STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

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{F 000} INITIAL COMMENTS {F 000}

An unannounced Medicare/Medicaid second revisit to the standard survey ending 5/19/17 was conducted 8/8/17 through 8/10/17. The first revisit survey was conducted 7/10/17 through 7/12/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long-Term Care requirements. Corrected deficiencies are identified on the CMS-2567B. No complaints were investigated during the survey.

The census in this 174 certified bed facility was 164 at the time of the survey. The survey sample consisted of 15 current record reviews (Residents #1 through #15).

{F 280} SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP {F 280}

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

1. On 8/17/17, the MDS/Regional Case Mix Coordinator reviewed and revised the care plan for Resident #208 related to ineffective breathing problem to include, administration of oxygen as per physician order. Resident #208 receives oxygen at liter flow as ordered by physician.

2. On 8/17/17, facility Executive Director initiated a quality improvement monitoring of residents with oxygen administration to ensure resident's care plan has been reviewed and revised to reflect administration of oxygen per physician order. DC/Designee completed a quality monitor of current residents on oxygen to ensure oxygen is being administered at liter flow per physician orders. There were no discrepancies identified.

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

V Hope | Director | 8/17/17

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

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{F 280}	Continued From page 1	{F 280}		

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(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.

3. By 8/17/17, the MDS/Regional Case Mix Coordinator reeducated the IDT on the review and revision of care plans for residents on oxygen to ensure residents have updated care plans that meet the resident's medical, nursing, mental, and psychosocial needs.

4. The DCS/Nurse Manager/MDS Coordinator to conduct Quality Improvement Monitoring of care plans 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

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(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for one resident (Resident #208) of 15 residents in the survey sample to revise the comprehensive care plan timely.

1. For Resident #208, the facility staff failed to review and revise the Care Plan for ineffective breathing problem since 7/7/16.

Resident #208 was a 70 year old who was admitted to the facility on 1/4/10. Resident #208's diagnoses included Heart Failure, Chronic Respiratory Failure, and Unspecified Convulsions.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 280} Continued From page 3

of 6/19/17, coded Resident #208 as having a Brief Interview of Mental Status Score of 2, indicating severely impaired cognition.

On 8/8/7 a 2:00 P.M. a tour was conducted of the facility. The Unit Manager (Licensed Practical Nurse - LPN B) was present. Resident #208 was in the activity room. Her oxygen concentrator was set at at 3.5 liters per minute. LPN B confirmed that it was set at 3.5 liters per minute.

On 8/8/17 a review was conducted of Resident #208's clinical record, revealing the following physician's order, "8/1/17. Oxygen at 4L/MIN via nasal cannula continuously." On 8/8/17 at 2:45 P.M. an interview was conducted with LPN B, who stated, "Oxygen is to keep airway patent to make sure they're breathing. If it's not right it's in conflict with the order."

On 8/8/17 at 2:48 P.M. a second observation was conducted of Resident #208, who had been moved from the activity room and left in her bedroom. LPN B was present. Resident #208 was sitting in her wheelchair alone in her room with the nasal cannula in her nose, however the oxygen concentrator was switched off. Therefore, she was not receiving physician ordered oxygen continuously. When LPN B noticed that the oxygen concentrator was off, she stated, "The machine is off. I can't win for losing."

LPN B then turned the oxygen concentrator back on and set it to 4 liter per minute. She then walked down the hallway and asked three people to identify the Certified Nursing Assistant who had brought Resident #208 to her bedroom.

CNA A was identified as the person who relocated

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Resident #208 from the activity room to her bedroom. On 8/8/17 at 2:50 P.M. an interview was conducted with CNA A. He stated, "I took her out of the activity room to change her brief. I always leave the oxygen on."

Resident #208's care plan read, "7/7/16. The resident has the potential for an ineffective breathing pattern related to Hx. (history) of Dysphasia, Dementia, CHF (Chronic Heart Failure), Respiratory Failure. This was the current care plan, which had not been reviewed or revised since 7/7/16. On 8/8/17 at 3:30 P.M. The facility Director of Nursing submitted this care plan and stated, "They are going to revise this care plan today."

