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 _____	C 01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated survey was conducted 1/4/2017 through 1/5/2017. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 174 certified bed facility was 163 at the time of the survey. The survey sample consisted of 6 current Resident reviews (Residents #1 through #6) and 1 closed record review (Resident #7)

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) — F 157

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

1. Resident #2 and #3 had no adverse reaction to deficiency of practice. Nursing will comply with insulin sliding scale orders and treatment. Nursing will notify physician for all clarifications. Nursing has notified the physician of blood sugar readings on the dates stated on 2567 pertaining to resident #2 and #3.
2. DCS/Designee will identify all residents with diabetes and will do a 30 day look back to ensure all blood sugar sliding scale were followed as ordered and physician notification were made as needed.

RECEIVED
FEB 07 2017
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director	1/26/17

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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	495327	A. BUILDING _____ B. WING _____	C 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4493 FOREST HILL AVENUE RICHMOND, VA 23225

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F 157	Continued From page 1	F 157		

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(a)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(8); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to notify the physician of changes in condition for two Residents (Residents #2 and #3) in a survey sample of 7 Residents.

1. For Resident #2, the staff failed to notify the physician of a finger stick blood sugar greater than 500 mg/dl (milligrams per deciliter) on 11/10/16 and 11/17/16, per physician orders.
2. For Resident #3, the facility staff failed to notify the physician for a blood sugar reading greater

3. DCS/Designee will audit all medical records with diagnosis of Diabetes 3xweek x 4 weeks to ensure insulin sliding scale orders are followed per physician order and notifications are made as needed. Staff will be educated on documentation on Blood Glucose reading and following Physician orders.
4. DCS/Designee will review Medication Administration records weekly 5x a week to ensure physician orders are followed. Plan of Correction will be reviewed at monthly Qapi.
5. AOC on 2/7/17.

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F 157	Continued From page 2	F 157		

than 500 mg/dl on 10/29, 10/30, 11/21/2016.

The findings included:

Resident #2 was admitted to the facility 2/18/15. Her diagnoses included type II diabetes mellitus, stroke, bipolar, hypertension, depression, anxiety and obesity.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) was coded as an annual assessment. She was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #2 was coded as requiring extensive to total assistance of one to two staff members to perform all of her activities of daily living other than eating. She required set-up assistance only for eating.

Review of Resident #2's clinical record revealed a signed physician's sliding scale order initially dated 12/18/15 that read:
"Humalog 100 U (units)/ 1 ml (milliliter) Sliding Scale BS (Blood Sugar): If < (less than) 200=0 U (units); 201-300=4 U; 301-400=8 U; 401-500=12 U; > (greater than) 500 = 15 U, Record Amount and Site, Call MD (medical doctor) If Blood Glucose is Less than 100 or Greater than 500."

Corresponding entries were noted on the November 2016 MAR (medication administration record) as follows:
a. On 11/10/16 at 4:30 p.m. the blood sugar reading was 556 and the amount of insulin administered was documented '15 U'. According to the physician ordered sliding scale, Resident #2's physician was ordered to be notified for blood sugar results greater than 500.

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F 157	Continued From page 3	F 157		

b. a. On 11/17/16 at 7:30 a.m. the blood sugar reading was 580 and the amount of insulin administered was documented '15 U'. According to the physician ordered sliding scale, Resident #2's physician was ordered to be notified for blood sugar results greater than 500.

A thorough review of the clinical record revealed no documentation Resident #2's physician was notified of the finger stick blood sugar measurement of >500 mg/dl on 11/10/16 at 4:30 p.m. or on 11/17/16 at 7:30 a.m.

1/5/17 at 1:15 p.m., the DON (director of nursing) was informed and stated, "I didn't find any additional information on the blood sugar or notification of the MD"

On 1/5/17 at 2:15 p.m., the administration was informed of the failure of the staff to notify Resident #2's physician of the blood sugar measurements that was greater than 500 mg/dl, per physician orders.

2. For Resident #3, the facility staff failed to notify the physician for a blood sugar reading greater than 500 mg/dl on 10/29, 10/30, 11/21/2016.

