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

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 07/12/2017

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 revisit and complaint 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. Two complaints were investigated.

The census in this 174 certified bed facility was 161 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #101 through #113 and #115) and one closed record review (Residents #114).

{F 225} SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

483.12(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of

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{F 225}

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

F 225

1. Certified Nursing Assistant B (CNA B) attended paper orientation to include education on Abuse/Neglect with the Staff Development Coordinator on 7-5-17 and 7-6-17. CNA B did not provide any direct care to center residents prior to the verification of CNA B's Virginia CNA certification on 7-7-17. CNA B did have a background check, OIG check and Abuse Registry Check on 6-23-17, as well as, abuse and neglect training with a signed attestation on 7-5-17.

2. Current center staff members' employee personnel files were reviewed by the Center's Human Resources Payroll Coordinator/Human Resources Assistant to ensure that the files were complete with the Virginia State Board of Nursing Licensure Check/Nurse Aide Certification check, Criminal Background Check, Virginia State Board of Nursing/Nurse Aide Abuse Registry

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director	7/24/17

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 225} Continued From page 1

actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

{F 225}

check, Office of the Inspector General Check, and Telephone Reference Checks, as well as, Abuse/Neglect Attestation on 7-13-17 and 7-14-17. Follow based on findings.

3. The Regional Director of Clinical Services educated the Executive Director/Director of Clinical Services/Assistant Director of Clinical Services/Staff Development Coordinator/Human Resources Payroll Coordinator/Human Resources Assistant with regard to F225 and Center's policy and procedure for Abuse and Neglect to ensure that verification of potential new hires are complete with the Virginia State Board of Nursing Licensure Check/Nurse Aide Certification check, as applicable, along with a Criminal Background Check, Virginia State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, and Telephone Reference Checks, prior to a job offer being made or attendance in orientation.

4. The Executive Director/Director of Clinical Services/Regional Director of Clinical Services/ Regional Director of Operations to conduct Quality monitor of 10 pending new hire employees' files 1 x weekly for 12 months to ensure the completion of Licensure/Certification checks for Licensed Nurses/ Certified Nursing Assistants prior to Orientation, Background checks, Office of the Inspector General checks prior to Orientation, State of Virginia Abuse Registry Checks prior to Orientation, Telephone Reference Checks prior to a job offer being made or attendance in orientation. The results of Quality Improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services.

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This REQUIREMENT is not met as evidenced by:

Based on staff interview and facility documentation review, the facility staff failed to verify the certification of one of two employees (Certified Nursing Assistant B-CNA B) until after the hire date.

For CNA B hired on 7/3/2017, the facility staff did not verify the certification until four days after the hire date and two days after orientation.

Findings included:

On 7/11/2017 at 3 PM, the Facility Administrator was asked to have the Human Resources Director talk with the surveyors. The Administrator stated the Human Resources Director had resigned about 30 days prior to survey and that the position had not yet been filled. The Administrator stated employees had been hired since the AOC (Allegation of Compliance) date of 7/3/2017.

On 7/11/2017 at 3:15 PM, an interview was conducted with the Facility Administrator who stated there were two employees hired on 7/3/2017 but they did not start orientation until 7/5/2017 due to the 4th of July holiday. The Administrator presented a list of two employees hired on 7/3/2017, one was a Business Development Coordinator and the other was a Certified Nursing Assistant.

Review of the Human Resources records of the two new employees hired on 7/3/2017 revealed the certification of CNA B was not verified until after the hire date. Further review of the file for Certified Nursing Assistant B (CNA B) revealed

{F 225} The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance. The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver.

5. Allegation of Compliance Date: 7-24-17.

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the "License Lookup" was conducted on 7/7/2017 at 8:07 AM.

On 7/12/2017 at 11:30 AM, an interview was conducted with the Human Resources Assistant (Employee A) who stated CNA B was in the facility for orientation on 7/5/2017 but did not work with residents. Employee A stated CNA B was hired for the 11-7 shift and was not scheduled to work until the week of 7/20/2017.

Review of the Facility document, Resident Abuse Policies and Procedures, Effective 11/30/2014, Revision date 2/1/2017, revealed documentation for the following under "Screening" section: "Persons applying for employment with a The Company facility (sic) will be screened for a history of abuse, neglect, or mistreating residents to include: ...Verify license or registration prior to hire."

During the end of day debriefing on 7/12/2017 at 11:50 AM, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

{F 226} SS=D 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

483.12
(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

{F 225}

F 226

1. Certified Nursing Assistant B (CNA B) attended paper orientation to include education on Abuse/Neglect with the Staff Development Coordinator on 7-5-17 and 7-6-17. CNA B did not provide any direct care to center residents prior to the verification of CNA B's Virginia CNA certification on 7-7-17. CNA B did have a background check, OIG check and Abuse Registry Check on 6-23-17, as well as, abuse and neglect training with a signed

{F 226} attestation on 7-5-17.

2. Current residents residing on the secured unit on 7-10-17 were assessed by a licensed nurse via a skin sweep for suspicious injuries. No suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) were noted at those times. Social Services Director/ Activity Director interviewed current residents residing in the center who were able to participate in and interview (with a Brief Interview for Mental Status –BIMS of 13 or above) on 7-13-17and 7-14-17 to ensure that he/she had not been subject to abuse.

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(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed for one of two employees, Certified Nursing Assistant B (CNA B), hired on 7/3/2017 to implement and operationalize their Abuse policies and procedures for screening persons applying for employment for a history of abuse, neglect or mistreating residents.

For CNA B, the facility staff failed to check the certification prior to hire on 7/3/2017. The Certification Lookup was verified on 7/7/2017.

