PRINTED: 08/15/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 08/03/2017
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2017
ENVOY	OF WINCHESTER, LL	c		110 LAUCK DR WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JUD BE COMPLETION
F 164 SS≂D	survey was conduct Corrections are requirements. The survey/report will follow the census in this eat the time of the successive of 13 currest (Residents #1 throur ecord reviews family a does not require the room for each resident has of personal and medical personal and medical personal and medical records #1 throur ecords at \$483.70 (i) (2) or other laws. §483.70 (i) Medical records. (2) The facility must	ledicare/Medicaid standard ed 8/1/17 through 8/3/17. uired for compliance with 42 ral Long Term Care Life Safety Code low. O certified bed facility was 54 rvey. The survey sample ent resident reviews gh #12 and #17) and 4 closed idents #13 through #16), 83.70(i)(2) PERSONAL ENTIALITY OF RECORDS Cy includes accommodations, written and telephone rsonal care, visits, and not resident groups, but this facility to provide a private ent. as a right to secure and I and medical records. the right to refuse the release lical records except as r applicable federal or state	F 16	this plan of correction does constitute an admission or agreement by the provider truth of the facts alleged o correctness of the conclusi forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because o requirements under State a Federal law.	of the rons set of the and serve of SEP 0 6 2017 on VDH/OLC
		d in the resident's records,		medication pass.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

regardless of the form or storage method of the

(X6) DATE

- Lity RN, LNHA

Executive Director

12017

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.

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	т		(OMB_NO. 0938-0391		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING	j	·	C 08/03/2017		
NAME OF	PROVIDER OR SUPPLIER		*	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	SONODIE II		
ENVOY	OF WINCHESTER, LL	c			LAUCK DR ICHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÖ PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION		
F 164	Continued From pa	ige 1	F	164				
	records, except wh	en release is-			3)Clinical staff will be educated			
	(i) To the individual				On policy/procedure for privac	У		
	representative whe	re permitted by applicable law;			Of keeping Medical Records clo	sed		
	(ii) Required by Lav	۸.			During medication pass on			
	(, 1.04002.03.2.2.	' •			08/30/2017, by the DCS.			
	(iii) For treatment, p	payment, or health care			Education will be			
	operations, as pern with 45 CFR 164.50	nitted by and in compliance			Given X 2 months(September			
	WICH CH 10 CH 101W	,			/October)			
	(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain privacy of the clinical record for one of 6 residents during medication administration; Resident #12,				4) A Medication Pass Observation will be complete o Clinical staff monthly x 2 month By the DCS/Unit manager to en Privacy of records is being main (September/October) Results will be taken to QAPI for review and recommendations if neede 5) Date of Compliance: 09/05/5	ns sure ntained. o d.		
- ((()	(Medication Adminis of the medication of unsupervised, on 3 facility staff and 1 re	Resident #12's MAR stration Record) open on top art, while the cart was different occasions. Eight esident were observed during the 3 observations.			RECE SEP 0 VDH	1VEL 6 2017 1OLC		

Resident #12 was admitted to the facility on 7/7/17 with the diagnoses of but not limited to:

		AND HUMAN SERVICES	FORM APPROVED					
STATEMENT	OP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A BUILC		E CONSTRUCTION	VIB NO. 0938-039- (X3) DATE SURVEY COMPLETED		
		495389	B. WING	l		C		
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	08/03/2017		
ENVOY	OF WINCHESTER, LL	Ç			10 LAUCK DR VINCHESTER, VA 22603			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	. 10		PROVIDER'S PLAN OF CORRECTION	-		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	FULL DREEN (EACH CODDECTIVE ACTION OUT II D.D.					
	weaknesses, osteon high cholesterol, low Disease. The most recent MI an admission/5-day (Assessment References Resident #12 was contact in ability to me scoring a 15 out of a (Brief interview for More i	nt shoulder, galt and mobility porosis, high blood pressure, w back pain, and Parkinson's DS (Minimum Data Set) was assessment with an ARD ence Date) of 7/14/17. The solded as being cognitively ake daily life decisions, a possible 15 on the BIMS Mental Status) exam. The tal care for bathing, hygiene, isfers; supervision for eating; of bowel and bladder. m., RN #1 (Registered and preparing and cations to Resident #12. He ng medications: (milligrams), 1 tab (tablet) mcg (micrograms), 1 tab	F1	164		0 6 2017 1/O)1-C		
.annewers		m., RN #1 returned to the cart com, reviewed the MAR for	•			·		

		AND HUMAN SERVICES				FORM	: 08/16/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENT/FICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING	;		l l	C /03/2017
NAME OF F	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY	OF WINCHESTER, LL	C		1	LAUCK DR NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 164	Continued From pa	ige 3	F	164			
	an order for cough	medicine and noted there					1
		n went to the nurse's station to dioptain an order. RN#1		i			:
		at 7:17 a.m., having left the	į				·
		supervised for a second time.			•		
	· Four staff member: ·	s passed by the cart.	į.	1			
		a.m., RN #1 then went back		:	•		1
		room to administer the tussing on he prepared. He left the					
	MAR on top of the	cart, open and unsupervised a					
		dent and 3 staff members were by the medication cart.					
	interview was cond Practical Nurse). S medication cart is should be locked, i	ximately 9:30 a.m., an ucted with LPN #2 (Licensed She stated that when a eft unsupervised, the drawers he MAR should be closed, and es, etc., should not be left on					
	Administration did	ility policy for Medication not document any criteria for was closed and the resident's		!			
		ximately 2:00 p.m., the DON g - Administrative Corporate		ļ			•
	Staff (ASM) #2) wa	as made aware of the findings.		!			:
	No further information the survey.	tion was provided by the end of		:			1
		continuation Departmen Oth adition					1
		sentials for Practice, 6th edition pages 69-70 was used as a	ì				!
	reference for confi	dentiality and read in part:					1 1 1
		onfidentiality in healthcare has tance in the United States.					!
		known as HIPAA (Health					•

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/15/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DAT COA	TE SURVEY MPLETED
		495389	B. WING	3	and the same of th	i	C /03/2017
NAME OF P	ROVIDER OR SUPPLIER	**************************************		ŞTR	REET ADDRESS, CITY, STATE, ZIP CODE	, , , , ,	10012413
ENVOY C	F WINCHESTER, LL	C		I	LAUCK DR NCHESTER, VA 22603	_	
(X4) ID PREFIX - TAG :	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X8) COMPLETION DATE
	1996) requires that health information rathird party without legislation defines the patients for protection diminishing access for violations. You amedical records with Health care workers health care information con results, diagnosis a family members or permitted access to information without References: [1] Requip is used Parkinson's Diseas Information obtained https://medlineplus.tml [2] Synthroid is used Information obtained https://medlineplus.tml [3] Tylenol is used Information obtained information obtained https://medlineplus.tml	y and Accountability Act of those with access to personal not disclose the information to patient consent. HiPAA he rights and privileges of on of privacy without to quality care and sets fines cannot copy or forward hout a patient's consent. It is are not allowed to share tion with others without sent. This includes laboratory and prognosis. In addition, friends of the patient are not the patient's personal health the patient's consent." to treat the symptoms of e. d from gov/druginfo/meds/a698013.head to treat hypothyroidism. d from gov/druginfo/meds/a682461.head treat mild to moderate pain.		164	UEFICIENCY)		
	[4] Tussin Is used to	o relieve chest congestion by cough up mucus and clear the					

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(2	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		İ	С	
NAME OF	PROVIDER OR SUPFLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP CO	DE	08/03/2017	
ENVOY	OF WINCHESTER, LL	c		110 LAUCK DR WINCHESTER, VA 22603	<i></i>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) E COMPLÉTION TE DATE	
F 164	Continued From pa	ge 5	F 1	164	<u> </u>		
		gov/druginfo/meds/a682494.h					
F 226 SS=D	483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES	3.95(c)(1)-(3) NT ABUSE/NEGLECT, ETC	F 2	226 F Tag 226			
	1 Octoled			1)An FRI was submitted			
	483,12			For Resident #7 allegation			
	(b) The facility must written policies and	develop and implement procedures that:		of abuse per regulation.			
	(1) Prohibit and prev	ent abuse, neglect, and		2 An investigation was con-	a		
	exploitation of reside	ents and misappropriation of		of staff on 08/3 and 08/4 a	Jucted		
	resident property,			residents for any unreport	nd		
	(2) Establish policies	and procedures to		abuse allegations	ed		
	investigate any such	allegations, and		FRI(s) submitted as indicate			
	(3) Include training a §483.95,	s required at paragraph					
	•			investigation conducted and	4	•	
	483.95	and overlidation to addition t		staff suspended pending			
	the freedom from ab	and exploitation. In addition to use, neglect, and exploitation (3.12, facilities must also		outcome of investigation as	indicate	ed.	
	provide training to th	eir staff that at a minimum		3) Staff educated on			
	educates staff on-			08/3 and 08/4/17 on			
	(c)(1) Activities that (constitute abuse, neglect,		policy/procedure of abuse			
	exploitation, and mis	appropriation of resident		reporting by the DCS/ED.			
	property as set forth			Education of Abuse reportin	•		
	(c)(2) Procedurás foi	reporting incidents of abuse,		part of orientation and annu-	gis		
	neglect, exploitation, resident property	or the misappropriation of		education calendar,	al .		
	prevention.	agement and resident abuse		350			
	This REQUIREMENT	F is not met as evidenced		· · · · · · · · · · · · · · · · · · ·	200		

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	KO FOR MEDICARE	& MEDICAID SERVICES			_OMB NO. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 08/03/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/03/2017
ENNOVA	ST MANAGESTER III	^		110 LAUCK PR	
ENVOY	OF WINCHESTER, LL	G		WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 226	facility document reand in the course of was determined that investigate an allegate residents, Resident On 7/11/17 Resident facility administrator member) #1, that a assistant) #4, had "a failed to follow the facility at a failed to follow the facility and investigating and the findings include Resident #7 was ad with diagnoses that to; anemia (a low redepression, acid refl and chronic kidney of Resident #7's most a set), a quarterly asset (assessment referent Resident #7 as having mental status) score indicating that Resid with daily decision materials at the facility reports revealed, in produce Communicate Grievance; Communicate Grievance; Communicate Communicate Communicate and status and status and status are status are status are status and status are status and status are status are status are status and status are status are status are status	interview, staff interview, view, clinical record review complaint investigation, it the facility staff failed to ation of abuse for one of 17 #7. It #7 communicated to the ASM (administrative staff CNA (certified nursing an attitude" with her. ASM #1 acility policies and procedures allegation of verbal abuse. Individual to the facility on 1/3/16 included, but were not limited do blood cell count), lux, low functioning thyroid disease. Indeed to the facility on 1/3/16 included, but were not limited do blood cell count), lux, low functioning thyroid disease. Indicate the facility on 1/3/16 included and facility on 1/10/17, coded against with an ARD ance date) of 7/10/17, coded against with an ARD ance date of 15 out of a possible 15, ent #7 is cognitively intact	F 2	4) Allegations of abuse will be investigated per policy a FRI sent, All sent will be taken t QAPI for review and recommendations if needed. 5) Date of Compliance: 09/05	to
		sident #7). Relationship; ed to: (check mark beside			

Administrator). Name: (name of ASM #1).