Resident #3 was admitted to the facility 6/10/15 and readmitted after hospitalization on 11/28/16. Her diagnoses included type II diabetes mellitus, hypertension, coronary artery disease, and urinary tract infection.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) was coded as a quarterly assessment. She was coded a BIMS (Brief Interview of Mental Status)

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EMPOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

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F 157	Continued From page 4	F 157		

score of 15, cognitively intact. Resident #3 was coded as requiring supervision of one staff member to perform all of her activities of daily living other than bathing. She required total assistance only for bathing.

On 1/5/16 at 9:00 a.m., a review of Resident #3's clinical record was conducted and revealed the following orders for physician notification:

1. Fasting Blood Sugar once a day every morning - Read - Notify MD if Blood Sugar < (less than) 60 or > (greater than) 400.
a. On 10/29/16 at 9:00 a.m. the blood sugar reading was 567
b. On 10/30/16 at 9:00 a.m. the blood sugar reading was 514.

2. "Humalog 100 U (units) / 1 ml (milliliter) Before Meals and at Bedtime per Sliding Scale for Blood Sugar: 0-150 Give 0 Coverage; 150-200 Give 2 Units SUBQ (subcutaneous); 201-250 Give 4 Units SUBQ; 251-300 Give 6 Units SUBQ; 301-400 Give 8 Units SUBQ 400+ CALL MD (medical doctor)."
Corresponding entries were noted on the December 2016 MAR (medication administration record) as follows:
a. On 12/9/16 at 11:30 a.m. the blood sugar reading was 500 and the amount of insulin administered was documented '10 U'. According to the physician ordered sliding scale, Resident #3's physician was ordered to be notified for blood sugar results greater than 400.
b. On 12/9/16 at 4:30 p.m. the blood sugar reading was 495 and the amount of insulin administered was documented '8 U'. According to the physician ordered sliding scale, Resident #3's physician was ordered to be notified for

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F 157	Continued From page 6 blood sugar results greater than 400. A thorough review of the clinical record revealed no documentation Resident #3's physician was notified of the finger stick blood sugar measurement of >400 mg/dl on 10/29, 10/30 and 12/9/16. On 1/5/17 at 11:05 a.m., LPN (licensed practical nurse) C was informed of the missing documentation on the dates in question. LPN C stated she would check into it and provide follow-up information. On 1/5/17 at 1:15 p.m., an interview was conducted with the DON (Director of Nursing) at which time she was informed of the three occasions the physician orders were not followed for notification of blood sugar readings greater than 400. On 1/5/17 at 1:55 p.m., the DON (director of nursing) was informed and stated, "I didn't find any evidence of physician notification." On 1/5/17 at 2:15 p.m., the administration was informed of the failure of the staff to notify Resident #3's physician of the blood sugar measurements that was greater than 400 mg/dl, per physician orders. No additional information was provided.	F 157		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the	F 279		

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F 279	Continued From page 6 results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)-	F 279	1. Resident #3 had no adverse reaction to deficiency practice. MDS will add the appropriate care plan for resident care plan. Education will be provided to MDSC on the care plan process. 2. 100% of all Residents with Diabetic Management care plans will be audit. 3. All new residents with diabetic management care plans will be reviewed in clinical meeting. 4. All diabetic management new orders will be care plan in clinical meeting. 5. Lead MDSC/Designee will audit 5% of Diabetic care plan weekly. 6. RCMC to complete audits Biweekly To ensure MDSC audits are being maintained. Plan of correction will be reviewed at monthly QAPI. AOC on 2/7/17.	

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(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to develop a comprehensive care plan for one Resident (Resident #3) of 7 residents in the survey sample.