Findings included:

{F 226} The questions that they were asked were the following: 1.Has anyone/staff mistreated you since you have been a resident here? 2. Has anyone/staff threatened you or been sexually inappropriate with you since you have been a resident here? 3. Are you fearful of anyone/staff member while residing here? No further allegations were made.
Current residents residing in the center on 7-13-17 and 7-14-17 were assessed by a licensed nurse via a skin sweep for suspicious injuries. No suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) were noted at those times.
Current Department Head Staff along with the Nursing, Dietary, Housekeeping/Laundry, and Therapy employees (to include PRN and Contract staff) were interviewed to ensure that none had witnessed any abuse or neglect that had not been previously reported. No staff members worked beyond 7-24-17 without having been interviewed prior to the start of their shift. Department Head Staff along with the Nursing, Dietary, Housekeeping/Laundry, and Therapy employees acknowledged that they were aware of the different types of abuse/neglect and who to report it to and how soon. No further allegations were made by staff at that time.
Current staff members' employee personnel files were reviewed by the Center's Human Resources/Payroll Coordinator to ensure that the files were complete with the Virginia State Board of Nursing Licensure Check/Nurse Aide Certification check, Criminal Background Check, Virginia State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, and Telephone Reference Checks, as well as, Abuse/Neglect Attestation.
The Center's Quality Assurance/Performance Improvement Committee (consisting of the Medical Director, Director of Clinical Services, and at least 3 additional center staff members (to include at least one direct care staff member) met on 7-14-17 to review the Center's Policy and Procedure

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On 7/11/2017 at 3 PM, the Facility Administrator was asked to have the Human Resources Director talk with the surveyors. The Administrator stated the Human Resources Director had resigned about 30 days prior to survey and that the position had not been filled yet. The Administrator stated employees had been hired since the AOC (Allegation of Compliance) date of 7/3/2017.

On 7/11/2017 at 3:15 PM, an interview was conducted with the Facility Administrator who stated there were two employees hired on 7/3/2017 but they did not start orientation until 7/5/2017 due to the 4th of July holiday. The Administrator presented a list of two employees hired on 7/3/2017, one was a Business Development Coordinator and the other was a Certified Nursing Assistant.

Review of the Human Resources records of the two new employees hired on 7/3/2017 revealed the certification of CNA B was not verified until after the hire date. Further review of the file for Certified Nursing Assistant B (CNA B) revealed the "License Lookup" was conducted on 7/7/2017 at 8:07 AM.

On 7/12/2017 at 11:30 AM, an interview was conducted with the Human Resources Assistant (Employee A) who stated CNA B was in the facility for orientation on 7/5/2017 but did not work with residents. Employee A stated CNA B was hired for the 11-7 shift and was not scheduled to work until the week of 7/20/2017.

Review of the Facility document, Resident Abuse Policies and Procedures, Effective 11/30/2014,

{F 226} for Abuse. The policy was adopted without any changes or revisions.

3. Current Department Head Staff along with the Nursing, Dietary, Housekeeping/Laundry, and Therapy employees (to include PRN and Contract staff) were educated by the Executive Director/Director of Clinical Services/Staff Development Coordinator/Nurse Manager regarding the center's policy and procedure for abuse and neglect as well as Regulation F226 on 7-13-17 and 7-14-17. Staff members not educated by 7-24-17, will not work without having been educated prior to the start of their next scheduled shift. Department Head Staff along with the Nursing, Dietary, Housekeeping/Laundry, and Therapy employees acknowledged that they were aware of the different types of abuse/neglect and who to report it to and how soon. Newly hired staff members will be educated regarding abuse and neglect and will sign the abuse attestation during their orientation period.

4. The Executive Director/Social Services Director/ Activity Director/Director of Clinical Services/Nurse Manager will conduct (QI) monitoring of regulation F226 by conducting interviews of inter-viewable residents (those with a BIMS score of =>13) and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the State of Virginia. QI monitoring will be conducted 2 x weekly for 3 months, then 1 x weekly for 9 months using a sample size of 10 inter-viewable residents and 10 staff members. The Director of Clinical Services/Nurse Manager will conduct skin sweeps of 10 residents 2 x weekly or 3 months, then 1 x weekly for 9 months to ensure no suspicious injuries that could constitute an allegation of abuse and/or neglect that would need to be reported to the State of Virginia.

The Executive Director/Director of Clinical Services/Regional Director of Clinical Services/Regional Director of Operations will review employees' files for completion Abuse/Neglect training with a signed attestation prior to direct care or contact with a resident, 2 x weekly for 3 months, then 1 x weekly for 9 months utilizing a sample size of 5 newly hired employees.

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Revision date 2/1/2017, revealed documentation of the following under "Screening" section: "Persons applying for employment a The Company facility (sic) will be screened for a history of abuse, neglect, or mistreating residents to include: ...Verify license or registration prior to hire."

During the end of day debriefing on 7/12/2017 at 11:50 AM, the facility Administrator and Director of Nursing were informed of the findings.

No further information was provided.

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

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.

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

{F 226} The results of Quality Improvement monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services.
The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance. The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver.
5. Allegation of Compliance Date: 7-24-17.
F280
{F 280} 1. Resident #107's care plan was updated to reflect resident's current code status by the Nurse Manager on 7-11-17.
2. Current Residents' care plans were reviewed by the Nurse Manager/Social Services Director on 7-11-17 and 7-13-17. Care Plans updated as indicated by findings of review by the Nurse Manager/Social Services Director at the time of discovery.
3. The Regional Director of Clinical Services/Regional Case Mix Coordinator/Nurse Manager conducted education with the Department Head Members and Licensed Nurses on 7-13-17 and 7-14-17 with regard to F280 and the center's policy and procedure for care planning with emphasis on ensuring that the resident's code status/advance directive is documented on the resident's care plan to honor the resident's wishes.
Education also included that the DCS, Nurse Managers, and Interdisciplinary Team will review new orders during the clinical meeting Monday-Friday to ensure that updates are made to the resident's care plan, as appropriate.

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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.

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

(E) To the extent practicable, the participation of

{F 280}

4. The DCS/Nurse Manager/Social Services Director to conduct Quality Improvement Monitoring of care plans to ensure that the resident's code status/advance directive is documented on the resident's care plan to honor the resident's wishes 2 x weekly for 3 months, then 1 x weekly for 9 months utilizing a sample size of 10 residents.
The results of Quality Improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services.
The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance. The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver.
5. Allegation of Compliance Date: 7-24-17.

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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 staff interview and clinical record review, the facility staff failed for one (Resident #107) of 15 residents in the survey sample, to revise the comprehensive care plan.

Resident #107's advanced directives was ordered as a DNR (do not resuscitate), however the care plan listed the resident as a full code.