PRINTED: 08/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C (X4) STREET ADDRESS, CITY, STATE, ZP CODE (X6) LAUCK DR (X6) DATE SURVEY COMPLETED C (X6) DATE SURVEY COMPLETED			I AND HUMAN SERVICES 8 MEDIC <u>AID SERVICES</u>				M APPROVED O. 0938-0391
ANAME OF PROVIDER OR SUPPLIER ENVOY OF WINCHESTER, LLC PAUL D FREET TAG TAG FROUDERS SAMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATICN) FREET TAG FROUDERS RAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATICN) FREED Communicated via; (check mark by Verbal), Concerned about (check mark by other) CNA Altitude. Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident was afraid to report. Did tel (name of past ADON) (assistant director of nursing). Told (name of CNA #4) has an attitude want it reported. Documentation of investigation; Assigned by; (name of ASM #1). Findings of investigation: spoke to (name of CNA#4) regarding concern, does not feel that she has attitude with resident, will be more friendly with resident when interacting with resident. Resolution; Complainty grievance resolved; (check mark by "yes") Complainty are resolved. Resolution; Complainty grievance resolved; (check mark by "yes") Complainty are resolved. Resolution; Complainty grievance resolved; (check mark by "yes") Complainty are resolved. Resolution; Complainty grievance resolved; (check mark by "yes") Complainty are resolved. Resolution; Complainty grievance resolved; (check mark by "yes") Complainty grievance resolved; (check mark by "y	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		(X3) D,	ATE SURVEY OMPLETED
ENVAYOR OR BUPPLER ENVAYOR WINCHESTER, LLC (XA) ID (SAMMARY STATELEART OF DEFICIENCIES (EACH DEPRICIPATY OR LSC IDENTIFYING INFORMATION) FREEIX TAG F 226 Continued From page 7 Communicated via; (check mark by Verbal), Concerned about (check mark by verbal), Concerned about (check mark by other) CNA- Attitude, Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident was affered to report. Did tel (name of past ADON) she did not want treported, Documentation of investigation; Assigned by; (name of ASM #1). Findings of investigation: spoke to (name of mark) of actions taken: resolved. Resolution; Complainant remarks: Resident Results of actions taken: resolved. Resolution; Complainant remarks: Resident states that CNA has been great to her and no more issues. Will let me know if any more problems." A review of Resident #7's comprehensive care plan dated 11/22/16 did not reveal any documentation regarding shuse and psychosocial well-being. An interview was conducted on 8/3/17 at 10:00 a.m. with ASM #2, the director of nursing. ASM #2 was asked to describe the process for an alegation of abuse. ASM #2 stated, "The staff member is suspended pending an investigation, the administrator is notified and a FRI (facility reported incident) is completed and sent to the state agency pending investigation." ASM #2 was asked if CNA #4 was still involved in caring for Resident #7, ASM #2 stated that she was. ASM #2 further stated that she was unaware of the grievance and she was not asked to investigate.			495389	B. WING		0	
OXA 10 D SUMMARY STATEMENT OF DEFICIENCIES (SAM PROVIDERS PLAN OF CORRECTION (SACH DEPOSITENCY MAST BE PRICEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION). F 226 Continued From page 7 Communicated via; (check mark by Verbal), Concerned about (check mark by other) CNA-Attitude. Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident Assigned by: (name of past ADON) [assistant director of nursing]). Told (name of past ADON) [assistant director of investigation: spoke to (name of CNA #4) regarding concern, does not feel that she has attitude with resident, when Interacting with resident. Results of actions taken: resolved. Resolution; Complaint/ grievance resolved; (check mark by 'yes') Complaint grievance resolved; (check mark by 'yes') Complaint fremarks: Resident states that CNA has been great to her and no more issues. Will let me know if any more problems." A review of Resident #7's comprehensive care plan dated 11/22/16 did not reveal any documentation regarding abuse and psychosocial well-being. An interview was conducted on 8/3/17 at 10:00 a.m. with ASM #2, the director of nursing. ASM #2 was asked to describe the process for an allogation of abuse. ASM #2 stated, "The staff member is suspended pending an investigation," ASM #2 was asked to folk and a FRI (facility reported incident) is completed and sent to the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the state agency pending investigation." ASM #2 was asked to find the find the find the find the find the pending investigation." ASM #2 was asked to find the find t	NAME OF F	PROVIDER OR SUPPLIER		΄			
FREETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 7 Communicated via; (check mark by Verbal). Concerned about (check mark by other) CNA-Attitude. Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident was africal to report: Did tel (name of past ADON) she did not want it reported. Decumentation of investigation; Assigned by: (name of ASM #1). Findings of investigation; sooke to (name of CNA #4) regarding concern, does not feel that she has attitude with resident, will be more friendly with resident when Interacting with resident. Results of actions taken: resolved, (check mark by 'yes') Complaint framarks; Resident states that CNA has been great to her and no more issues. Will let me know if any more problems.' A review of Resident #7's comprehensive care plan dated 11/22/16 did not reveal any documentation regarding abuse and psychosocial well-being. An interview was conducted on 8/3/17 at 10:00 a rm. with ASM #2, the director of nursing. ASM #2 stated, "The staff member is suspended pending an investigation, the administrator is notified and a FRI (facility reported incident) is completed and sent to the state agancy pending investigation. "ASM #2 stated, "The staff member is suspended pending an investigation, the administrator is notified and a FRI (facility reported incident) is completed and sent to the state agancy pending investigation." ASM #2 stated, "The staff member is suspended pending an investigation asked if CNA #4 was still involved in caring for Resident #7, ASM #2 stated that she was unaware of the grievance and she was not asked to investigate.	ENVOY (OF WINCHESTER, LL	c			NOTES TO SERVICE STATE OF THE	
Communicated via; (check mark by Verbal). Concerned about: (check mark by other) CNA-Attitude. Describe concern in detail: Resident stated CNA (name of CNA #4) has an attitude with resident. Resident was afraid to report. Did tel (name of past ADON) (assistant director of nursing)). Told (name of past ADON) she did not want it reported. Documentation of investigation; Assigned by; (name of ASM #1). Findings of investigation: spoke to (name of CNA #4) regarding concern, does not feel that she has attitude with resident, will be more friendly with resident when interacting with resident. Results of actions taken: resolved. Resolution; Complaint' grievance resolved; (check mark by "yes") Complaint grievance resolved; (check mark by "yes") Complaint remarks: Resident states that CNA has been great to her and no more issues. Will let me know if any more problems." A review of Resident #7's comprehensive care plan dated 11/22/16 did not reveal any documentation regarding abuse and psychosocial well-being. An interview was conducted on 8/3/17 at 10:00 a.m. with ASM #2, the director of nursing. ASM #2 was asked to describe the process for an allegation of abuse. ASM #2 stated, "The staff member is suspended pending an investigation, the administrator is notified and a FRI (facility reported incident) is completed and sent to the state agency pending investigation." ASM #2 was asked if CNA #4 was still involved in caring for Resident #7. ASM #2 stated that she was. ASM #2 further stated that she was unaware of the grievance and she was not asked to investigate.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
on the survey team on 8/3/17 at 10:40 a.m. with	F 226	Communicated via Concerned about: Attitude. Describe stated CNA (name with resident. Res teil (name of past / nursingl). Told (name want It reported. Assigned by: (naminvestigation: spol regarding concernatitude with resideresident when interesident was dealth and attended 11/22/1 documentation regwell-being. An interview was dealth allegation of abuse member is susper the administrator in reported incident) state agency pendasked if CNA #4 when the stated the grievance and she was a further stated the grievance and she was a further was a further stated the grievance and she	c (check mark by Verbal). (check mark by other) CNA - concern in detail: Resident of CNA #4) has an attitude lident was afraid to report: Did ADON [assistant director of me of past ADON) she did not cocumentation of investigation; e of ASM #1). Findings of ke to (name of CNA #4) , does not feel that she has ent, will be more friendly with racting with resident. Results esolved. Resolution; her ersolved; (check mark by the remarks: Resident states that at to her and no more issues. I any more problems." ent #7's comprehensive care of did not reveal any garding abuse and psychosocial conducted on 8/3/17 at 10:00 the director of nursing. ASM escribe the process for an e. ASM #2 stated, "The staff haded pending an investigation, is notified and a FRI (facility is completed and sent to the illing investigation." ASM #2 was vas still involved in caring for #2 stated that she was. ASM hat she was unaware of the was not asked to investigate.		:26		

PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495389 B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 8 F 226 ASM #3, the nurse practitioner. During the interview ASM #3 stated there was a CNA (CNA #4) who was rude to the residents. ASM #3 stated the staff was afraid to report this behavior to administration fearing their tires would be slashed. An interview was conducted on 8/3/17 at 10:45 a.m. with ASM #3, the family nurse practitioner, in the presence of ASM #1, the administrator, and ASM #2 (the director of nursing). ASM #3 was asked If she was aware of any CNAs being verbally abusive to any of the residents in the facility. ASM #3 stated, "I have heard a CNA speak rudely to a resident, but I don't remember when," When asked which CNA, ASM #3 stated that it was CNA #4. When asked to describe the situation, ASM #3 stated, "She (CNA #4) was in one hallway and I heard her yelling at a resident In another hallway, I went to the nurse's station to see what the problem was." ASM #3 was asked if she intervened or if she reported the incident, ASM #3 stated, "The nurses were there, we discussed it, I am not sure if anyone intervened." When asked the name of the nurse present ASM #3 stated it was a nurse who was no longer employed with the facility. ASM #3 further stated that Resident #7 had confided that she was afraid of CNA#4, she was afraid of retallation. ASM #3 was asked whether or not what she heard constituted abuse, ASM #3 stated it was verbal

abuse. ASM #3 was asked if she was responsible for reporting allegations of abuse, ASM #3 stated that she was but did not do it.

On 8/3/17 at 10:50 a.m. ASM #1, the

administrator, was asked specifically about the complaint/grievance report submitted to ASM #1 by Resident #7, and whether or not that was an

PRINTED: 08/15/2017

		AND HUMAN SERVICES				FORM	08/15/2017 APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIF	PLE CONSTRUCTION		0938-0391
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	1		G		PLETED
		405000		_		1	c
Note: Or	province on Alignites	495389	B. WING		Charles - The Ch	08/	03/2017
MANE OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR		
ENVOY	OF WINCHESTER, LL	С		1	WINCHESTER, VA 22603		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	Ь	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	/ MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL(CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
F 226	i Continued From pa	ura Q	. E.	226			
1 640		. ASM #1 stated, "I did not	F 2	4Z(u ,		
	report this because	I did not think it was abuse					
	when I spoke to the	resident and to (name of					
		was asked to describe her					1
		was provided with an . ASM #1 stated that she					
		nvestigation which involved					i
		ent from person with the					:
		ld suspend the employee obtain witness statements			Į.		
		mbers and other residents to	i		:		
	determine whether	or not there was abuse. When					
		ed this process in this situation					
	involving Resident?	#7, ASM #1 stated that she did			•		
	HOC.				1		
		kimately 12 noon an interview					
•		Resident #7, Resident #7					
		ad a problem with CNA #4. that she (CNA #4) had an					
		th her and she had talked to					
	the activities directo	or who reported the situation to			!		
		Resident #7 further stated,	•		,		
		etter now, she is friendlier." sked if she was fearful of	: 				
		nt #7 stated that she was not.			·		:
	Resident #7 was as	sked if CNA #4 was equally					
		ints, Resident #7 stated that					1
		the could say was that (name stam things around and she			-		
		t like that, Resident #7 further			•		
		n't really want to talk about it.					
	On 0/2/47 at 40-00	n m ASM #4 was made	!				
		p.m. ASM #1 was made rsation with Resident #7 and	•				1
		FRI should be completed.					i !
	ASM #1 stated any	time there was an allegation of					
		ther stated that (name of CNA "have an attitude" but was					

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1				OMB NO	<u>0. 0938-0391</u>
	FOF DEPICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		(X3) DA	TE SURVEY
		495389	B. WING				O.S	C 3/03/2017
NAME OF	PROVIDER OR SUPPLIER	SOCIAL PROPERTY AND	,	STRE	ET ADDRESS, CIT	Y. STATE, ZIP CODE	1 00	770372017
ENVOY	OF WINCHESTER, LL	C		110 L	AUCK DR			
				WIN	CHESTER, VA	22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORR	S PLAN OF CORRECT ECTIVE ACTION SHOU ENCED TO THE APPR DEFICIENCY)	JLDBE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 10	F 2	26			, , ,	***
	· · · · · · · · · · · · · · · · · · ·	that attitude was manifested.	' -	.20				
		ity titled "Resident Abuse"						
	revealed, in part, the following documentation: "Policy: It is inherent in the nature and dignity of							
		e Company that he / she be						
		an rights, including the right to						
		neglect, mistreatment, and /						
		of property. Verbal Abuse:						
	Statements made to a resident which result in ridicule or humiliation of the resident. Any use of							
		ured language that includes						
		and derogatory terms to						
	other residents or v	isitors within hearing range, to						
		regardless of their age, ability disability. Definition of						
		n abusive act is any act or						
		y cause or causes actual				•		
		ical or emotional harm or						
		or any act which willfully his rights by law or as stated						
		of Abuse: The abuse						
	~	her designee shall investigate						
		ions of abuse. Preliminary						
		ediately upon an allegation of						
		e suspect shall be segregated pending the investigation						
		ation (sic). Investigation: The						
	abuse coordinator s	hall take statements from the						
		and all possible witnesses						
,	alleged abuse."	mployees in the vicinity of the						
	No further information	on was provided prior to the						
	end of the survey pr	ocess.			F Tag 272			
	483.20(b)(1) COMP	REHENSIVE	F 2	72		and lower West Bear in	f**	
SS=D	ASSESSMENTS				1)Resident #3	3,#6, # ECEN	I have the	
						y worksheet of		