The facility staff failed to include Resident #3's physician ordered diabetic management plan in the Comprehensive Care Plan

The findings included:

Resident #3 was admitted to the facility 6/10/15 and readmitted after hospitalization on 11/28/16. Her diagnoses included type II diabetes mellitus, hypertension, coronary artery disease, and urinary tract infection.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/5/16 was coded as a quarterly assessment. She was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #3 was coded as requiring supervision of one staff member to perform all of her activities of

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F 279	Continued From page 8	F 279		

daily living other than bathing. She required total assistance for bathing. Diabetes was coded under Active Diagnoses

On 1/5/17 at 9:00 a.m., a review of the clinical record was conducted and revealed the following:
1. A Comprehensive Care Plan which did not include interventions for Resident #3's diabetic management.
2. Current physician orders for Resident #3's diabetic management included:
a. Fasting Blood Sugars once a day every morning in which the physician was to be notified if the blood sugar measurements was less than 60 or greater than 400.
b. Scheduled subcutaneous injections of 15 units of Lantus 100 unit/1 ml (milliliter) at bedtime.
c. Sliding Scale Insulin (SSI) orders dated 11/29/16 - "Humalog 100 U (units) / 1 ml (milliliter) Before Meals and at Bedtime per Sliding Scale for Blood Sugar: 0-150 Give 0 Coverage; 150-200 Give 2 Units SUBQ (subcutaneous). 201-250 Give 4 Units SUBQ; 251-300 Give 6 Units SUBQ. 301-400 Give 8 Units SUBQ. 400+ CALL MD (medical doctor)."
3. A lab report dated 10/3/16 with the Hemoglobin A1C 11.3 (High). Reference Range 4.0 – 6.0. ("The A1C test gives you a picture of your average blood glucose (blood sugar) control for the past 2 to 3 months. The results give you a good idea of how well your diabetes treatment plan is working." http://www.diabetes.org)
On 1/5/17 at 11:30 p.m. an interview was conducted with the Director of Nursing (DON) regarding Resident #3's diabetic management as it was reflected in Comprehensive Care Plan. After reviewing the Comprehensive Care Plan, the DON stated, "Oh, it's included in the plan for Alteration in Perfusion.

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F 279	Continued From page 9 A review of the Alteration for Perfusion revealed that care plan did not include objectives, interventions or timeframes of Resident #3's physician ordered diabetic management.. On 1/5/17 at 2:15 p.m., the administration was informed of findings. No additional information was provided.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation, and clinical record review, the facility staff failed to follow the professional standards of nursing for medication administration for one Resident (Resident #3) in a survey sample of 7 Residents. For Resident #3, the facility staff failed to document blood glucose measurement on 11/19/2016, the administration of Lantus on 11/19/16 at 9 p.m., and the amount of Humelog administered 11/21/16 at 11:30 a.m. The blood sugar measurement on 12/9/16 at 8:03 p.m., was illegible and there was no documentation of insulin administration. The findings included: Resident #3 was admitted to the facility 6/10/15 and readmitted after hospitalization on 11/28/16.	F 281	1. 1.Resident #3 had no adverse reactions related to deficiency practice. Physician will be notified to clarify any changes in insulin sliding scale, blood sugar readings and treatment. Physician was notified and clarifications orders were received for resident #3. 2. DCS/Designee will identify all residents with diabetes and will do a 30 day look back t ensure all blood sugar sliding scale orders were followed per physician order. MD will be notified for any discrepancies.	

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Her diagnoses included type II diabetes mellitus, hypertension, coronary artery disease, and urinary tract infection.

Resident #3's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/4/16 was coded as a quarterly assessment. She was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #3 was coded as requiring supervision of one staff member to perform all of her activities of daily living other than bathing. She required total assistance for bathing. Diabetes was coded on the MDS under Active Diagnoses.

On 1/5/16 at 9:00 a.m., a review of Resident#3's clinical record was conducted and revealed the following:

1. October 2016 MAR (Medication Administration Record) had an order entry for Lantus 30 units SQ (subcutaneous) at bedtime. This was ordered on 11/18/16 and discontinued on 11/22/16. There was no documentation on the MAR that the Lantus was administered on 11/19/16.

2. November 2016 MAR, Sliding Scale Insulin (SSI) orders dated 11/18/16 read - " Humalog 100 U (units) / 1 ml (milliliter) Before Meals and at Bedtime per Sliding Scale for Blood Sugar: < (less than) 150 = 0 units; 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-400 = 8 units. > (greater than) 400 CALL MD (medical doctor)."
a. On 11/19 at 11:30 a.m., there was no documentation of a finger stick blood sugar measurement and no documentation of insulin administration.