The findings included:

Resident #107 was admitted to the facility on 3/24/17 with the diagnoses of, but not limited to, dementia, congestive heart failure, atrial fibrillation, and diabetes mellitus type 2. Resident #107 was admitted to hospice services on 5/25/17.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 5/31/17. The MDS coded Resident #107 with severe

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cognitive impairment and required extensive assistance from staff for most activities of daily living.

On 7/11/17 at 10:35 a.m., Resident #107 was observed awake, lying in bed, but did not respond when spoken to. A hospice staff member stated she just finished providing care to the resident.

On 7/11/17 at 10:45 a.m. Resident #107's clinical record was reviewed. The review revealed signed physician's orders dated 6/14/17 and 7/5/17 which included "*** CODE STATUS *** 05/24/17: DO NOT RESUSCITATE."
Review of Resident #107's care plan included: "Focus Resident has advanced directives of FULL CODE
Date Initiated: 04/20/2017...
Revision on : 04/20/2017..."

On 7/11/17 at 4:05 p.m. the Administrator and Director of Nursing were informed of the findings. Clarification of DNR vs. Full Code was requested.

On 7/12/17 at 11:45 a.m. when the Administrator (Admin-A) and Director of Nursing (Admin-B) were asked about the code status on the care plan vs. the physician's order, Admin-B stated the "Resident is a DNR and her care plan has been updated." No further information was provided by the facility staff.

{F 323} SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free

{F 280}

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F-323

1. Resident #101 has been placed on increased supervision.

a) Regarding the incident on July 7, 2017:

- Resident #101 and Resident #104 were immediately separated on 7-7-17 during the course of the incident by nursing staff, and police were notified on 7-7-16 by the Executive Director.
- Resident #101 was placed on 1:1 and was removed from the secured unit and placed on another unit.
- Assigned CNA on the unit was immediately suspended pending the outcome of the investigation on 7-7-17.

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from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to provide supervision for 2 residents (Resident #101 and #104) in a survey sample of 15 residents.

On 7/7/17, Resident #101 and #104, both cognitively impaired residents living on the locked unit, were found partially unclothed in a resident room engaging in sexual activity. Resident #101 had committed an act of sexual assault against another resident (Resident #103) in the locked unit on 6/14/17.

The finding included:

Resident #101 and Resident #104 were checked for injuries by the licensed nurse on 7-7-16 and no apparent injuries were noted to either resident at that time related to the incident.

- Resident #101's and Resident #104's physicians were notified of the incident by the licensed nurse on 7-7-17 for any new orders.
- The Executive Director filed an initial report for abuse with the state of Virginia and Office of Licensure and Certification, as well as with APS, and the Ombudsman on 7-7-16, and initiated an investigation, which was completed to resolution.
- The Executive Director sent the final 5 Day Report including details of the investigation to the state of Virginia and Office of Licensure and Certification, as well as with APS, and the Ombudsman on 7-10-17.
- Resident #101 and Resident #104 were each evaluated and treated by the psychiatric nurse practitioner. No mental anguish was noted upon review of either resident.
- Resident #101's and #104's care plans were reviewed/updated by the IDT on 7-10-17 and then again on 7-12-17 to reflect current behaviors and interventions.
- Resident #101's and Resident #104's behavior monitoring flow records were reviewed and updated by the IDT to reflect current behaviors, triggers, non-pharmacological interventions, and pharmacological interventions on 7-11-17.
- Resident #101 and #104 were reviewed by the Interdisciplinary Team in the Behavior Management Meeting on 7-14-17 to ensure appropriate interventions are in place to meet each resident's needs.

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On 6/14/17, Resident #101 sexually assaulted Resident #103 in her room. The incident was reported by the facility to the state agency using the Facility Reported Incident (FRI) form. The incident was documented as follows on the form "Facility staff reported that (Resident #101) went into (Resident #103) room and forced himself on her placing one hand on her neck with the other under her dress. (Resident #103) is fought at (sic) (Resident #101) scratching him. Staff intervened immediately, but it took two of them to get him off of her. The police were called, and en route. Both residents were assessed for injury. (Resident #101) received minor scratches. (Resident #103) sustained no injuries, but was very shaken by the incident. She stated that she does not want to be moved off of the unit as long as 'he gets out of here'."

This incident took place on the locked unit where both residents resided.

Resident #101, a 76 year old, was admitted to the facility on 12/6/16. His diagnoses included major cognitive disorder due to dementia, Alzheimer's disease, hypertension, diabetes, and elevated lipids. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/8/17. He was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. He was coded to ambulate with supervision (oversight, encouragement or cueing). He was coded to have disorganized thinking. He was not coded to have any behaviors or to wander.

Resident #101 did not have a history of sexual violence. The facility verified his criminal

{F 323} 2. The Interdisciplinary Team Members reviewed current residents for behaviors by means of observation, staff /resident interviews and chart reviews on 7-14-17. Residents were asked:

i. Has anyone/staff mistreated you since you have been a resident here?

ii. Has anyone/staff threatened you or been sexually inappropriate with you since you have been a resident here?

iii. Are you fearful of anyone/staff member while residing here?

Residents determined to have behaviors to include but not be limited to sexually targeted behaviors were reviewed at a weekly Behavior Management Meeting on 7-14-17 with the IDT to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The center IDT interviewed Staff members in various departments on various shifts on 7-13-17 and 7-14-17 to determine observation or knowledge of residents with behaviors.

3. The Director of Clinical Services (DCS)/Staff Development Coordinator (SDC)/Nurse Manager educated Facility Staff (to include the ED and staff in the following departments: Nursing, Social Services, Activities, Admissions, Business Office, Human Resources/Payroll, Therapy, Dietary, Housekeeping/ Laundry, MDS) on identification of accidents/ incidents which can include behaviors but not be limited to sexual and/or physical targeted behaviors. Facility Staff (to include the ED and staff in the following departments: Nursing, Social Services, Activities, Admissions, Business Office, Human Resources/Payroll, Therapy, Dietary, Housekeeping/Laundry, MDS) have been educated by the DCS/SDC/Nurse Manager to intervene and report sexual and physical targeted behaviors to the resident's nurse for further intervention, documentation in the medical record, and follow up with the Physician for any new orders. The nurse will also

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background check on 12/5/16, prior to admittance to the facility.