On 8/9/17 at 3:00 P.M. the Administrator (Administration A), and Director of Nursing (Administration B) were informed of the findings. No further information was received.

{F 328} SS=D 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS

(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

{F 280}

{F 328}

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1. On 8/9/17, Resident #208 was re-assessed by nurse manager. Resident had no signs or symptoms of respiratory distress or air hunger. Resident #208's MD was notified. No new orders were given.

2. On 8/9/17, current residents on oxygen administration were assessed to determine liter flows were set per physician's order. There were no discrepancies identified.

3. On 8/9/17 education provided to current nursing staff by the DCS, ADCS, and Nurse Managers related to the following...

a) Having a nurse present while transferring residents from one oxygen device to another to ensure resident is receiving oxygen therapy per physician's order
b) Oxygen concentrators to be unplugged versus turned off for the beep reminder when not in use
c) Licensed nurses re-educated on how to properly set and read liter flow on oxygen flow meters with return demonstration

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{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. (j) 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	

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{F 328}	Continued From page 6	{F 328}		

prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed, for 1 resident (Resident #208) of the survey sample of 15 residents, to administer oxygen per physician's order.

For Resident #208, the facility failed on two occasions, to administer oxygen per physician's order.

The Findings included:

Resident #208 was a 70 year old who was admitted to the facility on 1/4/10. Resident #208's diagnoses included Heart Failure, Chronic Respiratory Failure, and Unspecified Convulsions.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of /19/17, coded Resident #208 as having a Brief Interview of Mental Status Score of 2, indicating severely impaired cognition.

On 8/8/7 a 2:00 P.M. a tour was conducted of the facility. The Unit Manager (Licensed Practical Nurse - LPN B) was present. Resident #208 was in the activity room. Her oxygen concentrator was set at at 3.5 liters per minute. LPN B confirmed that it was set at 3.5 liters per minute.

On 8/8/17 a review was conducted of Resident #208's clinical record, revealing the following physician's order, "8/1/17. Oxygen at 4L/MIN via nasal cannula continuously." On 8/8/17 at 2:45 P.M. an interview was conducted with LPN B,

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who stated,"Oxygen is to keep airway patent to make sure they're breathing. If it's not right it's in conflict with the order."

On 8/8/17 at 2:48 P.M. a second observation was conducted of Resident #208, who had been moved from the activity room and left in her bedroom. LPN B was present. Resident #208 was sitting in her wheelchair alone in her room with the nasal cannula in her nose, however the oxygen concentrator was switched off. Therefore, she was not receiving physician ordered oxygen continuously. When LPN B noticed that the oxygen concentrator was off, she stated, "The machine is off. I can't win for losing."

LPN B then turned the oxygen concentrator back on an set it to 4 liter per minute. She then walked down the hallway and asked three people to identify the Certified Nursing Assistant who had brought Resident #208 to her bedroom.

CNA A was identified as the person who relocated Resident #208 from the activity room to her bedroom. On 8/8/17 at 2:50 P.M. an interview was conducted with CNA A. He stated, "I took her out of the activity room to change her brief. I always leave the oxygen on."

Resident #208's care plan read, " 7/7/16. The resident has the potential for an ineffective breathing pattern related to Hx. (history) of Dysphasia, Dementia, CHF (Chronic Heart Failure), Respiratory Failure. This was the current careplan, which had not been reviewed or revised 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 today."

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On 8/9/17 a review was conducted of facility documentation, revealing the Oxygen Therapy Policy Revised on 11/9/15. It read, "Review physician's order. Start O 2 flowrate at the prescribed liter flow or appropriate flow for administration device. Place delivery device on resident"

On 8/9/17 at 3:00 P.M. the Administrator (Administration A), and Director of Nursing (Administration B) were informed of the findings. No further information was received.