3. DCS/Designee will audit all blood sugars on medical records 3xweek x4weeks to ensure physician orders are followed. Staff will be educated on blood sugar readings and complying with physician orders.
4. DCS/Designee will review Medication Administration records Weekly 4x week to ensure physician orders are followed. Plan of Correction will be reviewed at monthly QAPI.
5. AOC is 2/7/17.

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b. On 11/21 at 11:30 a.m., there was a blood sugar reading of 427, however there was no documentation of the amount of insulin administered or physician notification for the blood sugar that was greater than 400.

3. December 2016 MAR, Sliding Scale Insulin (SSI) orders dated 11/29/16 read - " Humalog 100 U / 1 ml Before Meals and at Bedtime per Sliding Scale for Blood Sugar: 0-150 Give 0 Coverage; 150-200 Give 2 Units SUBQ (subcutaneous); 201-250 Give 4 Units SUBQ; 251-300 Give 6 Units SUBQ; 301-400 Give 8 Units SUBQ 400+ CALL MD." On 12/9 at 11:30 a.m., the blood sugar reading was illegible and the amount of insulin administered was not documented.

A thorough review of the clinical record failed to indicate Resident #3 had refused blood sugar testing or insulin administration on the dates in question. Valid physician orders were evident for the above concerns.

On 1/5/17 at 11:05 a.m., LPN (licensed practical nurse) C was informed of the missing documentation on the dates in question. LPN C stated she would check into it and provide follow-up information.

On 1/5/17 at 1:15 p.m., an interview was conducted with the DON (Director of Nursing) at which time she was informed of the missing documentation and she said she would follow-up.

On 1/5/17 at 1:55 p.m., a follow-up interview with the DON was conducted at which time she stated she did not have any information to add regarding the missing documentation.

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	495327	A. BUILDING _____ B. WING _____	C 01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 Review of the facility's policy entitled, Medication - Oral Administration of, read: "Chart on MAR according to policy." Review of the facility's policy entitled, Blood Glucose Monitoring read, "Document result in nurses's notes and/or on Medication Administration Record (MAR) with any insulin administration. Lippincott was cited as the facility's primary resource for professional nursing standards. Guidance was given to nursing by "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, After administering a medication, record it immediately on the appropriate record form." On 1/5/17 at 2:15 p.m., the administration was informed of the failure of the staff to follow professional standards of nursing in the documentation of medication administration.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services.	F 309		

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consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(i) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to implement physician ordered diabetic management for two Residents (Residents #2 and #3) in a survey sample of 7 Residents.

1. For Resident #2, on two occassions, the facility staff did not follow for the physician's orders to be notified of finger stick blood sugars greater than 500.

2. For Resident #3, the facility staff failed to follow the physician's Sliding Scale Insulin (SSI) orders for insulin administration and physician notification.

The findings included:

For Resident #2, the facility staff failed to follow the physician Sliding Scale Insulin (SSI) orders for insulin administration and physician notification.

Resident #2 was admitted to the facility 2/18/15. Her diagnoses included type II diabetes mellitus,

1. Resident #2 and #3 had no adverse reaction to deficiency of practice. Nursing will comply with Insulin sliding scale orders and treatment. Nursing will notify physician for all clarifications.
2. DCS/Designee will identify all residents with diabetes and will do a 30 day look back to ensure all blood sugar sliding scale were followed as ordered and physician notification were made as needed.
3. DCS/Designee will audit all medical records 3xweek x 4 weeks with diagnosis of Diabetes to ensure Insulin sliding scale orders are followed per physician order and notifications are made as needed. Staff will be educated on documentation on Blood Glucose reading and notifying the Physician.
4. DCS/Designee will review Medication Administration records weekly 4x week to ensure physician orders are followed. Plan of Correction will be review at monthly QAPI.
5. AOC on 2/7/17.

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stroke, bipolar, hypertension, depression, anxiety and obesity.

Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/5/16 was coded as an annual assessment. She was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #2 was coded as requiring extensive to total assistance of one to two staff members to perform all of her activities of daily living other than eating. She required set-up assistance only for eating. Resident #2 was coded for Diabetes in the Active Diagnoses section of the MDS.