Resident #101 was observed to be with his 1:1 sitter through out the duration of the survey. On 7/11/17 at 10:55 a.m., Employee E sat next to Resident #101 on the couch in the main dining room. Employee E was asked if she knew why she was sitting with Resident #101. She answered appropriately. Employee E was also asked if she was given instructions regarding her 1:1 duty. She stated that she was to stay within arms length of the resident and be sure that he didn't escape.

Resident #103, a 67 year old, was admitted to the facility on 4/4/14. Her diagnoses included dementia, schizophrenia, bipolar disease, seizure disorder, hypertension, anxiety, and depression. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/18/17. She was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment. She was coded to have disorganized thinking. She required assistance with activities of daily living.

After this incident, Resident #101 was moved off of the locked unit with 1:1 supervision. Resident #103 remained in the locked unit.

Resident #101's care plan "Potential for impaired or inappropriate behaviors r/t (related to) cognitive loss" was updated on 6/16/17 to add "sexual aggressive toward other resident." New interventions added included 6/14/17- transfer to another unit and psych eval and 6/15/17- Increased supervision.

{F 323} document on the 24-hour report so the information will be shared with the IDT during the morning meeting for review and to ensure appropriate follow through. Incidents will be thoroughly investigated and reported, as required. Residents with sexual and/or physical targeted behaviors will have a care plan in place with interventions.

Facility Staff (to include the ED and staff in the following departments: Nursing, Social Services, Activities, Admissions, Business Office, Human Resources/Payroll, Therapy, Dietary, Housekeeping/ Laundry, MDS) have been educated by the DCS/ SDC/Nurse Manager that revisions are required to be made to the resident's care plan to include interventions, as needed, for behaviors to include but not be limited to sexual and physical targeted behaviors.

Facility Staff (to include the ED and staff in the following departments: Nursing, Social Services, Activities, Admissions, Business Office, Human Resources/ Payroll, Therapy, Dietary, Housekeeping/Laundry, MDS) have been educated by the DCS/SDC/Nurse Manager to follow the resident's plan of care for specific interventions for resident's behaviors.

Facility Staff (to include the ED and staff in the following departments: Nursing, Social Services, Activities, Admissions, Business Office, Human Resources/Payroll, Therapy, Dietary, Housekeeping/ Laundry, MDS) have been educated by the DCS/SDC/Nurse Manager that a Hall Monitor will be in place on the secure unit each shift to provide increased supervision to the residents on the secure unit for resident safety. Staff members, who have not been educated by 7-24-17 will not work until they are educated prior to the start of their next scheduled shift.

4. QI Monitoring to be conducted by the Executive Director/DCS/Nurse Manager 2 x weekly for 3 months, then 1 x weekly for 9 months with regard to Regulation F323 utilizing a record review for a sample size of 5 residents to

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{F 323}	Continued From page 13 On 6/16/17, Resident #101 was evaluated by the Psychiatric Mental Health Nurse Practitioner (PMHNP). The progress note read "(Resident #101) had an incident on Wednesday which he assaulted another resident. He was found choking and on top of another resident. He denies recollection of the incident. When asked if he has been thinking about sex more than usual. He notes, "I've been through with women for a long time. I didn't do nothing. I didn't hurt nobody." In the past, he has become agitated with staff when he is found taking other's clothing. It has never been reported previously that he was sexually aggressive or violent. He denies SI/HI (suicidal ideation/ homicidal ideation). He has been with a sitter on 1:1 since the incident. The sitter notes that he has been calm, cooperative, and polite-he is eating well and sleeping well." "O: (Resident #101) smiles appropriately and greets the undersigned. He answers inappropriately to the orientation questions- when asked the date, he began talking about work, he believed the sitter was his wife, he did not know where he was. He did state his full name. He is polite, calm and cooperative. His speech is normal rate, rhythm, volume, cadence, and tone. His thoughts are confused. He makes his needs known. He denies hallucinations, paranoia or delusions and there is no evidence he is responding to internal stimuli. His affect is congruent with eurymic affect. Medications and treatment plan discussed. His eye contact and psychomotor activity is appropriate. He is steady on his feet and walks well. He is given the opportunity to ask questions." "A: F03.91 Unspecified Dementia with behaviors Deferred	{F 323}	ensure the following: Staff identify resident incidents/accidents which can include but not be limited to sexual and/or physical targeted behaviors. • Staff intervenes and report resident incidents/ accidents to include physical and/or sexual behaviors to resident's nurse for documentation in the resident's medical record. • Licensed Nurse notifies resident's Responsible Party and Physician for any new orders. • Documentation of incident/accident is on the 24 Hour Report for review by IDT to ensure appropriate interventions. • Incidents/Accidents are thoroughly investigated and/or reported to the State of Virginia, as deemed appropriate. • Resident with behaviors has a care plan in place with interventions. • Resident's care plan is reviewed/revised, as needed. • Staff knows to refer to Resident's care plan for specific interventions. • Hall Monitor is in place on the secure unit for increased supervision of residents and safety. The results of Quality Improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services. The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance. The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver. 5. Allegation of Compliance Date: 7-24-17.	

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DDD, HTN (hypertension), DM II (diabetes), Gen muscle weakness
Allegies: Sulfa
SNF (skilled nursing facility), AMS"

"P: Continue Seroquel 50 mg (milligram) QAM (every morning)
Seroquel 100 mg (milligram) QHS (every evening)
Melatonin 3 mg (milligram) QHS (every evening)
RTC in 4 weeks
Add Lupron Depo 3.75 IM (intramuscularly)
Call 804-370-0111 if behavior escalates and is more aggressive"

Resident #101 was also seen by the facility social services on 6/16/17. The progress notes read "6/16/17 12 p Psychosocial Follow-up: Resident continues to be on a 1 to 1. He is still adjusted and wandering around the first floor with his one to one. SW (social work) to continue to closely monitor for any behavioral changes."

A second social services note was written on 6/16/17 at 3:30 p.m.. The note read "Incident: Resident was involved in an altercation with a staff person, his 1 to 1 aid. Resident became very aggressive and not easily re-directed. Crisis was called and stated they they could not come out until after 5 p.m. 1 to 1 aid was changed. Now waiting for crisis to arrive. SW (social work) to follow up."

