8/7 a 2:00 P.N facility. The Unit Manurse - LPN B) was in the activity room set at at 3.5 liters puthat it was set at 3.  On 8/8/17 a review #208's clinical recomplysician's order, nasal cannula complemental cannula complemental cannula complemental cannula complemental conflict with the order conflict with the order conflict with the order conducted of Resimoved from the activity as sitting in her with the nasal cannula cannula cannula concentral she was not received the continuously. When oxygen concentral machine is off. I concentral continuously when the continuously is off. I concentral continuously with the continuously when concentral continuously with the continuously when concentral continuously when continuously when concentral continuously when continuously wh	Resident #208 as having a lental Status Score of 2, impaired cognition.  M. a tour was conducted of the anager (Licensed Practical s present. Resident #208 was . Her oxygen concentrator was per minute. LPN B confirmed 5 liters per minute.  Was conducted of Resident ord, revealing the following '8/1/17. Oxygen at 4L/MIN via tinuously." On 8/8/17 at 2:45 was conducted with LPN B, en is to keep airway patent to breathing. If it's not right it's in	s k e	0}	

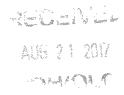
FORM CMS-2567(02-99) Previous Versions Obsolete

CNA A was identified as the person who relocated

Event ID: 1FXQ13

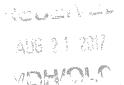
Facility ID: VA0085

If continuation sheet Page 4 of 9



PRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391

	OT OTTOTOTO					Time to the second second
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONST ING		(X3) DATE SURVEY COMPLETED
						R
		495327	B. WING			08/10/2017
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
ENVOY O	F WESTOVER HILLS	S			ND, VA 23225	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
{F 280}	bedroom. On 8/8/1 was conducted with out of the activity realways leave the or Resident #208's caresident has the pobreathing pattern resident resi	n the activity room to her 7 at 2:50 P.M. an interview h CNA A. He stated, "I took her com to change her brief. I xygen on."  are plan read, "7/7/16. The otential for an ineffective elated to Hx. (history) of	{F 2	·	F328  On 8/9/17, Resident #208 assessed by nurse manag had no signs or symptom distress or air hunger. Re MD was notified. No new	er. Resident s of respiratory sident #208's
	Failure), Respirato care plan, which has revised since 7/7/1 facility Director of Nanada and stated, "Tare plan today."  On 8/9/17 at 3:00 Nanada and States at 2:00 Nanada an	ntia, CHF (Chronic Heart ry Failure. This was the current ad not been reviewed or 6. On 8/8/17 at 3:30 P.M. The Nursing submitted this care they are going to revise this P.M. the Administrator and Director of Nursing		2	given.  On 8/9/17, current reside administration were asse determine liter flows wer physician's order. There discrepancies identified.	ents on oxygen ssed to e set per
{F 328} SS=D	(Administration B) No further informa	were informed of the findings. tion was received. 5)(h)(i)(j) TREATMENT/CARE	{F 3		<ul> <li>On 8/9/17 education pro- current nursing staff by the and Nurse Managers related following</li> </ul>	he DCS, ADCS,
	proper treatment a	o ensure that residents receive and care to maintain mobility lth, the facility must:		a)		
	with professional s	e and treatment, in accordance standards of practice, including ations from the resident's s) and		b)	physician's order ) Oxygen concentrators to versus turned off for the when not in use	be unplugged
	appointments with	ssist the resident in making a qualified person, and portation to and from such		c)		r flow on



PRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	ATE SURVEY DMPLETED			
		495327	B. WING		0	8/10/2017	
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WESTOVER HILLS				STREET ADDRESS. CITY. STATE, ZIP COD 4403 FOREST HILL AVENUE RICHMOND, VA 23225	DREST HILL AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	AMARA DEFENDING TO THE AM	HOULD BE	(X5) COMPLETION DATE	
IE 200) G			(F- C	201			

#### {F 328} Continued From page 5

- (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
- (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
- (i) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the

{F 328}

4. The DCS/Nurse Manager to conduct quality monitoring of residents on oxygen to ensure delivery device is set on appropriate liter flow per physicians order daily times 30 days, weekly times 2 months, and monthly times 6 months. Quality Improvement Monitoring results to be reported to the facility

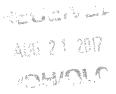
> QAPI Team during regularly scheduled monthly QAPI Meetings. Quality monitoring schedule to modified based on findings.