On 1/5/17 at 11:30 a.m., Resident #2 was observed in her room, in a bariatric bed, drinking a Mountain Dew soda. A 1 liter bottle of Mountain Dew was observed on her bedside table. Resident #2 was interviewed and said she had no concerns regarding her care in the facility.

On 1/5/17 at 11:40 a.m., a review of Resident #2's clinical record was conducted and revealed the following:

1. A Comprehensive Care Plan dated 6/28/16 that included a focus on Diabetes. Interventions included monitoring for hypo and hyperglycemia, providing medications as ordered, obtaining blood glucose levels as ordered and notifying MD (Medical Doctor) as ordered.

2. A lab report dated 9/14/16 with an Hemoglobin A1C of 6.7 (high). Reference Range was 4.0-6.0. ("The A1C test gives you a picture of your average blood glucose (blood sugar) control for the past 2 to 3 months. The results give you a good idea of how well your diabetes treatment

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ENVOY OF WESTOVER HILLS	4463 FOREST HILL AVENUE RICHMOND, VA 23225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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plan is working." http://www.diabetes.org)

3. An Annual Nutrition Evaluation dated 10/27/16, under Summary read, "Resident drinks 2L (liters) Mountain Dew about 3 x week. ...eating candy during weight loss counseling."

4. A current signed physician's insulin sliding scale initially ordered on 12/18/15 read: "Humalog 100 U (units) / 1 ml (milliliter) Sliding Scale BS (Blood Sugar) : If < (less than) 200=0 U; 201-300=4 U; 301-400=8 U; 401-500=12 U; > (greater than) 500 = 15 U, Record Amount and Site, Call MD (medical doctor) If Blood Glucose is Less than 100 or Greater than 500."

5. Corresponding entries were noted on the November 2016 MAR (Medication Administration Record):
a. On 11/10/16 at 4:30 p.m., the blood sugar reading was 555 and the amount of insulin administered was documented '15 U'. According to the physician ordered sliding scale, Resident #2's physician was ordered to be notified for blood sugar results greater than 500.

b. On 11/17/16 at 7:30 a.m., the blood sugar reading was 539 and the amount of insulin administered was documented '15 U'. According to the physician ordered sliding scale, Resident #2's physician was ordered to be notified for blood sugar results greater than 500.

A thorough review of the clinical record revealed no documentation Resident #2's physician was notified of the finger stick blood sugar measurement of >500 mg/dl on 11/10/16 at 4:30 p.m. or on 11/17/16 at 7:30 a.m.

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On 1/5/17 at 11:50 a.m., an interview was conducted with LPN (Licensed Practical Nurse) A regarding Resident #2's blood sugar measurement history. LPN A stated, "I can recall her blood sugar being over 500 on one occasion and the doctor had to be notified." LPN A said the Resident had left the facility to attend a buffet on that occasion.

On 1/5/17 at 12:00 p.m., an interview was conducted with LPN B, the unit manager, regarding the facility staff failure to notify the physician of her blood sugar greater than 500. After reviewing Resident #2's clinical record, LPN B stated, "I don't know why the physician wasn't informed. They (the nursing staff) should have completed an SBAR (Situation, Background, Assessment, Review and Notify) form.

On 1/5/17 at 1:15 p.m., the DON (director of nursing) was informed and stated, "I didn't find any additional information on the notification to the MD or blood sugars that were greater than 500.

On 1/5/17 at 2:15 p.m., the administration was informed of the failure of the staff to notify Resident #2's physician of the blood sugar measurements that were greater than 500 mg/dl, per physician orders. No additional information was provided.

2. For Resident #3, the facility staff failed to follow the physician Sliding Scale Insulin (SSI) orders for insulin administration and physician notification.

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Resident #3 was admitted to the facility 6/10/15 and readmitted after hospitalization on 11/28/16. Her diagnoses included type II diabetes mellitus, hypertension, coronary artery disease, and urinary tract infection.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) was coded as a quarterly assessment. She was coded a BIMS (Brief Interview of Mental Status) score of 15, cognitively intact. Resident #3 was coded as requiring supervision of one staff member to perform all of her activities of daily living other than bathing. She required total assistance for bathing. Resident #3 was coded for Diabetes in the Active Diagnoses section of the MDS.