Resident #101 was sent to the hospital for psychiatric evaluation on 6/16/17. He returned to the facility on 6/23/17. A physician progress note dated 6/23/17 read "Readmit note 76 year old man with advanced dementia who was sent to inpt (inpatient) psych (psychiatry) on 16 Jun after

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an episode of sexual assault and aggressive behaviors." The plan section of the note read "1) Dementia- cont (continue) 1:1 sitter, cont (continue) psych C/S (consult)".

The PMHNP evaluated Resident #101 again on 6/26/17. The progress note read "After seeing (Resident #101) Friday 6/16, he became aggressive towards staff and was TDO'd to (hospital name). They did not increase or alter medications except D/C Melatonin. The medications ordered, Lupron Depo and added Seroquel 25 mg QAM were not ordered- He is currently only taking Seroquel 100 mg QHS. This afternoon, he was talkative, social and polite. He is standing at the nurses' station and laughing when others laugh. He is calm. When the undersigned sees him again in the evening- 1900 [7:00 PM], he is observed raising his voice at staff and becoming irritable when the nurse tries to give him his medications. The undersigned clarifies the order and shows her the written slip. She assures the undersigned that it will be ordered."

"O: (Resident #101) smiles appropriately and greets the undersigned. He answers inappropriately to the orientation questions- he responds that he was the president and only knew the date because the sitter told him. He did state his full name. He remains on 1:1 and is calm throughout most days. He "sun downs" at night and his behaviors escalate most nights. He is polite, calm and cooperative. His speech is normal rate, rhythm, volume, cadence and tone in the afternoon. At 1900, his voice becomes louder and angry in tone. His thoughts are confused. He makes his needs known and is redirectable during the day. He denies hallucinations,

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paranoia or delusions and there is no evidence he is responding to internal stimuli. His affect is congruent with euthymic affect in day- irritable/ inappropriate at night. Medications and treatment plan discussed. His eye contact and psychomotor activity is appropriate. His eye contact is appropriate. He is steady on his feet and walks well. He is given the opportunity to ask questions."

"P: Add Seroquel 25 mg (milligram) QAM (every morning)
Seroquel 100 mg (milligram) QHS (every evening)
RTC in 4 weeks
Add Lupron Depo 3.75 IM (intermuscular)
Call 804-370-0111 if behavior escalates and is more aggressive"

A telephone order was written on 6/26/17 for the Lupron Depo 3.75 milligram IM monthly. According to the June 2017 Medication Administration Record (MAR), Resident #101 was administered the Lupron Depo on 6/28/17.

The medication Lupron Depot 3.75 milligrams is also known by the brand name of leuprolide acetate injection. This medication is a synthetic gonadotropin-releasing hormone.

According to information from the article "Pharmacological Interventions with Adult Male Sexual Offenders'" from the Association for the Treatment of Sexual Abusers (ATSA) website accessed at http://www.atsa.com/pharmacological-interventions-adult-male-sexual-offenders on 7/14/17 at 12:15 p.m., leuprolide acetate is used to manage sexual behaviors. The article read "A number of

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hormonal agents have been introduced as pharmacological treatments for reducing testosterone and sexual drive in individuals with paraphilias and/ or who have engaged in sexually abusive behaviors. Primary examples include medroxyprogesterone acetate (MPA- Depo Provera), leuprolide acetate, cyproterone acetate, and gonadotropin-releasing hormone analog. These chemical agents, referred to as antiandrogens, act by breaking down and eliminating testosterone and inhibiting the production of leutinizing hormone through the pituitary gland, which in turn inhibits or prevents the production of testosterone. Because testosterone is associated with sexual arousal, the use of these agents generally results in a reduction of sexual arousal. This reduction in sexual arousal is assumed to also reduce the motivation for the sexually offending in individuals predisposed to such behaviors."

During an interview with the Director of Nursing (DON) on 7/12/17 at 9:30 a.m., the DON stated that the Lupron Depot injection took some time to become effective. When asked what the length of time was for the medication to reach effectiveness, the DON stated that she was not sure.

The Lupron Depot injection was administered to Resident #101 on 6/28/17, the same day he was taken off of 1:1 supervision and placed back on the locked unit. Resident #103 was moved off of the locked unit when Resident #101 was moved back on to the unit.

On 7/7/17, another FRI form involving Resident #101 was submitted to the state agency. The incident was documented as follows "Facility staff

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reported that (Resident #101) and (Resident (#104) were discovered in another residents room exhibiting sexual behavior toward one another. Neither were in apparent duress. It did not appear that they were actually having intercourse. The residents were immediately separated. Each resident was assessed for signs or symptoms of injury. None were found. A room change was initiated immediately onto a separate unit for (Resident #101). He was also placed on one to one supervision."

In addition, the FRI form section titled "Employee action initiated or taken" read "(staff name) was suspended pending investigation for failure to remain on assignment."

On 7/11/17 at 3:40 p.m., the incident was reviewed with the Administrator. When asked about the employee who failed to remain on assignment, the Administrator stated that the staff, a Certified Nursing Assistant (CNA D) was currently suspended during the investigation. He stated that they had not decided whether to bring her back or terminate her employment. He stated that CNA D was sitting in the day room watching TV during the shift and during the time that the incident occurred. He stated that the unit manager (RN A) found CNA D in the day room.

The Administrator was asked if he conducted interviews as part of the investigation. He stated yes, they were in a separate file. The interviews were requested for review.

Resident #104, a 63 year old, was admitted to the facility on 4/2/16. Her diagnoses included dementia, anxiety, depression, dysphagia, hypertension, and chronic obstructive pulmonary

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disease. Her most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 4/20/17. She was coded to have severely impaired cognition. She was not coded to have behaviors or to wander. She required assistance with activities of daily living.

Resident #104 was first observed during the initial tour of the facility on 7/10/17 at 2:30 p.m. While standing in the area just outside of the dining room, Resident #104 walked up to this surveyor and grabbed both hands. There was a nurse and an activity staff in the dining room at this time. They did not re-direct Resident #104. This surveyor, with hands still in the grasp of the resident, directed Resident #104 into the dining room and asked her to sit down at a table.

The final report for the FRI submitted on 7/7/17 was completed on 7/10/17. The FRI read "On June 28, (Resident #101) was returned to the Secured Unit for his own safety, and because he seems to flourish in the more controlled environment. At the same time, his one to one supervision was removed as he was deemed safe to be on the Secured Unit with medication management recently implemented."