5. Allegation of Compliance: August 19, 2017

Event ID: 1FXQ13

Facility ID: VA0085

If continuation sheet Page 6 of 9



PRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB N	NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495327	B WING		. (	R 08/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	řE, ZIP CODE	
ENVOY OF WESTOVER HILLS				4403 FOREST HILL AVENUE		
ENVOY C	F WESTOVER HILLS	5		RICHMOND, VA 23225		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETION DATE
{F 328}	Continued From pa	age 6	{F 3:	28}		
:	prosthetic device. This REQUIREME	NT is not met as evidenced				
	by:					
	Based on observa	ation, staff interview, clinical facility document review, the				
	facility staff failed.	for 1 resident (Resident #208)				
	of the survey samp	ole of 15 residents, to per physician's order				
	For Resident #208	3, the facility failed on two				
	occasions, to adm order.	inister oxygen per physician's				
	The Findings inclu	ded:				
	admitted to the factorial diagnoses include	s a 70 year old who was cility on 1/4/10. Resident #208's d Heart Failure, Chronic e, and Unspecified	8			
	Assessment with of /19/17, coded F	a Set, which was a Quarterly an Assessment Reference Date Resident #208 as having a Brief al Status Score of 2, indicating cognition.	e :			
	facility. The Unit N Nurse - LPN B) w in the activity roor set at at 3.5 liters	.M. a tour was conducted of the Manager (Licensed Practical as present. Resident #208 was m. Her oxygen concentrator wa per minute. LPN B confirmed 3.5 liters per minute.				
	#208's clinical rec	w was conducted of Resident cord, revealing the following "8/1/17. Oxygen at 4L/MIN via ntinuously." On 8/8/17 at 2:45				

FORM CMS-2567(02-99) Previous Versions Obsolete

P.M. an interview was conducted with LPN B,

Event ID: 1FXQ13

Facility ID: VA0085

If continuation sheet Page 7 of 9



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/17/2017 **FORM APPROVED** 

	S COP MEDICARE	& MEDICAID SERVICES			C		0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495327	B. WING	-		į.	R / <b>10/2017</b>
NAME OF F	ROVIDER OR SUPPLIER	1		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		_		440	3 FOREST HILL AVENUE		
ENVOYC	F WESTOVER HILLS	5		RIC	CHMOND, VA 23225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 328}	Continued From pa	age 7	{F 3	328}			
()	•	n is to keep airway patent to		,			
		breathing. If it's not right it's in					
	conducted of Reside moved from the act bedroom. LPN B was sitting in her was sitting in her was sitting in her was sitting in her was not received continuously. When oxygen concentrate machine is off. I call LPN B then turned on an set it to 4 lites down the hallway as	P.M. a second observation was dent #208, who had been stivity room and left in her was present. Resident #208 wheelchair alone in her room hula in her nose, however the or was switched off. Therefore, ring physician ordered oxygen in LPN B noticed that the or was off, she stated, "The an't win for losing."  The oxygen concentrator backer per minute. She then walked and asked three people to ded Nursing Assistant who had					
	CNA A was identifi Resident #208 from bedroom. On 8/8/1 was conducted wit	#208 to her bedroom.  ed as the person who relocated  m the activity room to her  17 at 2:50 P.M. an interview  th CNAA. He stated, "I took her  coom to change her brief. I					
	Resident #208's caresident has the pobreathing pattern roughly Dysphasia, Demer Failure), Respirato	are plan read, "7/7/16. The otential for an ineffective related to Hx. (history) of ontia, CHF (Chronic Heart ory Failure. This was the current ad not been reviewed or revised					

FORM CMS-2567(02-99) Previous Versions Obsolete

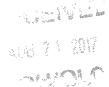
today."

since 7/7/16. On 8/8/17 at 3:30 P.M. The facility Director of Nursing submitted this careplan and stated, "They are going to revise this careplan

Event ID: 1FXQ13

Facility ID: VA0085

If continuation sheet Page 8 of 9



PRINTED: 08/17/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			OND NO. 0330-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495327	B. WING		R 08/10/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2017
				4403 FOREST HILL AVENUE	
ENVOT	OF WESTOVER HILL:	J		RICHMOND, VA 23225	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE COMPLETION
{F 328}	Continued From pa	age 8	{F 3	328}	
	documentation, rev Policy Revised on physician's order. S prescribed liter flow	was conducted of facility wealing the Oxygen Therapy 11/9/15. It read, "Review Start O 2 flowrate at the w or appropriate flow for ice. Place delivery device on			
	(Administration A),	P.M. the Administrator and Director of Nursing were informed of the findings. tion was received.			