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

	O DO SERVICE S	T WEDION OF OFTAICES	Т			<u> </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		495389	B. WING	3 E		C D9/03/3047
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	08/03/2017
ENVOY	OF WINCHESTER, LL			11	10 LAUCK DR VINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ЧX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 272	Continued From page	ige 11	F	272	Section V was updated	
	(b) Comprehensive		, ,	<i>L</i> 1 <i>L</i>	To include the location	
					and date of information	
	(1) Resident Asses	sment Instrument. A facility				
	must make a compr	rehensive assessment of a			For the trigger on 08/02/17	
	preferences, using t	trengths, goals, life history and the resident assessment			by the MDS RN.	
		ecified by CMS. The			2) Quality monitoring of CAA	
	assessment must in	nclude at least the following:			worksheet(s) of current	
	(i) Identification an	nd demographic information			residents reviewed	
	(ii) Customary routi	ine			by the IDT by 09/05/17	
	(iii) Cognitive patter				to ensure that the CAA	
	(iv) Communication					
	(v) Vision,				has the location and date	
	(vi) Mood and behar				of the information for the	
	(vii) Psychological w				trigger. Follow up based on	
	(viii) Physical fun problems.	nctioning and structural			findings of quality monitoring	
	(ix) Continence.					
		sis and health conditions.				
	(xi) Dental and nutri	tional status.			3) Education will be given 08/28/17	
	(xii) Skin Conditions.	4			to IDT by the ED on CAA worksheet	
	(xiii) Activity purs				on information requirement	
	(xiv) Medications				for location and date of the	
	(xv) Special treatmen					
	(xvi) Discharge p	nanning. tion of summary information			triggered area.	
		onal assessment performed				
	on the	лат авзеванцент реполнец			4) The DC5/designee to quality monl	itor
	care areas	s triggered by the completion			10% of CAA worksheets developed	
	of the Minimum Data	a Set (MDS).			by the IDT monthly. Quality monitori	ing
		tion of participation in			schedule modified based on findings	
		ssessment process must			Quality Monitoring results to be	
	include direct	and an annihilation with			Reviewed by the QAPI committee	
		on and communication with as communication with			For recommendations if needed.	
	licensed and	as communication with			The state of the s	
		ed direct care staff members				
					5) Compliance Date: 09/05/2017	



		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 08/15/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DA	TE SURVEY
		495389	B. WING	;		01	C 3/03/2017
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		7,0011011
ENVOY	of Winchester, LL	C		1	110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	RTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION , DATE
F 272	Continued From pa	age 12	F	272	2		
	observation and co as well as commun non-licensed direct shifts. This REQUIREMED by: Based on staff interest and clinical record facility staff falled to date on the compreset) for three of 17 sample, Resident #8. 1. The facility staff and date of information date day admission ARD of 3/15/17. 3. The facility staff location information CAA Summary workesident #8's admission date and date of information date of information day admission are day admission are day admission are day admission and date of information day admission are day admission ar	rocess must include direct mmunication with the resident, lication with licensed and care staff members on all NT is not met as evidenced erview, facility document review review, it was determined that a document the location and chensive MDS (minimum data residents in the survey 43, Resident #6 and Resident failed to document the location ation for the triggered areas on worksheet of Section V of day admission MDS in ARD (assessment reference failed to document the location ation for the triggered areas on the failed to document the location ation for the triggered areas on the failed to document date and in for the triggered areas on the risheet of Section V of ission/5-day MDS assessment sement reference date) of					
	The findings includ	de;	,				

PRINTED: 08/15/2017

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER: COMPLETED A. BUILDING C 495389 R. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE YAG TAG DEFICIENCY) F 272 Continued From page 13 F 272 1. The facility staff failed to document the location and date of information for the triggered areas on the CAA Summary worksheet of Section V of Resident #3's five day admission MDS assessment with an ARD (assessment reference date) of 7/8/17. Resident #3 was admitted to the facility on 7/1/17 with diagnoses that included but were not limited to: falls, difficulty swallowing, irregular heartbeat, chronic kidney disease and dementia. The most recent MDS assessment was a 14 day assessment with an ARD (assessment reference date) of 7/15/17. The resident was coded as having a BiMS (brief Interview for mental status) of 12 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the CAA (care area assessment) worksheet on the five day admission MDS assessment with an assessment reference date of 7/8/17, revealed the following triggered areas did not evidence documentation as to the location and dates from where the information was obtained to complete the assessment: ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence, psychosocial well-being, activities, falls, feeding tube, dehydration/fluid maintenance, pressure ulcer and psychotropic drug use. An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked why location and date was included on the CAA worksheet, RN #5

stated. "To make sure that anyone looking at the

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DATE

PRINTED: 08/15/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495389 3. WING STREET ADDRESS, CITY, STATE, ZIP CODE

FORM APPROVED
OMB NO, 0938-0391

(X3) DATE SURVEY
COMPLETED

C
08/03/2017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

WINCHESTER, VA 22603

PROVIDER'S PLAN OF CORRECTION
(PACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

F 272 Continued From page 14
MDS knows where we go
When asked where the to

ENVOY OF WINCHESTER, LLC

MDS knows where we got the information from." When asked where the location and date were documented, RN #5 stated, "The location and date is supposed to be on the CAA face sheet and on the CAA worksheet." RN #5 was asked to review Resident #3's CAA worksheet for the five day admission MDS assessment with an assessment reference date of 7/8/17. When asked if the location and dates of the information were documented, RN #5 stated, "No." When asked what reference the staff used to complete the MDS assessments, RN #5 stated, "The RAI (resident assessment instrument)."

The staff member who completed the five day admission MDS assessment for Resident #3 no longer worked at the facility and could not be interviewed.

On 8/2/17 at 6:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

According to the CMS's RAI Version 3.0 Manual: Section V of the MDS documents at the top of the page the following instructions:

- 1. Check column Alf the Care Area is triggered.
- 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.

F 272

ID

PREFIX

TAG

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: 8GEZ11

Facility ID: VA0123

If continuation sheet Page 15 of 78

PRINTED: 08/15/2017

		AND HUMAN SERVICES				FORM	08/15/2017 APPROVED
	NO FOR WEDICARE FOR DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M(1)	TIDES	CONSTRUCTION		. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	1, ,		CONGINGUINA	CON	E SURVEY PLETED
		495389	B. WING			1	C
NAME OF	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE	1 06/	03/2017
ENVOY	OF WINCHESTER, LL	С			LAUCK DR NCHESTER, VA 22603		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	lo	<u>:</u>	PROVIDER'S PLAN OF CORRECTIO		175)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 272	Continued From pa	ge 15	. F2	272			
*	Information column the CAA can be fou should include infor factors, risks and at this care area. Review of CMS's (C Services) RA! (Resiversion 3.0 User's Norther CAA) PROCESS A Other Consideration CAAs. Use the "Lo Documentation" cold (Section V of the MI CAA information and documentation can record. Also indicate Planning Decision" area is addressed in No further information.	be found in the resident's e in the column "Care whether the triggered care in the care plan." on was provided prior to exit. alled to document the location					
·	and date of informa the CAA worksheet	tion for the triggered areas on of Section V of Resident #6's MDS assessment with an					·
	with diagnoses that to: stroke, diabetes Review of the most quarterly assessme coded the resident	mitted to the facility on 3/2/17 included but were not limited and difficulty speaking. recent MDS assessment, a nt, with an ARD of 6/15/17 as being moderately impaired ons. The resident was coded			,		į

		AND HUMAN SERVICES				FORM	: 08/15/2017 I APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	re survey MPLETED
		495389	B. WING			08	C /03/2017
NAME OF F	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·		EET ADDRESS, CITY, STATE, ZIP CODE	-	
ENVOY C	of Winchester, Ll	¢			LAUCK DR NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	OTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 16	· · F2	72			
	as being independe	ent in activities of daily living.	:	;			;
	worksheet on Resk assessment with an following triggered documentation as the where the information the assessment: the assessment: the behavioral symptom psychotropic drug. An interview was cop.m. with RN (regist coordinator, When was included on the stated, "To make si MDS knows where When asked where documented, RN # date is supposed to and on the CAA woreview Resident #3 admission MDS as 3/15/17. When ask	(care area assessment) dent #6's admission MDS n ARD of 3/15/17 revealed the areas did not evidence of the location and dates from on was obtained to complete ognitive loss, communication, ms, falls, pressure ulcer and conducted on 8/2/17 at 4:30 detered nurse) #5, the MDS asked why location and date of CAA worksheet, RN #5 ure that anyone looking at the we got the information from." In the location and date were stated, "The location and of be on the CAA face sheet orksheet." RN #5 was asked to orks CAA worksheet from the sessment with an ARD of ed if the location and dates of					
	"No."	re documented, RN #5 stated,					
	admission MDS for	who completed the five day - Resident #3 no longer worked ould not be interviewed.		ļ			
	member) #1, the a	o.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the	•				
	No further informat	tion was obtained prior to exit.	1				

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

Event ID; 8GEZ11

Facility ID: VA0123

If continuation sheet Page 17 of 78



PRINTED: 08/15/2017

		AND HUMAN SERVICES				FORM	08/15/2017 APPROVED
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	F CORRECTION	IDENTIFICATION NUMBER:	, ,		LE CONS ROCTION	COM	E SURVEY IPLETED
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NAME OF PROVIDER OR SUPPLIER			B. WING			08/	03/2017
NAME OF	MOVIDER OR SUPPLIER			}	TREET ADDRESS, CITY, STATE, ZIP COOE		
ENVOY OF WINGHESTER, LLC				1	VINCHESTER, VA 22603		
(X4) ID		TEMENT OF DEFICIENCIES	lD lD		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		YMUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·	
F 272	Continued From pa	до 1 "У		מעמ	•		
l See / La	· ·	failed to document date and	Γ.	272			
		for the triggered areas on the	;		•		!
		ection V of Resident #8's					
		DS assessment with an ARD ince date) of 4/21/17.					:
	(Badossinent Foloro	riod datay of the first					
		imitted to the facility on					
•		acently readmitted on 4/14/17 of but not limited to dementia,			F 		
		nigh blood pressure, diabetes,			: :		,
		ain, hypothyroidism, high	:				
		slon, anxiety, Parkinson's ease, epilepsy, migraines,	;				
i		tructive pulmonary disease,	i				
	osteoarthritis, kidne	ey disease and cancer of the					
	renal pelvis.		,		i		
	The most recent Mi	DS (Minimum Data Set) was a					
		ent with an ARD (Assessment					
		7/22/17. The resident was initively intact in ability to make					,
	daily life decisions,	scoring a 14 out of a possible					1
		lef Interview for Mental Status)					
		it was coded as requiring total ipervision for transfers,					
	dressing, and hygis	ne; as independent for eating;					
	and as continent of	bowel and bladder.					
	A review of the adn	nission/5-day MDS					
	assessment with a	n ARD of 4/21/17, documented	i		RECE	IVE	
		Area Assessment (CAA) resident triggered for the					
	following areas:	roaldettrutifiliteren incille			SEP 0 (à 2017	
			•		Weeks B B B	al e	
	02. Cognitive Loss	/Dementia //Rehabilitation Potential			VILDER	LIES!	^{(eq}
		rence and Indwelling Catheter					1
	09. Behavioral Sym						•
.	11. Falls		•				

PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING __ C 495389 B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 272 Continued From page 18 F 272 12. Nutritional Status 14. Dehydration/Fluid Maintenance 16. Pressure Ulcer 17. Psychotropic Drug Use 19. Pain Next to each of the above listed areas, in the column titled "Location and Date of CAA documentation" was documented, "CAA WS (worksheet) dated 4/27/17" except for 09. Behavioral Symptoms which was dated 5/1/17 and 19, Pain which was dated 4/28/17. A review of the CAA worksheets revealed that only section 12. Nutritional Status, contained any clinical record date and location documentation. The areas of 02. Cognitive Loss/Dementia, 05. ADL Functional/Rehabilitation Potential, 06. Urlnary Incontinence and Indwelling Catheter, 09. Behavioral Symptoms, 11, Falls, 14. Dehydration/Fluid Maintenance, 16. Pressure Ulcer, 17. Psychotropic Drug Use, and 19. Pain did not contain any date and location information. On 8/3/17 at approximately 10:00 a.m., an Interview was conducted with RN #5 (Registered Nurse - the MDS nurse). She stated that location and date information should be on the CAA

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Instrument).

worksheet or documented in Section V of the MDS. RN #5 reviewed the above MDS and stated that the date and location information was not documented, and therefore, the information used to complete the MDS could not be tracked. She stated the person that completed this MDS was no longer at the facility. When asked what policy the facility uses to complete the MDS, RN

#5 stated the RAI manual (Resident Assessment

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/15/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495389 -B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID. PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 272 Continued From page 19 F 272 On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. F 279 483.20(d);483.21(b)(1) DEVELOP F 279 F Tag 279 SS=D COMPREHENSIVE CARE PLANS 1)Resident #3 care plan for 483.20 Psychosocial well-being was (d) Use. A facility must maintain all resident updated and Resident #6 assessments completed within the previous 15 months in the resident's active record and use the care plan for behavior was results of the assessments to develop, review updated on 08/02/17. and revise the resident's comprehensive care by the MDS RN. plan. Care plans of current 483 21 residents reviewed (b) Comprehensive Care Plans by the IDT 09/05/17 to ensure that (1) The facility must develop and implement a care plans are current and comprehensive person-centered care plan for each resident, consistent with the resident rights complete according to the set forth at §483.10(c)(2) and §483.10(c)(3), that triggered CAA .Follow up includes measurable objectives and timeframes based on findings to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive 3) Education given care plan must describe the following -08/28/17 to IDT by the ED on developing a care plan that (i) The services that are to be furnished to attain Is complete according or maintain the resident's highest practicable physical, mental, and psychosocial well-being as to the CAA that is triggered, required under §483.24, §483.25 or §483.40; and to include psychosocial well-being and behavior (ii) Any services that would otherwise be required care plan from information under §483.24, §483.25 or §483.40 but are not gathered. provided due to the resident's exercise of rights

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

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FMACA	OF WINCHESTER, LL	C		l	VINCHESTER, VA 22603	
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	treatment under §4. (iii) Any specialized rehabilitative service provide as a result of recommendations. findings of the PASA rationale in the residential representation of the PASA rationale in the residential representation of the PASA rationale in the residential representation of the PASA rationale in the residential representation. (iv) In consultation we residential representation of the residential general desired outcomes. (B) The residential production of the residential residential residential requirements and consultation of the requirements set for section. This REQUIREMENTATION of the residential record refacility staff failed to care plan for two of the resident #3 residential residentia	uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. ith the resident and the ative (s)- oals for admission and reference and potential for cilities must document it's desire to return to the essed and any referrals to es and/or other appropriate ose, in the comprehensive care, in accordance with the th in paragraph (c) of this T is not met as evidenced view, facility document review eview, it was determined that develop a comprehensive 17 residents in the survey and Resident #6.	F2		4) The DCS to quality monitor 10% of care plans developed by the IDT month to ensure triggered CAA is care planned. Monitoring results to be reviewed by the QAP committee for recommendations if needed. Quality monitoring schedule modified based on finding 5) Compliance Date: 09/05/2017	1
	well-being for Reside	iled to develop a plan for psychosocial ent #3 as identified on the essment) of the five day				

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/15/2017 APPROVED : 0938-0391
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NAME OF	PROVIDER OR SUPPLIER		I	STR	EET ADDRESS, CITY, STATE, ZIP CO		
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F 279	with an ARD (asse 7/8/17. 2. The facility staff comprehensive ca Resident #6 as ide admission MDS as 3/15/17. The findings included the facility staff comprehensive ca well-being for Resident #3 was a admission MDS (nowith an ARD (asse 7/8/17. Resident #3 was a with diagnoses that to: falls, difficulty such children with of 7/15/17. The resident with of 7/15/17. The resident with of 7/15/17. The resident with diagnoses that to: falls, difficulty such children with of 7/15/17. The resident with of 7/15/17. The resident with diagnoses that to: falls, difficulty such control indicating the resident with the falls with diagnoses that to: falls, difficulty such control indicating the resident with the falls with the fall w	ninimum data set) assessment ssment reference date) of falled to develop a re plan for behavior for ntifled on the CAA of the sessment with an ARD of		279			
	assessment refere	ence date of 7/8/17 ction V. Care Area, 07. -Belno: A. Care Area Triggered		,			

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Event ID: 8GEZ11

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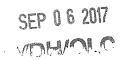
		AND HUMAN SERVICES				FORM	: 08/15/2017 APPROVED : 0938-0391
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F 279		ted (indicating the area was	F	279			
	documented (indica	Planning Decision, an X was ating a care plan would be hosocial well-being).					
	plan initiated on 7/1	t #3's comprehensive care 12/17 did not evidence a psychosocial well-belng plan					
	p.m. with LPN (lice manager. When as comprehensive car nurses look at the utilize the care plan had comprehensive	onducted on 8/2/17 at 2:00 nsed practical nurse) #4, unit sked which staff used the re plan, LPN #4 stated, "All the care plan. Social services can n." When asked why residents a care plans, LPN #4 stated, i care for the patlent."	1	::			
	p.m. with RN (regist coordinator, When	onducted on 8/2/17 at 4:30 stered nurse) #5, the MDS asked who would develop a nosocial well-being, RN #5 worker."		· ·			
	p.m. with OSM (oth social worker. OSM process followed we for a care plan to be "I go Into the CAA plan from that." Will developed, OSM # important to know issues we need to	onducted on 8/2/17 at 4:45 her staff member) #7, the A #7 was asked about the A hen a CAA triggered an area be developed. OSM #7 stated, worksheet and develop a care hen asked why a care plan was f7 stated, "Because It's if they (the residents) have develop a plan so everyone It to see they get the care they		:			
	deserve." OSM #7 #3's CAA workshe	was asked to review Resident et from the five day admission with an assessment reference					

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Event ID:80EZ11

Facility ID: VA0123

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 08/15/2017 NAPPROVED): 0938-0391
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F 279	date of 7/8/17. OSA should be developed OSM #7 was asked comprehensive car well-being. OSM #7 On 8/2/17 at 6:00 pmember) #1, the addirector of nursing findings. Review of the facility Care" documented interdisciplinary plator each resident astate and federal resident that includitimetables to meet nursing, and mental are identified in the Direct care staff shand follow their Resident that includitimetables to meet nursing, and mental are identified in the Direct care staff shand follow their Resident that includitimetables to meet nursing. Essay (Potter and Perry, freference for care a written guideline promoting continuity criteria to be used care. The written coordinates resour	A #7 stated that a care plan of for psychosocial well-being to review Resident #3's e plan for psychosocial a stated, "It's not there," .m. ASM (administrative staff dministrator and ASM #2, the were made aware of the ty's policy titled, "Plans of		279	CONTRACT)		

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easy to continue care from one nurse to another.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A, BUILDING _ Ċ 495389 8. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 279 Continued From page 24 F 279 If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to develop a comprehensive care plan for behavior for Resident #6 as identified on the CAA of the admission MDS assessment with an ARD of 3/15/17. Resident #6 was admitted to the facility on 3/2/17 with diagnoses that included but were not limited to: stroke, diabetes and difficulty speaking. Review of the most recent MDS, a quarterly assessment, with an ARD of 6/15/17 coded Resident #6 as being moderately impaired to make dally decisions. The resident was coded as being independent in activities of daily living. Review of the CAA summary from Resident #6's admission MDS with an ARD of 3/15/17 in section V documented, Care Area 09. Behavioral Symptoms, A. Care Area Triggered, an X was documented (Indicating the care area was triggered); B. Care Planning Decision an X was documented (indicating a care plan would be developed). Review of Resident #6's comprehensive care plan initiated on 3/16/17 did not evidence

documentation of a behavior care plan.

An Interview was conducted on 8/2/17 at 2:00 p.m. with LPN (licensed practical nurse) #4, unit manager. When asked which staff used the care

	H AND HUMAN SERVICES LE & MEDICAID SERVICES				FORM	: 08/15/2017 1APPROVED : 0938-0391
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care plan. Social plan." When aske LPN #4 stated, "patient." An interview was p.m. with RN (reg coordinator. When care plan for beh "The social worker. Os process staff folk care plan to be d into the CAA wor from that." When developed, OSM important to know issues we need t knows about it at deserve." OSM # #6's CAA worksh assessment with stated that a care behavioral sympl review Resident for behavioral sy there." On 8/2/17 at 6:06 member) #1, the director of nursin findings.	ed, "All the nurses look at the services can utilize the care and why residents had care plans, that is the plan of care for the conducted on 8/2/17 at 4:30 istered nurse) #5, the MDS in asked who would develop a avioral sympioms, RN #5 stated,		279			

PRINTED: 08/15/2017
FORM APPROVED
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F 281	Continued From pa 483.21(b)(3)(i) SER PROFESSIONAL S	VICES PROVIDED MEET	F 281 F 281	F Tag 281	
00-2	(b)(3) Comprehensi			1)Resident #3 Clinical record Was updated on 08/02/27 to	
		ed or arranged by the facility, omprehensive care plan,		clarify the correct weight by the MDS RN. Medication nurse was Educated by the DCS on proper	
(i) Meet professional standards of quality. This REQUIREMENT is not met as eviden by: Based on observation, staff interview, facility document review and clinical record review was determined that facility staff falled to for professional standards of practice for one or residents in the survey sample, Resident #3 for two of six residents in the medication parabolic observation, Resident #5 and Resident #17. 1. The facility staff falled to clarify Resident weight change from 206 pounds on 7/1/17 to pounds on 7/17/17.		IT is not met as evidenced on, staff interview, facility declinical record review, it facility staff failed to follow		Medication administration wher The state surveyor made her aw Of Resident #5 and #17 medicati Being given at the same time On 08/2/17.	are ions
		nts in the medication pass nt #5 and Resident #17.		2) A review of current residents Weights conducted on 08/29/17 to ensure that weights are corre documented accordingly. Licens nurses observed during medicat	ct and ed
	Resident #5 and Re	repared medications for both sident #17 at the same time, com to administer the residents.		to ensure only one resident's me being given at a time by the DCS/ manager 5 x week x 2 weeks star 08/28/2017 then weekly times 4	dications 'Unit ting
	The findings include 1. Facility staff failed	to clarify Resident #3's		then monthly. Quality monitorin schedule modified based on find	g
	weight change from pounds on 7/17/17.	206 pounds on 7/1/17 to 169 mitted to the facility on 7/1/17		3) Education provided on 08/30/2 To weight committee by the DCS	on the
	with diagnoses that i	ncluded but were not limited		Policy/Procedure of obtaining an	d

to: falls, difficulty swallowing, irregular heartbeat,

chronic kidney disease and dementia.

PRINTED: 08/15/2017

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

FORM APPROVED
OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
COMPLETED
C
B. WING
08/03/2017

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

ENVOY OF WINCHESTER, LLC

STREET ADDRESS. CITY, STATE, ZIP CODE

110 LAUCK DR

WINCHESTER, VA 22603

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

495389

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 27

The most recent MDS (minimum data set), was a 14 day assessment, with an assessment reference date (ARD) of 7/15/17. The resident was coded as having a BIMS (brief interview for mental status) of 12 indicating the resident was cognitively intact to make daily decisions. Resident #3 was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving tube feedings. In Section K of the MDS the resident's weight was documented as being 169 pounds.

Review of Resident #3's admission MDS assessment with an ARD of 7/8/17 in section K revealed the resident's weight was documented as being 206 pounds.

Review of the nursing admission assessment dated 7/1/17 at 4:50 p.m. documented the resident's weight as being 206.4 pounds.

Review of the nurse's notes did not evidence documentation regarding the weight change of 37 pounds in 14 days.