In addition, the FRI read "It is care planned that (Resident #104) often engages other residents with inappropriate touching often requiring redirection. Based on this, (Resident #104) behavior is considered to be a root cause related to (Resident #101) most recent behavior; therefore in order to keep her safe (Resident #101) has again been removed from the Secured Unit where (Resident #104) resides. Also, he has again been placed on one to one supervision.

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Further, facility staff who provide care for (Resident #101 and Resident #104) have been educated to keep each from the other's proximity."

Resident #104's care plan was reviewed. The "focus" area "Potential for impaired or inappropriate behaviors r/t (related to) wandering, aggressive to staff and residents at times, refusing vital signs, resident bumps into furniture at time and inappropriate touch" were included. This focus area was added to the care plan on 4/21/16. On 7/10/17, the intervention "redirect when touching inappropriately" was added to the care plan by a corporate staff (Admin E).

On 7/12/17 at 8:40 a.m., the unit manager, Registered Nurse A (RN A), was interviewed. RN A was asked to describe "inappropriate touch" as it related to Resident #104. RN A stated that Resident #104 would touch the faces and arms of both male and female residents, but RN A felt that Resident #104 sought the attention of males. When asked how long Resident #104 had exhibited the touching behaviors, RN A stated she was unsure and she needed to look at the clinical record. The record could not be located on the unit, so RN A was asked to find out when the behaviors began and get back to this surveyor.

At 9:05 am, RN A stated that she just talked with the Director of Nursing (DON) and Admin E about the inappropriate touching. RN A stated that they decided that the behaviors should be described as "unaware of others' boundaries" rather than inappropriate touching. RN A stated that she had only worked at the facility since April 2017, and Resident #104 had exhibited the touching behavior since that time. At 9:15 a.m., RN A

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returned to speak to the survey team and stated that the inappropriate touching was actually considered "loving behaviors."

During the same interview with RN A, the incident between Resident #101 and Resident #104 was discussed. RN A stated that approximately 10-15 minutes before the incident occurred on 7/7/17, 4;00 p.m., she had entered the locked unit to do rounds. At this time, RN A found Certified Nursing Assistant D (CNA D) sitting in the dining room watching TV. RN A stated that she instructed CNA D to be up and out on the floor rounding during the shift and that sitting during the shift was not allowable. RN A stated that she expected the nurses to be out on the floor during their shift. RN A stated that she saw Resident #101 in the hallway during this time.

After talking to CNA D, RN A stated that she left the unit and waited at the nursing station just outside of the the door to the locked unit. She stated she waited about 10-15 minutes before going back into the unit to check on CNA D. RN A stated that when she went back on the unit, another CNA informed her that she had found Resident #101 and Resident #104 together in a resident room. After being informed of the incident, RN A proceeded to the dining room where she found CNA D still sitting and watching TV. RN A stated that she felt the incident may not have happened if CNA D had not been seated in the dining room.

RN A documented the incident in Resident #104's clinical record. The nursing note read "7/7/17 1630 (4:30 p.m.) At approx 1600 (4:00 p.m.) writer was approached by CNA. She stated that during her 15 min rounds she witness the

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resident lying on the bed with another resident between her legs. The nurse aide did not observe penetration. Residents were immediately separated. Writer witnessed resident w/o (without) a brief or pants. Resident was observed walking back & forth smiling. No s/s (signs/ symptoms) of pain or distress noted. VS (vital signs) taken BP (blood pressure) 100/62 P (pulse) 70 R (respirations) 17 T (temperature) 97.6. Resident was given a bed bath + appropriately dressed. Skin assessment was completed 0 skin issues abrasions or tears observed. RP (responsible party)/ MD (doctor) were made aware. Will cont. to closely monitor residents."

RN A also documented the incident in Resident #101's clinical record. The note read "7/7/17 1630 (4:30 p.m.) At approx 1600 (4:00 p.m.) writer was approached by CNA. She stated that during her 15 min rounds she witness the resident between another residents legs. Residents were separated. Nurse aide did not observe penetration. Writer witnessed resident pulling up his pants. Resident VS (vital signs) taken BP (blood pressure) 128/74 P (pulse) 82 R (respirations) 19 T (temperature) 98.4. Resident was given a bed bath + dressed appropriately. Skin assessment was completed 0 issues, abrasions bruises or skin tears noted. RP (responsible party)/ M (doctor) were made aware. Resident was moved to unit 2 and is now on 1:1 supervision."

On 7/12/17 at 9:15 a.m., the Director of Social Services (Employee D) was interviewed. Employee D stated that prior to the first incident on 6/14/17, Resident #101 had not displayed any signs of sexual or anger tendencies. Employee D

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stated that Resident #101 had recently had a major decline in cognition. He stated that a Brief Interview of Mental Status assessment had just been completed for Resident #101 and he scored a 3 indicating severely impaired cognition. When asked why the facility felt Resident #101 was safe to put back on the locked unit, Employee D stated that Resident #101 had received the shot (lupron depot) and there had not been any real incidents since the first. Employee D stated that since Resident #101 had not exhibited any behaviors, the facility felt that he was back to normal.

Employee D also stated that they felt it was ok to put Resident #101 back in the locked unit since the first victim no longer lived on the unit. When asked if Resident #101 had any concept of who Resident #103 (first victim) was or what had happened, Employee D stated no. When asked if Resident #101 would target Resident #103 specifically or if any woman on the unit could be a target, Employee D stated that he would not know Resident #103 to target her specifically.

The DON joined the discussion at approximately 9:30 a.m. Employee D was asked to describe Resident #104's touching behaviors. Employee D described Resident #104 as pleasant, sweet, non-verbal, affectionate, touches shoulders, grabs hands and goes to a lot of men. Employee D stated that he does not feel that Resident #104's touching is sexual, just affectionate.

The DON was asked what staff are supposed to do when Resident #104 touches others inappropriately. She stated that staff is to redirect Resident #104. It was reviewed that Resident #104 approached this surveyor and grabbed both hands during the initial tour of the facility. It was

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reviewed that both staff members who observed the interaction did not redirect the resident.

Both the DON and Employee D were asked if they felt that a resident such as Resident #104, with a history of inappropriate touching behaviors, was safe from Resident #101 who had committed a sexual assault three weeks prior in the locked unit. The DON stated that they felt Resident #104 was safe.