Resident #3 was observed in her room on 1/4/17 at 10:20 a.m., and on 1/5/17 at 11:00 a.m. On both occassions, Resident #3 was asleep in her bed.

On 1/5/16 at 9:00 a.m., a review of Resident#3's clinical record was conducted and revealed the following:
1. A Comprehensive Care Plan revised on 4/12/16 which did not include interventions for Resident #3's diabetic management.
2. October 2016 MAR (Medication Administration Record) had an order entry for Lantus 30 units SQ (subcutaneous) at bedtime. This was ordered on 11/18/16 and discontinued on 11/22/16. There was no documentation on the MAR that the Lantus was administered on 11/19/16.

3. November 2016 MAR, Sliding Scale Insulin (SSI) orders dated 11/18/16 read - "Humalog 100

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F 309	Continued From page 18 U (units) / 1 ml (milliliter) Before Meals and at Bedtime per Sliding Scale for Blood Sugar: < (less than) 150 = 0 units; 150-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-400 = 8 units. > (greater than) 400 CALL MD (medical doctor)." a. On 11/19 at 11:30 a.m., there was no documentation of a finger stick blood sugar measurement and no documentation of insulin administration. b. On 11/21 at 11:30 a.m., there was a blood sugar reading of 427, however there was no documentation of the amount of insulin administered or physician notification for the blood sugar that was greater than 400. 3. December 2016 MAR, Sliding Scale Insulin (SSI) orders dated 11/29/16 read - " Humalog 100 U / 1 ml Before Meals and at Bedtime per Sliding Scale for Blood Sugar: 0-150 Give 0 Coverage; 150-200 Give 2 Units SUBQ (subcutaneous); 201-250 Give 4 Units SUBQ; 251-300 Give 6 Units SUBQ; 301-400 Give 8 Units SUBQ; 400+ CALL MD." On 12/9 at 11:30 a.m., the blood sugar reading was illegible and the amount of insulin administered was not documented. A thorough review of the clinical record failed to indicate Resident #3 had refused blood sugar testing or insulin administration on the dates in question. Valid physician orders were evident for the above concerns. On 1/6/17 at 11:05 a.m., LPN (licensed practical nurse) C was informed of the missing documentation on the dates in question. LPN C stated she would check into it and provide follow-up information.	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4103 FOREST HILL AVENUE RICHMOND, VA 23225

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On 1/5/17 at 1:15 p.m., an interview was conducted with the DON (Director of Nursing) at which time she was informed of the following concerns regarding Resident #3 physician ordered diabetic care:
1. The Comprehensive Care Plan did not include goals and interventions for care of her diabetes.
2. The three occassions the physician orders were not followed for notification of blood sugar readings greater than 400.
3. The two occassions, there was no documentation of insulin administration.
4. Documentation of a blood sugar reading was illegible on 12/9 at 8:00 p.m.
The DON said she would review Resident #3's clinical record and provide follow-up information.

On 1/5/17 at 1:55 p.m., a follow-up interview with the DON was conducted at which time she stated she did not have any additional information.

Review of the facility's policy entitled, Blood Glucose Monitoring read, "Document result in nurses's notes and/or on Medication Administration Record (MAR) with any insulin administration.

Guidance was given in the Fundamental's of Nursing 7th Edition, Potter-Perry, page 692, "The quantity and distribution of a medication in different body compartments change constantly. When a medication is prescribed, the goal is a constant blood level within a safe therapeutic range. The client and nurse need to follow regular dosage schedules and adhere to prescribed doses and dosage intervals."

Also, same source, page 337, "The physician is responsible for directing medical treatment.

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F 309	Continued From page 20 Nurses follow physicians' orders unless they believe the orders are in error or harm clients." On 1/5/17 at 2:15 p.m., the administration was informed of the facility staff failure to implement Resident #3's physician ordered diabetic management. RELATED COMPLAINT DEFICIENCY	F 309		