Review of Resident #3's vital signs and weight record documented, "7/1/17 -- 206.4. 7/15/17 -- 169.8." There was no documentation regarding the weight change on the form. The nurse who entered in the weight on 7/15/17 was not available to be interviewed.

An interview was conducted on 8/2/17 at 4:30 p.m. with RN (registered nurse) #5, the MDS coordinator. When asked who entered the weights into the MDS assessments, RN #5 stated, "Dietary puts in the heights and weights." When asked who reviews the information in the

F 281

Documenting correct weights. Education given by the DCS to licensed nurses on 08/30/17 on correct policy/procedure for medication pass.

4) Quality monitoring conducted weekly times 4 weeks then monthly On 15% of current residents weights by the

DCS/Designee to ensure compliance.
Monthly observations completed on
Licensed nurses on Medication pass to
Ensure compliance. Results of quality
monitoring taken to monthly QAPI
meeting for review
and recommendations if needed.

5) Compliance Date: 09/05/17

		AND HUMAN SERVICES & MEDICAID SERVICES			·	FORM	: 08/15/2017 APPROVED . 0938-0391	
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A sho A a v ficon w A (i) v m # v v d p s Li i v ti A p t f s F c v v v v v v v v v v v v v v v v v v	tated, "When the A ave been a warnin hange, Someone I warnin hange, Someone I make a significant change and a significant	RN #5 stated she did. RN #5 MDS is locked there would go that there was a significant had to override the warning." Inducted on 8/3/17 at 8.45 ified nursing assistant) #2. the process the staff follows nge in a resident's weight, here is a discrepancy the to have them (residents') Inducted on 8/3/17 with LPN nurse) #4, the unit manager. The process staff follows if a ficant change in weight, LPN uid trigger something was admission weight was admission weight was a clarification note." When rate weight was important, important to know if there's a ey (residents') are losing tube feeding she's getting isn't		281				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING NAME OF PROVIDER OR SUPPLIER (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	3) DATE SURVEY COMPLETED C 08/03/2017
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ENVOY OF WINCHESTER, LLC 110 LAUCK DR WINCHESTER, VA 22603	1
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nutrition problem. We give it to the dietitlan," ASM #2 was asked what professional standard the facility used. ASM #2 stated, "We use our policies." A request for a policy on clarification and documentation of a discrepancy in a resident's condition was requested; ASM #2 stated they did not have a policy. The RN who completed the MDS no longer worked at the facility and was unable to be interviewed. No further information was provided prior to exit. The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005), also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, offective manner." 2. The facility staff prepared medications for both Resident #5 and Resident #17 at the same time, before entering the room to administer the medications to both residents.	

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Event ID: 8GEZ11

Facility ID: VAD123

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 08/15/2017 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		NSTRUCTION	(X3) DA	ATE SURVEY MPLETED
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	1/26/16 and readmidiagnoses of but not kidney failure, sleep cancer, morbid obe depression with psysyndrome, high blod bladder, a colostom diabetes. The most Set) was a quarterly (Assessment Referresident was coded ability to make daily out of a possible 15 for Mental Status) et Resident #17 was a diagnoses of but not breast, ovary, kidnerestless leg syndror spinal stenosis, high chronic obstructive the recent admission completed. The addocumented that the person, place and timemory were intact independent for decompletical Nurse) was practical Nurse, was appeared to the recent admission completed. The addocumented that the person place and the memory were intact independent for decompletical Nurse, was appeared to the recent admission of the control of the con	Imitted to the facility on ted on 7/28/17 with the of timited to: sepsis, acute of apnea, large intestine sity, high cholesterol, who tic features, chronic pain od pressure, overactive by, an artificial eye, and the recent MDS (Minimum Data of assessment with an ARD ence Date) of 3/13/17. The last being cognitively intact in the BIMS (Brief Interview exam. Indicated on 7/18/17 with the state of the timited to: cancer of the by, and lung; depression, ne, cataracts, heart disease, in cholesterol, anxiety, and pulmonary disease. Due to not the MDS was not yet mission nursing assessment to resident was oriented to lime; short and long term it; and the resident was observed preparing and cations for Resident #5. She	F 2	81			
	" Aspirin [2] 81 m	000 units, 1 tab (tablet) g (milligrams), 1 tab [3] 325 mg, 1 tab nlts (injection)	:				

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	CON	APLETED .
		495389	B. WING		1	C
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE 1 08/	<u>/03/2017</u>
ENVOY	OF WINCHESTER, LL	С		110 LAUCK DR WINCHESTER, VA 22603	1402	*
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281	LPN #2 was then of medications for Resthe following medications for moshe stated that she do that. LPN #2 states for Resthe for Rest	000 mg, 1 tab 0 mg, 2 tabs 10 mg, 1 tab 10 mg, 1 tab 10 mg, 1 tab 10 mg, 1 tab , 1 tab 0 units (injection) bserved preparing sident #17. LPN #2 prepared atlons for Resident #17: 0 mg (injection) 1 mg, 1 tab mcg (micrograms) (inhaler) 1 tab ng, 1 tab ng, 1 tab 250 mg, 1 tab 300 mg, 1 tab 160-4.5 mcg (inhaler) 100 mg, 1 tab units, 1 tab	F 2	281		

PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIEP/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A, BUILDING _ \circ 495389 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ð (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 281 Continued From page 32 F 281 A review of the facility policy for Medication Administration documented, in all capital letters, "PREPARE MEDICATION FOR ONLY ONE RESIDENT AT A TIME." On 8/3/17 at approximately 2:00 p.m., the DON (Director of Nursing - Administrative Corporate Staff (ASM) #2) was made aware of the findings. No further information was provided by the end of the survey. References: [1] VItamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as esteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://vsearch.nlm.nih.gov/viv/slmo/cgi-bin/quervmeta?v%3Aproject=medlIneplus&v%3Asources= medlineplus-bundle&query=vitamin+d&_ga=2.19 2500842.1377447934.1502114951-734861906.1 502114951 [2] Aspirin is used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen); to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack; to prevent ischemic strokes (strokes that occur

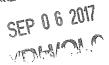
FORM CMS-2587(02-99) Pravious Versions Obsolete

when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke

Event ID: 8GEZ11

Facility ID: VA0123

Fcontinuation sheet Page 33 of 76



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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495389 B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X&) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 281 Continued From page 33 F 281 or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h 131 Ferrous sulfate provides the iron needed by the body to produce red blood cells. It is used to treat or prevent fron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems. Information obtained from https://medlineplus.gov/druginfo/meds/a682778.h [4] Lanuts is a long-acting, man-made version of human insulin. Insulin glargine works by replacing the insulin that is normally produced by the body and by helping move sugar from the blood into other body tissues where it is used for energy. It also stops the liver from producing more sugar. Information obtained from https://medlineplus.gov/druglnfo/meds/a600027.h [5] Metformin is used alone or with other medications, including insulin, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a696005.h tml

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F 281	Continued From pa	age 34	F	281			
	including yeast infe- throat, esophagus to the stomach), at chest and waist), lu Information obtains	to treat fungal Infections, tellons of the vagina, mouth, (tube leading from the mouth adomen (area between the ungs, blood, and other organs, ed from .gov/druginfo/meds/a690002.h					
	symptoms of hay for their substances information obtains	ed to temporarily relieve the ever (allergy to pollen, dust, or n the air) and other allergles, ad from .gov/druginfo/mads/a697038,h					
	(a condition in which contract uncontroll urination) control urination) controlled urination overactive bladder muscles hadder muscles hadder muscles information obtain	sed to treat overactive bladder ch the bladder muscles ably and cause frequent eed to urinate, and inability to control urgent, frequent, or ion in people who have (a condition in which the ave uncontrollable spasms). ed from s.gov/druginfo/meds/a682141.h					
	combination of vita sometimes have of herbs. They are all simply vitamins. Marecommended are when they cannot nutrients from footinformation obtain	neral supplements contain a amins and minerals. They other ingredients, such as so called multis, multiples, or luttle help people get the tounts of vitamins and minerals or do not get enough of these d. the seed from s.gov/definitions/vitaminsdefinit		:			

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NAME OF PROVIDER OR SUPPLIER ENVOY OF WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR					
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F 281	່ Continued From pa	ge 35	· F	281				
	of human insulin. It replacing the insulin the body and by he blood into other bo energy. It also stop more sugar. Information obtains https://medlineplus.tml [11] Lovenox is use leg in patients who having hip replaces stomach surgery. I aspirin to prevent combination with withe leg. Information obtains https://medlineplus.tml	ed to prevent blood clots in the are on bedrest or who are ment, knee replacement, or tis used in combination with complications from angina eart attacks. It is also used in variarin to treat blood clots in ed from agov/druginfo/meds/a601210.h						
	meta?v%3Aprojec medlineplus-bundl 000206.13774479 02114951	n.nih.gov/vivisimo/cgi-bin/query t=medlineplus&v%3Asources= e&query=folio+acid&_ga=2.268 34.1502114951-734861906.15	3					
	shortness of breat tightness in patien pulmonary disease	d to prevent wheezing, h, coughing, and chest ts with chronic obstructive e (COPD, a group of diseases as and airways) such as chronic	· >			ļ į		

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bronchitis (swelling of the air passages that lead

Event ID: 8GEZ11

Facility ID; VA0123

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/15/2017 APPROVED
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F 281	sacs in the lungs). Information obtaine	πphysema (damage to air	F	281 :			
	symptoms of hay fe other substances in substances (such a cockroaches, and n Information obtaine				·		
	thoughts that won't perform certain acti attacks (sudden, ur fear and worry about posttraumatic stress psychological sympt frightening experier disorder (extreme for performing in fromormal life), it is also symptoms of premoincluding mood swith breast tenderness. Information obtaine https://medlineplus.	ive disorder (bothersome go away and the need to ons over and over), panic texpected attacks of extreme at these attacks), sidisorder (disturbing toms that develop after a nice), and social anxiety par of interacting with others and of others that interferes with o used to relieve the enstrual dysphoric disorder, nige, irritability, bloating, and				-	
	medications to treat treat mania (episod excited mood) in pe	ed alone or with other t certain types of selzures; to es of frenzied, abnormally cople with bipolar disorder disorder; a disease that					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/15/2017 APPROVED 0938-0391
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F 281	Continued From pa	ge 37	F 2	81			
	manla, and other a migraine headache headaches that had information obtained https://medlineplus	ve already begun. :d from .gov/druginfo/meds/a682412.h					:
	types of seizures in relieve the pain of the burning, stabbit for months or years treat restless legs that causes disconurge to move the lewhen sitting or lyin information obtains https://medlineplus.	ed from :,gov/druginfo/meds/a694007.h					
	shortness of breat caused by chronic (COPD; a group of chronic bronchitis Information obtain	sed to treat wheezing, h, and breathing difficulties obstructive pulmonary disease f lung diseases that includes and emphysema). ed from s.gov/drugInfo/meds/a602023.h	3				
	return of duodena part of the small in medications, such necessary to treat ulcers caused by pylori). Information obtain	used to treat and prevent the I ulcers (ulcers located in first intestine). Treatment with other as antibiotics, may also be and prevent the return of a certain type of bacteria (H. sed from s.gov/druginfo/meds/a681049.	h				

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO 0938-0391

	INO LOLV MIEDIOVIVE	. A MILDIOAID SERVICES			<u>OMB NO</u> . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDÉNTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
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F 281	infections, such as bronchitis (infection lungs), and infection and intestines. It als diarrhea. Information obtaine https://medlineplus.tml [21] Percocet is use severe pain. Information obtaine https://medlineplus.	used to treat certain bacterial pneumonia (a lung infection), of the tubes leading to the as of the urinary tract, ears, so is used to treat 'travelers' d from gov/druginfo/meds/a684026.h	F2	281	
	tml 483.45(f)(2) RESIDE SIGNIFICANT MED 483.45(f) Medication The facility must en- (f)(2) Residents are medication errors. This REQUIREMEN by: Based on staff intereview, and clinical incourse of a complain determined that the administer medication residents in the survival of the facility staff administration.	ENTS FREE OF ERRORS n Errors.	F3	333 F Tag 333 1)Resident#15 as he no longer resides in the facility. MD was made aware and measures put into place to ensure resident #15 condition was monitored for any adverse reactions, none noted.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0301