The DON stated that the 1:1 supervision was discontinued when Resident #101 was put in the locked unit. She stated he was on 15 minute checks while in the locked unit. When asked if the 15 minute checks were specific to Resident #101, the DON stated that the 15 minute checks were standard for all residents in the locked unit. When asked what different intervention was put into place to ensure all other residents on the locked unit were safe from Resident #101, the DON stated that nothing different was put into place. They felt that the 15 minutes checks were appropriate because the first victim (Resident #103) was off the unit.

The DON was asked about the lupron depot shot that Employee D had referenced. The DON stated that the shot takes some time to become effective, but she did not know how long. She searched the Internet from her phone but did not find the timeframe. It was reviewed with the DON and Employee D that the shot was administered to Resident #101 on 6/28/17. This is the same day that he was put back into the locked unit.

At the end of day meeting on 7/12/17, it was reviewed with the Administrator and DON that two cognitively impaired residents, Resident #104, a

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resident with a history of inappropriate touching behaviors often directed towards males and Resident #101, a resident who had recently committed a sexual assault in the locked unit, were unsupervised on the locked unit and found partially unclothed in a resident room engaging in a sexual act. It was reviewed that approximately 10-15 minutes prior to the incident, CNA D was found by the unit manager sitting and watching TV instead of performing rounds on the unit. After receiving immediate education by the unit manager, CNA D continued to sit and watch TV. CNA D was seated and watching TV during the incident.

At this time, the Administrator stated that CNA D was siting watching TV, went and rounded after the unit manager talked with her, and then went back to sitting and watching TV. It was reviewed with the Administrator that this is not the story that was told by RN A. RN A never stated that CNA D had rounded in between being observed sitting and watching TV. In addition, during the interview with the Administrator held on 7/11/17 at 3:40 p.m., he had previously stated that CNA D was sitting in the day room watching TV during the shift and during the time that the incident occurred.

The Administrator was reminded that he had not provided the staff interviews conducted during the investigation. He was asked again to provide them. At this time, the Administrator stated that he had conducted the interviews, but he had not written them down.

The DON was asked if the facility had a written policy describing 1:1 supervision, she stated no.

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The Administrator provided the staffing sheet for 7/7/17, the day the incident occurred. Six staff were highlighted as staff for the locked unit:
1. Unit Manager- not present on the unit during the incident
2. LPN- most likely passing meds or preparing to pass medications (per the DON, the facility staff tried to start passing meds at 4:00 p.m.)
3. CNA 1- found Resident #101 and #104
4. CNA 2- sitting and watching TV in the dining room
5. 1:1 staff- assigned to watch a specific resident, schedule says 4:30 p.m. start time
6. Activities staff (activities are done in the dining room or sun room).

While six staff were highlighted as present on the unit, the unit manager was not on the unit, the LPN was most likely passing meds, the 1:1 staff's shift did not start until 4:30 p.m., one CNA was sitting and watching TV, the activities staff may or may not have been working with residents and one CNA was on the floor to round. At the time of the survey, 24 residents were living on the locked unit.

No other information was provided.

COMPLAINT DEFICIENCY

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

F 328

F328
1. Resident #105's physician was notified on 7-12-17 by the Nurse Manager with regard to the oxygen being administered at 5 liters per nasal cannula. The physician gave new orders which were processed by the licensed nurse, at that time. Resident #105 suffered no harm. Resident #105 receives O2 per physician orders.
2. Current residents with oxygen orders were reviewed by the Assistant Director of Nursing to ensure that oxygen was being administered, per their physicians' orders, to include but not be limited to the appropriate liter flow. No discrepancies were noted at those times.

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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) 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

F 328

3. The Director of Clinical Services/Nurse Manager conducted education with Licensed Nurses with regard to F328 and the Center's policy and procedure for oxygen administration to ensure that residents with orders for oxygen are being administered oxygen per their physician's orders. Licensed Nurses not educated by 7-24-17 will not work without being educated prior to their next scheduled shift. Newly hired Licensed Nurses will be educated during their orientation period.

4. The Director of Clinical Services/Nurse Manager to review oxygen administration to quality monitor resident's oxygen is being administered, per their physicians' orders, to include but not be limited to liter flow, 2 x weekly for 3 months, and then 1 time weekly for 9 months, using a sample size of 10 residents. The results of Quality Improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services. The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance. The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver.

5. Allegation of Compliance Date: 7-24-17.

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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 prosthetic device.
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 #105) of 15 residents in the survey sample, to ensure oxygen was administered per physician's order.

Resident #105 was observed with oxygen in use and set on 5 liters per minute (lpm), however the physician's order was for 2 lpm.

The findings included:

Resident #105 was originally admitted to the facility on 6/8/16 and readmitted on 2/22/17 with the diagnoses of, but not limited to, congestive heart failure, dementia, atherosclerotic heart disease and diabetes mellitus type 2.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 4/27/17. The MDS coded Resident #105 with severe cognitive impairment; required extensive assistance from staff for most activities of daily living; and oxygen use.

On 7/11/17 at 9:00 a.m. Resident #105 was observed lying in bed with the head of bed up

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approximately 45 degrees. He was alert and conversational with some confusion. Resident #105 had humidified oxygen via nasal cannula in use set at 5 lpm. When asked how his breathing was Resident #105 stated "OK today." He did not show signs of respiratory distress.

On 7/11/17 at 9:30 a.m., Resident #105's clinical record was reviewed. The review revealed signed physician's orders which included: "OXYGEN AT 2L/MIN VIA NASAL CANNULA CONTINUOUSLY FOR SHORTNESS OF BREATH" with an order date of 4/22/17.

The medication administration record was initialed by Licensed Practical Nurse-C (LPN-C) on 7/11/17 for the 7 a.m.-3 p.m. shift. Resident #105's care plan included a focused area of "The resident has an ineffective breathing pattern r/t (related to) SOB (shortness of breath)." Interventions included "Oxygen as ordered."

On 7/11/17 at 1:45 p.m. Resident #105 was observed lying in bed, the humidified oxygen was still in use at 5 lpm. Resident #105 stated "I just fell, I tried getting into my wheelchair." He stated he had pain in his knees. LPN-C was in the hallway and notified of the resident's complaint of pain. LPN-C entered the room with the surveyor and performed a thorough assessment. When asked about the resident's oxygen setting, LPN-C stated "It shouldn't be at 5 (liters) and changed the setting to 2 lpm.