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>OMB NO</u>	, 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		LE CONSTRUCTION		E SURVEY MPLETED
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		495389	B. WING	,		08	/03/2017
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
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	CURALIA DV ETA	TENENT OF DECISIONS			WINCHESTER, VA 22603		
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E 333	Continued From se	20	- /	000			-
1 000	Continued From pa	ing the dosage ordered by the	F	333	2)Quality Review completed by		
	physician.	ing the dosage ordered by the			DCS/designee of Medical Record	5	
					of current residents for any		
	The findings include	ə:			medication discrepancies by		
	Resident # 15 was	admitted to the facility on			08/30/2017 to ensure no		
	1/7/17 with diagnos anemia, atrial fibrilla	es including but not limited to: ation (2), coronary artery			medication errors.		
		es, and hyperlipidemia.			3)Education provided to		
		st recent MDS (minimum data assessment with an ARD			Licensed nurses on 08/30/17		
		nce date) of 1/14/17, coded					
		nitively intact to make daily			By the DCS on correct medicatio	*1	
		5 out of 15 on the BIMS (brief late). Resident # 15 was			Administration and the 6 rights		
	discharged from the				when administrating medication	75.	
		sician's orders for Resident#			4)DCS/and or pharmacy consulta	ant	
		, the following: "Lyrica 225 mg nouth) BJD (two times a day)".			to observe medication observa	tions	
		ed by the physician on 1/9/17.			on licensed nurses for safe and		
		mooti en timete			accurate medication administra	ition	
		NTROLLED MËDICATION ORD" (a record used to			monthly. The results will be tak	en to	
	document and keep				QAPI Committee for recommer	idations	
	medications) for Re	sident # 15's documented:			if needed.		
		APSULE1/11/17 at 9:00 I 9." This line of the					
		d the initials of RN (registered			5)Date of Compliance: 09/05/2	017	
	nurse) # 3.				, , , , , , , , , , , , , , , , , , , ,		
	A review of the facil	ity investigation of this incident					
		on of this incident signed by					
		17. Review of this description of following: "On evening of					
		ile administering medication					
	(name of RN # 3) g	ave 9 lyrica tabs (symbol for					
		mg each for a total of 2,025					
	mg which is 8 (sic):	times the dosage prescribed.					

PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING _ C 495389 B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 333 Continued From page 40 F 333 (Name of RN #3) did not follow the 6 rights of medication administration, 1. Right drug; 2. Right dose; 3. Right time; 4. Right resident; 5. Right route; 6. Right documentation." When the overdose was discovered on the , morning of 1/12/17 the physician was notified and $^\circ$ Initially ordered IV (intravenous fluids). When the physician arrived at the facility and assessed the Resident he then discontinued the order for IV flulds. The Physician Progress Note of 1/12/17 at 10:30 a.m. documented the following: Subjective; 80 year old male...was given about 2000 mg (milligrams) of Lyrlca last night prescribed dose was 225 mg. Patient denies ill feeling, dizziness, confusion, nausea or abdominal cramping, Vital Signs: T (temperature) 98.9 P (pulse) 71, R (respirations) 18, BP (blood pressure) 100/49. EXAM: Alert and oriented X 3, Lungs clear, cardio vascular system - regular rate and rhythm, no edema, no swelling, no tremor... Assessment & Plan: A. Medication Error, Lyrica overdosing without any obvious consequences...B. Monitor Vital signs every two hours for remainder of shift; hold Lasix and KCL today and resume tomorrow, continue other meds (medications). Restart Lyrica tomarraw. The physician wrote the following order dated 1/12/17: "1. Monitor V/S (vital signs) Q (every) 2 hrs. & Neuro Checks Q 2 hrs X 24 hrs. 2. Hold Lyrica, Lasix & KCL today 1/12/17, 3. May resume; all tomorrow."

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

Review of the Neurological Assessment Flow Sheet revealed documentation that the order for

Event ID: 8GEZ11

Facility ID: VA0123

If continuation sheet Page 41 of 76



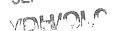
		AND HUMAN SERVICES & MEDICAID SERVICES				FOF	D: 08/15/2017 RM APPROVED O: 0938-0391
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ENVOY	OF WINCHESTER, LL	С			LAUCK DR NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	GEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) CDMPLETION DATE
F 333	out. Review of the administration reconstruction reconstruction reconstruction reconstruction. Other than the drop addressed on 1/12/Physician Progress and Neuro Checks Physician Progress p.m.) documented Re-evaluated in rocopost Lyrica overdos dizziness, dyspinea pain. States, "I just BP (blood pressure up on side of bed. Addistress)), respirate and diminished. Agasessment and Plapproximately 2000	Neuro Checks was carried MAR (medication rd) revealed documentation is were held as ordered. In blood pressure that was 17 at 1705 (noted in the Note below) the vital signs were within normal limits. Note on 1/12/17 at 1705 (5:05 the following: Subjective: orn due to hypotension status is Spouse present. Denles (shortness of breath) or chest chon't feel good." Vital Signs:) 80/44, 98/62. Exam: Silting Awake, alert, NAD (no acute ons non-labored. Lungs clear cleal pulse regular.		333			
	Physician Progress p.m.) documented year old male re-everror involving Lyric today. Denles head chest paln, palpatic bowel/bladder conc (temperature) 97.9, 16, and BP (blood wheelchair. Awake, distress), respiratio diminishedApical chest healing no S/	Note of 1/13/17 at 1700 (5:00 the following: Subjective: 80 raluated today after medication at Reports "feels better" dache, dizziness, dyspnea, ons, no abdominal pain or cernsVital signs: T, P (pulse) 63, R (respirations) pressure) 102/49. Exam: up in Alert, NAD (no acute ins non-labored. Lungs regular. Surgical wounds to S (signs /symptoms) of tent and Plan: Medication error	i .	to a Management state.			

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Event JD;8GEZ11

Facility ID: VA0123

SEP 0 6 2th pontinuation sheet Page 42 of 76



		AND HUMAN SERVICES & MEDICAID SERVICES				FÖRM	: 08/15/2017 IAPPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL		CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY APLETED
		495389	B. WING	***************************************		ŧ	C /03/2017
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	03/2011
ENVOY ()F WINCHESTER, LL	C			LAUCK DR NCHESTER, VA 22603		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 333	Continued From pa	ge 42	F S	333		**************************************	
	- no apparent adver weakness. Conside	rse reaction, generalized or changing Lasix to every poratory tests) on 1/16/17 and					
	RN # 3 was unable no longer employed	to be Interviewed as she was I at the facility.		i			
	LPN (licensed pract asked what she wo medications she ha order or a medicatio familiar. LPN # 2 storder by checking the MAR (medication are against the physicial stated that if she stifull call the physician at LPN # 2 stated she medication administights. During an the end capproximately 6:00 staff member) # 1, to	on 8/2/17 at 4:40 p.m. with ilical nurse) #2, LPN #2 was uld do if while passing d an unusual medication on with which she was not tated that she would clarify the medication card against the dministration record) and also an order. LPN #2 further ill had a question she would not possibly the pharmacy. has to follow the six rights of tration and then named the find day interview on 8/2/17 at p.m. with ASM (Administrative the administrator, and ASM #urses, this concern of the					
	medication adminis Review of the facilit Administration Of N following under "Po resident can expect administration of or Obtain and verify pl Medication Cart to I room, Verify Physic	tration policy was requested, y policy "Medications - Oral -853" documented the licy; It is the policy that the					

		AND HUMAN SERVICES & MEDICAID SERVICES						FORM	0: 08/15/2017 1 APPROVED 1. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE			TRUCTION		(X3) DA	TE SURVEY MPLETED
		495389	B. WING	; 				0.9	C /03/2017
NAME OF F	ROVIDER OR SUPPLIER		L		STREET	ODRESS, CITY, STAT	E, ZIP CODE		1441241
ENVOY	F WINCHESTER, LL	С			WINCHE	CK DR ESTER, VA 22603	i		
(X4) ID PREFIX TAG	(EACH BEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF : TAG			PROVIDER'S PLAN (EACH CORRECTIVE ROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
	any unfamiliar medi MEDICATION FOR TIME. Locate pressible Medication Chart medication on MARTHREE (3) TIMES: drug from the drawdrug to the resident package Chart or During an interview 9:00 a.m. with ASM the Regional Direct concern was review During an interview the pharmacist it was mg or more of Lyric advantages and the general side effects According to "Fund Edition, 2009: by Po"Professional stand Nurses Association Standards of Nursin activity of medication errors, it administration consadminister medication administration. The administration inclumedication, 2. The	r Nursing Drug Handbook for leations. PREPARE CONLY ONE RESIDENT AT A cribed medication in Compare unit/dose R. Read label on the container BEFORE REMOVING the er; BEFORE HANDING the er; BEFORE HANDING the And BEFORE DISCARDING TO MAR according to policy Fon 8/3/17 at approximately #1, ASM #2, and ASM #4, or of Clinical Services, this wed. Fon 8/3/17 at 9:40 a.m. with as revealed that doses of 450 a had no added benefits or at the side effects would be the cry and Potter, page 707, lards, such as the American 's Nursing: Scope and ng Practice (2004) apply to the on administration. To prevent follow the six rights medication errors one way, to an inconsistency in rights of medication exix rights of medication de the following: 1, The right client, 5, The right time, and 6. The	F	333	3				

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Event ID:8GEZ11

Facility ID: VA0123

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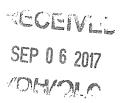
		AND HUMAN SERVICES & MEDICAID SERVICES				F	TED: 08/15/2017 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		3) DATE SURVEY COMPLETED
		495389	8. WING				C 08/03/2017
NAME OF F	ROVIDER OR SUPPLIER	9 7 1200200 7 7 9 2000000 100 3		STF	REET ADDRESS, CITY, STATE, ZIP	CODE	00/03/2017
ENVOY)F WINCHESTER, LL	C	•		LAUCK DR NCHESTER, VA 22603	*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PŁAN OF OC (EACH CORRECTIVE ACTIO CRÓSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIAT	
	149, "When you car day-to-day nursing proceed skills you bri ability to administer technical skill that rewide-ranging knowle professional judgen expertisethe nurse knowledge of drug thrugs produce after Also, on page 172, need to measure thresponse before detime to administer a Fundamentals of New Wilkins 2007 Lippin Medication Administrages 149 and 172. No further information References: (1) Lyrica® Preganeuropathic pain (professional if you have that occurs after infalso used to treat fit condition that may can denderness, tire asleep or staying as other medications to seizures in people values of medications to seizures in people values."	ndamentals of Nursing page re for a patient in your practice, one of the most ing to the bedside is your medicationsIt is a highly equires you to exercise edge, analytical skill, nent and clinical e must have a sound reminologyand effects the they're inside the body" "For some drugs you may e patient's therapeutic fermining whether it's the right nother dose,"(1). (1) ursing Lippincott Williams & cott Company Philadelphia tration-Medication Basics on was provided prior to exit. Abalin is used to relieve all from damaged nerves) ur arms, hands, fingers, legs, have diabetes or in the area of e had shingles (a painful rash ection with herpes zoster). It is promyalgia (a long-tasting cause pain, muscle stiffness edness, and difficulty falling sleep). Pregabalin is used with the pression of the pre	F	333	DEFICIENCY		
	works by decreasing	g the number of pain signals damaged nerves in the body.	:	<u> </u>			

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Facility ID: VA0123

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

	territoria de la companiona de la compan				<u> </u>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING_		C 08/03/2017
	PROVIDER OR SUPPLIER OF WINCHESTER, LL	С		STREET ADDRÉSS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	1 00/03/2011
(X4) ID PREFIX TAG	(ÉACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 333	website:	ge 45 s obtained from the following gov/druginfo/meds/a605045.h	F 30		
	with the speed or rh fibrillation (AF) is the arrhythmia. The cau electrical system. I from the following w https://search.nih.go	ov/search?utf8= ate=nih&query=Atrial+fibrillati			
	common type of her cause of death in the and women. This in the following websit https://search.nih.go	ov/search?utf8≕ ate=nih&query=Coronary+art			
F 431 SS=D	COMPLAINT DEFIC 483.45(b)(2)(3)(g)(h LABEL/STORE DRI	CIENCY) DRUG RECORDS, JGS & BIOLOGICALS	F 43		
	drugs and biological them under an agre §483.70(g) of this pa	art. The facility may permit el to administer drugs if State / under the general nsed nurse.		1)The medicine cart was locke once discovered that it had be unlocked and unattended by the Nurse on 08/02/17 to ensure the Resident #11 and #12 medicathwere safe guarded. Insulin per Removed from top of cart and Placed in the medication cart.	een he that dons ns