On 7/11/17 at 4:05 p.m., the Administrator and Director of Nursing (Admin-B) were informed of the oxygen administration observed at 9 a.m. and 1:45 p.m. set at 5 lpm.

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On 7/12/17 at 8:20 a.m., Admin-B stated and showed documentation of an investigation into Resident #105's oxygen. Admin-B stated the nurses had it set on 2 lpm and "He (the resident) could've changed the liters when he fell." Surveyor stated to Admin-B that his oxygen was observed prior to and after the fall on 5 liters per minute.

The facility policy titled "Oxygen Therapy" with an effective date of 11/30/2014 was reviewed and included:
"Procedure:
1. The nurse will organize the oxygen therapy as ordered by the resident's physician...
7. Adjust the flow of oxygen as ordered by the physician..."

No further information was provided by the facility staff.

{F 386} SS=D 483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS

(b) Physician Visits
The physician must--

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced

F 328

{F 386}

F386
1. Resident #101's and Resident 103's psychiatric services notes were signed on 7-12-17 by the Nurse Practitioner who wrote them. The notes were placed into Resident #101's and Resident #103's medical records by the Medical Records Coordinator on 7-13-17.
2. The Medical Records Coordinator conducted a review of current residents' medical records to ensure that documents requiring a physician's/physician extender's signature have been signed including but not limited to the residents' physicians'/physician extenders' visit notes.
3. Executive Director/Director of Clinical Services conducted education with the facility's Medical Director Attending Physicians, Physician Extenders, Podiatrist, Eye Doctor, and Dentist regarding Regulation F386 to ensure the physician (1) Reviews the resident's total program of care, including medications and treatments, at each visit, (2) Writes, signs, and dates progress notes at each visit;

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

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 07/12/2017

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 386} Continued From page 31

by:
Based on clinical record review and staff interview, the facility staff failed for 3 residents (Resident #101, #103 and #104) of 15 residents in the survey sample to ensure progress notes from the psychiatric nurse practitioner were signed.

No psychiatric nurse practitioner progress notes in the clinical records were signed.

The findings included:

Resident #101, a 76 year old, was admitted to the facility on 12/6/16. His diagnoses included major cognitive disorder due to dementia, Alzheimer's disease, hypertension, diabetes, and elevated lipids. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 5/8/17. He was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. He was coded to ambulate with supervision (oversight, encouragement or cueing). He was coded to have disorganized thinking. He was not coded to have any behaviors or to wander.

Resident #101's clinical record included progress notes written 6/16/17 and 6/26/17 by the psychiatric nurse practitioner. The notes were not signed.

Resident #103, a 67 year old, was admitted to the facility on 4/4/14. Her diagnoses included dementia, schizophrenia, bipolar disease, seizure disorder, hypertension, anxiety, and depression. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment

{F 386}

and (3) Signs and dates all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. The intent of Regulation F386 is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime.
The Executive Director also conducted education with the Medical Records Coordinator regarding Regulation F386 to ensure that residents' visit notes, consults, and orders are signed and dated by the residents' physicians/physician extenders, prior to placing them into the medical records.

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4. Executive Director/Director of Clinical Services/Medical Records Coordinator to conduct Quality Improvement monitoring of 5 residents' medical records 2 times weekly for 3 months, then 1 time weekly for 9 months to ensure that documents requiring a physician's/physician extender's signature have been signed, including but not limited to theresidents' physicians'/physician extenders' visit notes, which is an indication that the physician/physician extender is taking an active role in supervising the care of the resident.
The results of Quality Improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Executive Director and/or Director of Clinical Services.
The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary.

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reference date of 5/18/17. She was coded with a Brief Interview of Mental Status score of 13 indicating no cognitive impairment. She was coded to have disorganized thinking. She required assistance with activities of daily living.

Resident #103's clinical record included a progress note written 6/16/17 by the psychiatric nurse practitioner. This note was not signed.

Resident #104, a 63 year old, was admitted to the facility on 4/2/16. Her diagnoses included dementia, anxiety, depression, dysphagia, hypertension, and chronic obstructive pulmonary disease. Her most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 4/20/17. She was coded to have severely impaired cognition. She was not coded to have behaviors or to wander. She required assistance with activities of daily living.

Resident #104's clinical record included a progress note written 6/5/17 by the psychiatric nurse practitioner. This note was not signed.

On 7/12/17 at 10:45 a.m., the Administrator stated that he received the progress notes from the psychiatric nurse practitioner via email. He then gave them to the medical records department to file. The Administrator stated that it was the responsibility of medical records to obtain physician signatures on documents where the signature was required.

At this time, the facility had a representative (Employee C) from the psychiatric medical practice to meet with the survey team. Employee C was asked about the expected process, to

{F 386} to maintain substantial compliance.
The Quality Assurance Performance Improvement Committee consists of by not limited to the Executive Director, Director of Clinical Services, Medical Director (quarterly, at a minimum), and at least three other staff members to include, but not limited to, one direct care giver.
5. Allegation of Compliance Date: 7-24-17.

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{F 386}	Continued From page 33 include electronic record system and signature completion, for which the nurse practitioner was supposed to be using. Employee C stated that he needed to make a phone call and would get back with the survey team within an hour. As of the conclusion of the survey at 3:00 p.m., Employee C had not provided feedback.	{F 386}		

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

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1-800-828-1120
9960 Mayland Drive, Suite 401
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July 20, 2017

Mr. Victor Pope, Administrator
Envoy Of Westover Hills
4403 Forest Hill Avenue
Richmond, VA 23225

RE: Envoy Of Westover Hills
Provider Number 495327

Dear Mr. Pope:

Based on deficiencies cited during the survey ending May 19, 2017, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On July 10 through July 12, 2017, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. Two complaints were investigated during the survey. One complaint was substantiated, with deficiencies. One complaint was unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The 7/12/17 revisit established the facility continues noncompliance with program requirements, includingan isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elaine Cacciatore, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Officer's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are

disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the May 19, 2017 survey were forwarded to you under the June 30, 2017 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the July 12, 2017 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Elaine Cacciatore

Elaine Cacciatore, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Joann Atkins, Dmas (Sent Electronically)