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Event ID:8GEZ11

Facility ID: VA0123

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

CENIE	RS FOR MEDICARE	& MEDICAID SERVICES	r			<u> </u>	<u>O. 093</u> 8-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		LE CONSTRUCTION		ATE SURVEY OMPLETED
		495389	B. WING	i		۱ ,	C 8/03/2017
NAME OF	PROVIDER OR SUPPLIER	MATERIAL A. MONTH PORTY P. NO. CONT. CO. CO. CO. CO. CO. CO. CO. CO. CO. CO		5	STREET ADDRESS, CITY, STATE, ZIP CODE		414412011
ENVOY	OF WINCHESTER, LL	c		1	i10 LAUCK DR WINCHESTER, VA 22603		
0/ 0/15	TO VOAMMID	TEMENT OF DEFICIENCIES		<u> </u>	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-RÉFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 46	F 4	431	2) The set		
	•	vices (including procedures	•		2) The Other medicine cart was		
	that assure the acc	urate acquiring, receiving,			checked to ensure that it was		
		ministering of all drugs and the needs of each resident.			locked per policy.		
	(b) Service Consult:	ation. The facility must			3) Director of Clinical Services		
		e services of a licensed			will provide education to licen:	ed	•
	pharmacist who				nurses on 08/30/2017on the sa		•
	(2) Fetabliches a eu	stem of records of receipt and			guarding of medications	, -	
		ntrolled drugs in sufficient			in keeping medicine carts locke	d	
		eccurate reconciliation; and			when not in full view during	Li .	
	(2) Datamainas that	durin accounts one in audice and			medication administration.		
	that an account of a	drug records are in order and if controlled drugs is			••		
	maintained and per				Education will be provided mor to ensure compliance.	thiy	
	(g) Labeling of Drug	s and Biologicals.			Management team will		
		ils used in the facility must be			conduct observations of the		
	professional princip	ce with currently accepted			medication cart when making		
	appropriate access				rounds 5 x weekly to ensure		
	instructions, and the	e expiration date when			that medication cart is locked		
	applicable.				per policy, any variances will be		
	(h) Storage of Drug	s and Biologicals			reported to the DCS, immedia		
		ith State and Federal laws,			correction and re-education wil		
	-	e all drugs and biologicals in				be	
		ts under proper temperature			completed as necessary.		•
	have access to the	only authorized personnel to keys,					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976	provide separately locked, compartments for storage of ed in Schedule II of the ag Abuse Prevention and and other drugs subject to					
	abuse, except wher	i the facility uses single unit					

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Event ID: 8GEZ11

Facility ID: VA0123

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PRINTED: 08/45/2017

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	MAPPROVED 0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DA	ATÉ SURVEY OMPLETED
		495389	B. WING			C 8/03/2017
	PROVIDER OR SUPPLIER OF WINCHESTER, LL	c		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 431	package drug distril quantity stored is m be readily detected.	bution systems in which the inimal and a missing dose can	F 4	4) The observations related Medication carts not being will be discussed by the Exe Director during the QAPI m	locked ecutive	TO

- Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure medications were safely secured on one of 4 resident halls; the Gold hall.
- 1. While preparing and administering medications for Resident #11, LPN (licensed practical nurse) #2 failed to ensure medications in the medication cart, were secured from potential resident access on the Gold hall. LPN #2 went into the resident's room, leaving the medication cart unlocked. The medication cart was not in her line of sight.
- 2. While preparing and administering medications to Resident #12, RN (registered nurse) #1 failed to ensure medications in the medication cart, were secured from potential resident access on the Gold hall. RN#1 went into Resident #12's room to administer medications he prepared and left the medication cart unlocked. The medication cart was not in his line of sight; one resident and three (3) staff members were observed passing by the unlocked medication cart.
- 3. The facility staff failed to secure two insulin pens belonging to two different residents from potential resident and staff access on the Gold hall. Two residents and three staff members were observed passing by the unsecured medications lying on an isolation cart outside room 16.

- For review and recommendations If needed to sustain substantial compliance.
- 5) Compliance date: 09/05/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 08/15/2017 MAPPROVED D: 0938-0391
STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495389	B. WING	***************************************		0.0	C
NAME OF PRO	VIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CO	DE J VE	3/03/2017
ENVOY OF	WINCHESTER, LL	C	,		0 LAUCK DR INCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
	ontinued From pa he findings include		. F.	131			
7/ ce pr di di pr (N TI th w	20/17 with the dia ellulitis of the left le ellpheral vascular séase, cancer of tabetes, high choice essure. Due to the dinimum Data Setjue admission nurs e resident was ale th some short and 18/2/17 at 7:07 a. actical Nurse) was iministering medice pared the following significant and the signif	mg (milligrams), 1 tab 10 mg, 1 tab ig, 1 tab , 1 tab 000 units, 1 tab		1 to proper the second			
le fro vid pa O in Pr m sh	aving the cart unloant of the door to the work of the nurse. A less near the cart, an 8/3/17 at approxection was conducted Nurse). Shedication cart is lefould be locked, the	to the resident's room, cked. The cart was not in he resident's room and in full to residents were observed to imately 9:30 a.m., an oted with LPN #2 (Licensed he stated that when a ft unsupervised, the drawers a MAR should be closed, and s, etc., should not be left on					

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			Pt		08/15/2017
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	- No 1000 A		O	FURM, MB NO.	APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495389	B. WING	·		i	03/ 2017
NAME OF	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE	1100	
ENVOY	of Winchester, LL	C		1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFIGIENCY)	BE	(X5) COMPLETION DATE
	top of the cart. She that she had not see that she had not see A review of the facil Administration dld rensuring the medica secured when unsuring the medica secured when unsuring the secured when unsured (Director of Nursing Staff (ASM) #2) was No further information the survey. "A client's environm physical and psychological and client interact (expenses, school, clinic facility). Safety in hithe incidence of illnown improves or maintain and increases the continuous or maintain and increases the continuous or maintain and increases the continuous of the page 959. From Fundamentals Patricia A. Potter and Inc; Page 5: "Client care. You need to perform the second of the page 5: "Client care. You need to perform the page 959.	e stated that she did not realize curely locked the cart. ity policy for Medication not document any criteria for ation cart was locked and		431			
	and eliminating safe References:		•				
		alone or in combination with				•	

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		AND HUMAN SERVICES				Fr	TIN LED: FORM	APPROVED
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		495389	B. WING	·			1	C 03/2017
NAME OF	PROVIDER OR SUPPLIER			[[STREET ADDRESS, CITY, STATE, ZIP GOD	E	1 00)	VOIEUII
ENVOY	OF WINCHESTER, LL	C		1	110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
	also is used to previmprove survival aff Information obtaine https://medlineplus.tml [2] Glipizide ER is used to treat type 2 diabete body does not use is cannot control the alinformation obtaine https://medlineplus.tml [3] Lisinopril is used other medications to is used in combinate treat heart fallure. Limprove survival aff information obtaine https://medlineplus.tml [4] Actors is used with and sometimes with type 2 diabetes (collinot use insulin normation obtaine https://medlineplus.tml [5] Vitamin D3 helps://medlineplus.tml	o treat high blood pressure. It tent angina (chest pain) and ter a heart attack. It from gov/druginfo/meds/a684031.h used along with diet and etimes with other medications, etes (condition in which the insulin normally and, therefore, amount of sugar in the blood). If the diet in combination with the treat high blood pressure. It ion with other medications to der a heart attack. It is also used to ter a heart attack. It is diet and exercise program in other medications, to treat notition in which the body does nally and therefore cannot of sugar in the blood). If the gov/druginfo/meds/a699016.h is your body absorb calcium.	F.	431				
	bone, A lack of vitar	ne main building blocks of min D can lead to bone steoporosis or rickets. Vitamin			,			į

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D also has a role in your nerve, muscle, and

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Facility ID; VA0123

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		AND HUMAN SERVICES				FORM): 08/15/2017 (APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA), 0936-0391 TE SURVEY MPLETED
		495389	B, WING				C
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 08	/03/2017
ENVOY	OF WINCHESTER, LL	С		110	LAUCK DR INCHESTER, VA 22603		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPA DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 43 ⁴	: Continued From pag	ge 51	F	131			
	meta?v%3Aproject- medlineplus-bundle. 2500842.137744793 502114951 [6] Ranexa is used a medications to treat chest pain or pressult does not get enough information obtained https://medlineplus.gtml 2. While preparing a medications for Resident access on the into Resident access on the into Resident #12's	nih.gov/vivislmo/cgi-bin/query-medlineplus&v%3Asources= &query=vitamin+d&_ga=2.19 34.1502114951-734861906.1 alone or with other chronic angina (ongoing ure that is felt when the heart n oxygen). d from gov/druginfo/meds/a606015.h and administering ident #12, RN (registered nsure medications in the re secured from potential the Gold hall. RN #1 went					
		S (Minimum Data Set) was assessment with an ARD					

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/15/2017 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	.TIPI	LE CONSTRUCTION		1	0938-0391 SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILD	ING)		COW	PLETED
		495389	B. WING					C 03/2017
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STAT	E, ZIP CODE	1 00/	0012011
ENVOY	OF WINCHESTER, LL	C			i10 Lauck dr Winchester, VA 22603			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	; ID		PROVIDER'S PLAN		~	VIII VIII VIII VIII VIII VIII VIII VII
PRÉFIX TAG	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 431	Continued From pa	de 52		104	,			1
		ence Date) of 7/14/17. The		131				
	resident was coded	as being cognitively intact in						
		life decisions, scoring a 15 on the BIMS (Brief Interview			:			
	for Mental Status) e						,	
	On 9/2/17 of 7:07 a	.m., RN #1 (Registered			· 			
	Nurse) was observe							
		cations to Resident #12. He						
:		lligrams), 1 tab (tablet) g (micrograms), 1 tab 2 tabs			i.			
	the MAR (medicatio on top of the medica of the medication of medication cart was the sight; a majority	o the resident's room, leaving n administration record) open ation cart, with the front side art facing the hallway. The not in RN #2's entire view of of the medication cart was le of the door, and was not in			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
;		on of the above medications, red some cough medicine.			-			
;	medication cart, revi for cough medicine He then went to the	m., RN #1 returned to the iewed the MAR for an order and noted there wasn't any, nurse's station to check the order. RN #1 returned to the			 			
	Resident #12's room cough medication he medication cart unlo	m., RN #1 went back into n to administer the tussin [4] e prepared. He left the ocked; one resident and 3 observed passing by the						

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

Event ID: 8GEZ11

Facility ID: VA0123

If continuation sheet Page 53 of 76



		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/15/2017 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY APLETED
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NAME OF I	PROVIDER OR SUPPLIER		,	T8	REET ADDRESS, CITY, STATE, ZIP CODE	1 00,	103120117
ENVOY	OF WINCHESTER, LL	C			O LAUCK DR INCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION]	! IO PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
;	interview was condu Practical Nurse). S cart is left unsuperv locked, the MAR sh medications, needle top of the cart. A review of the facil	n cart. simately 9:30 a.m., an ucted with LPN #2 (Licensed he stated when a medication ised, the drawers should be	F	131			
	ensuring the medical secured when unsured when unsured to the secured when unsured to the secured when unsured to the secured when the secured the secured when the secured when the secured the secured when the	ation cart was locked and					
	Parkinson's disease Information obtained https://mediineplus.stml [2] Synthroid is use Information obtained https://mediineplus.stml	d from gov/druginfo/meds/a698013.h d to treat hypothyroldism. d from gov/druginfo/meds/a682461.h			SEP 0		
	Information obtained https://medlineplus.g tml	o treat mild to moderate pain, if from gov/druginfo/meds/a681004.h			vi ti. Jila 1860		

PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER A. BUILDING COMPLETED C 495389 B. WING 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22803 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) Continued From page 54 F 431 making it easier to cough up mucus and clear the Information obtained from https://medlineplus.gov/druginfo/meds/a682494.h 3. The facility staff failed to secure two Insulin pens belonging to two different residents from potential resident and staff access on the Gold hall. Two residents and three staff members were observed passing by the unsecured medications lying on an isolation cart outside room 16. An observation was made outside room 16 on the Gold hall on 8/3/17 at 8:15 a.m. A white plastic isolation cart was placed outside the room. The cart was not visible from inside the room. There was a clipboard on top of the cart and there were five insulin needles and two insulin pens containing Insulin lying on the clipboard. There . SEP 0 6 2017 was no staff in sight. At 8:16 a.m. a staff member wheeled a resident past the unsecured medications, a few seconds later a resident ambulated independently past the unsecured medications. Between 8:16 a.m. and 8:19 a.m. three staff members walked past the unsecured medications. At 8:19 a.m. a nurse came out of room 16, put other medications on the clipboard and sanitized her hands. An Interview was conducted with the nurse LPN (licensed practical nurse) #2 at that time. LPN #2 stated. "I have those (indicating the Insulin pens) to give to other residents. I can see them from the room." A request was made for the nurse to demonstrate how she could maintain line of sight on the medications. LPN #2 walked into the room with

her back to the door and approached the resident who was sitting in a wheelchair in the left hand corner of the room. There was no clear line of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH. CENTERS FOR MEDICARE					FORM	: 08/15/2017 APPROVED
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER	***************************************	1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	/03/2017
ENVOY OF WINCHESTER, LLC	3		1	i10 LAUCK DR WINCHESTER, VA 22603		
PRÉFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL OROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X8) COMPLETION DATE
cart. ASM (administration director of nursing we conversation. When practice to have two medications pulled fit unsecured out of stated, "No, that's no process the staff folloadministration, ASM one patient's medical grabbed the wrong of wrong insulin." ASM could maintain line of medications lying on room 16, when she wanother resident. As couldn't, no that's just patients could pick it hands on it." Review of the facility Oral Administration of the policy that the rest accurate administration docur "PREPARE MEDICA RESIDENT AT A TIM No further information" "Make sure all medic containers in a room"	ent's position to the Isolation rative staff member) #2, the ras present during the asked If it was the facility's different resident's rom the medication cart, lying iffs the line of sight, ASM #2 of right." When asked what owed during medication #2 stated, "You only doing atlon at a time. What if you one and gave the resident the #2 was asked if LPN #2 if sight with the unsecured the Isolation cart outside was in the room caring for SM #2 stated, "No, she at not safety. One of the up. Anyone could get their is policy titled Medications: Of documented, "Policy: It is sident can expect safe and ion" It y policy for Medication mented, in all capital letters, CION FOR ONLY ONE IE."	F- 4	431	SEP 0 6 2017		

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

Colony 1 1 I have	TO I OIL MEDICATIO	C MINEDIO/ND OCITATORS			<u></u>	MD MO	<u>. บรรต-บร</u> รา
	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
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	o, 11(110112012)() aa	_		WII	NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMÉNT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ae 56	E,	[41			
F 441	•	e)(f) INFECTION CONTROL,		141	F Tag 441		
	PREVENT SPREAM			t~r I	47		
		,			1)		
	(a) Infection preven	tion and control program.			Nurse identified in 2567 was		
	The feetite	tabliah an infration on online			Re- educated by the DCS regarding		
		tablish an infection prevention n (IPCP) that must include, at			following infection control		
	a minimum, the folk				practices for use of glucometers		
	·				08/02/17.		
		venting, identifying, reporting,					
		ontrolling infections and ases for all residents, staff,			2) DCS completed observations of		
		and other individuals			licensed nurses for following		
	providing services L				infection control practices.		
		l upon the facility assessment			Based on observation findings		
		g to §483.70(e) and following			licensed nurses re- educated by the		
	implementation is P	tandards (facility assessment			On proper sanitation of glucometer		
	impromotitation to t	11000 2),			prior to using and after use for eac	h	
	(2) Written standard	ls, policies, and procedures			resident requiring a glucometer		
		ich must include, but are not			check, and to only take one strip in	to	
	limited to:				room to use for that resident requ	iring	
	(i) A system of surve	eillance designed to identify			check.		
	possible communica	able diseases or infections					
		ead to other persons in the			3) DCS to provide re-education to		
	facility;				Licensed nurses on 08/30/2017 in	regards	
	(ii) When and to wh	om possible incidents of			to the policy/procedure for infection	n	
		ase or infections should be			control as related to the use of		
	reported;				glucometers		
					DCS/Unit manager to observe		
		ansmission-based precautions			Infection control practices during		
	to be followed to pre	event spread of infections;			Medication pass observation mont	hly	
	(iv) When and how resident; including b	isolation should be used for a out not limited to:			Follow up based on findings		

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING			С	
1141 1 0 0		490309	B. WING			08/03/2017	
	PROVIDER OR SUPPLIER DF WINCHESTER, LL	c		110 L	ET ADDRESS, CITY, STATE, ZIP CODE AUCK DR CHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 441		age 57 uration of the isolation, e infectious agent or organism	F	141	4) The observation results will be disc	Zuázeů	
	involved, and				In the QAPI committee meetings		
(B) A requirement		that the isolation should be the ssible for the resident under the			The committee will review and ma	ke	
	circumstances.				recommendations as needed		
(v) The circumstances under which the must prohibit employees with a commun disease or infected skin lesions from dir contact with residents or their food, if dir contact will transmit the disease; and		oyees with a communicable skin lesions from direct nts or their food, if direct			to sustain substantial compliance 5) Compliance date: 09/05/201	7	
		ne procedures to be followed direct resident contact.					
		cording incidents identified IPCP and the corrective e facility.					
		nel must handle, store, port linens so as to prevent the					
	(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced						
	by: Based on observarecord review, and was determined the follow infection conspread of infection administration for the	tion, staff interview, clinical facility document review, it at the facility staff failed to trol practices to prevent the and disease during medication wo of 6 residents in the stration observation; Residents					
	While preparing an	d administering medications to					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/15/2017 APPROVED : 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		CONSTRUCTION	TAG (EX)	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 087	03/2017
ENVOY (of winchester, Ll	C		110	LAUCK DR NGHESTER, VA 22603		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	ле 58	. 1-:	141	el se vicinissocomanistromanismo antico. L. J. J.	10000011121	!
, , , ,	•	_	F 1	+41			İ
ı		cility staff (LPN [licensed failed to sanitize the					
!		re and after use; and laid the					
		the resident's bed. LPN #2					:
		glucometer to obtain		i			
		l sugar reading, without	;	ļ			
		or having used it on Resident		ļ			
		the vial of test strips into the	! 				
	room of Resident #	5 .					
	The findings Include	יב					:
	The intumgs moreon		:	*	,		i
			}	;			
	Resident #11 was a	dmitted to the facility on		:			
		gnoses of but not limited to:					
		eg, depression, anxiety,		İ			1
		disease, chronic kidney					
		the submandibular gland,	:	Ì			!
		esterol, and high blood re recent admission, an MDS	Ì	;			
) had not yet been completed.					
		sing assessment documented	<u> </u>				
		ert to person and place only,					
	with some short and	d long term memory problems.	1	į			:
	m. f.l. 6.26m	N. M J. L H F 116		-	·		
		lmitted to the facility on	İ	•			
		Itted on 7/28/17 with the of limited to: sepsis, acute			•		
		apnea, large intestine		٠.			
		sity, high cholesterol,		!			:
		chotic features, chronic pain	1	Ì			
		od pressure, overactive		:			
		iy, an artificial eye, and					1
		t recent MD\$ (Minimum Data					;
		y assessment with an ARD			•		:
		ence Date) of 3/13/17. The					1
		as being cognitively intact in life decisions, scoring a 15					,
	- PRIOR TO WAKE DAIL	ODS OCHRENS SCOTING 21 12					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID:8GEZ11

Facility ID: VAC123

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PRINTED: 08/15/2017

		AND HUMAN SERVICES				PF	RINTED; FORM	08/15/2017 APPROVED
		& MEDICAID SERVICES	7	differentiated	COOR ARE 44	10	MB NO.	0938-0391
STATEMENT AND PLAN (l'OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		PLE CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	V HT Land Control of the Control of	Veni		STREET ADDRESS, CITY, STATE, ZIP COD		001	VOIZUII
ENVOY	OF WINCHESTER, LL			ı	110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH GROSS-REFERENCED TO THE API DEFICIENCY)	OULD	BE	(X6) COMPLETION DATE
F 441	out of a possible 15 for Mental Status) e coded as requiring bathing; supervisior transfers; was indepondent of bladder bowel. On 8/2/17 at 7:07 a Practical Nurse) was	ge 59 i on the BIMS (Brief Interview exam. The resident was extensive assistance for a for hygiene, dressing, and bendent for eating; and was and had an ostomy for	F	441				
	prepared the following Atenolol [2] 100 mg Glipizide ER (extend Lishnopril [4] 5 mg, 1 to Vitamin D3 [6] 1000 Ranexa [7] 500 mg,	ing medications: (milligrams), 1 tab (tablet) ded release) [3] 10 mg, 1 tab t tab ab units, 1 tab 1 tab						
	reading on Residen glucometer at the candinater medicate blood sugar. The resident she felt that it was regoing to re-test the medication cart, obtained a test strips Resident #11's room obtained a test strips the vial of test strips rechecked Resident administering the mands, LPN #2 return of lancets to the dra	ed obtaining a blood glucose that. She prepared the art, and went into the room to ons and test the resident's esuit of the blood sugar was per Deciliter). LPN #2 stated not a good sample and was resident. She returned to the ained additional lancets, and the LPN #2 re-entered nowith the vial of test strips, from the vial, and then laid to in the resident's bed as she that a blood sugar. After edications and washing her med the glucometer and vial over in the medication cart.	The state of the s					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/15/2017 APPROVED 0938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUKI		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER		<u></u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 087	03/2017
ENVOY	OF WINCHESTER, LL	C		1	LAUCK DR NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Continued From pa the vial of test strips	=	: . F	 441		**************************************	
	the viai of test strips	ş.					
	Practical Nurse) the Resident #5. She v administering media	.m., LPN #2 (Licensed en went to the room for vas observed preparing and cations for Resident #5. LPN		:	•		
	#2 prepared the foll Vitamin D 1000 unit Aspirin [8] 81 mg (n	s, 1 tab (tablets)	!	T			
	Ferrous sulfate [9] 3 Lanuts [10] 37 units Metformin [11] 1000	325 mg, 1 tab (Injection)) mg, 1 tab		:			voolninginging voolninging voo
	Diflucan (12] 100 m - Loratadine [13] 10 r - Coxybutynin [14] 10 r - Multivitamin [15], 1 - Novolog [16] 10 uni	ng, 1 tab mg, 1 tab tab					
	She then put on PP equipment, i.e., gov	E (personal protective /n, gloves) and went into the medications to Resident #5.					
		the glucometer or vial of test them with Resident #5, after vith Resident #11,		٠			
	interview was condu Practical Nurse). S	timately 9:30 a.m., an ucted with LPN #2 (Licensed he stated that she wipes down		:			
	her shift, and that the in contact with the r was not aware that	supplies at the beginning of ne glucometer does not come esident during testing, so she it was necessary to sanitize it ent unless a resident is on ction.	:	:			!
		ity policy for Medication of document any criteria for					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/15/2017 APPROVED : 0938-0391	
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		495389	B. WING	·		08/03/2017		
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ENVOY	OF WINCHESTER, LL	c '		Į.	LAUCK DR NGHESTER, VA 22603			
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F 441	Continued From pa	ce 61		441				
	1	supplies between each		· 7 * .				
	A review of the own glucometer docume			-				
	using this device. A monitoring system is potentially infectious transmitting blood-kepatients and health. The meter should be each patient. This system may only be patients when standmanufacturer's distribution of the public health in practice guideline is "FDA Public Health Fingerstick Devices Poses Risk for Transmitting for Transmitting Bid http://www.cdc.gov.vicesBGM.html NOTE:Glucose in testing multiple per disinfected between	precautions when handling or all parts of the glucose should be considered and are capable of porne pathogens between care professionals be disinfected after use on blood glucose monitoring a used for testing multiple dard precautions and the infection procedures are offication and standard ricks are: Notification: Use of son More than One Person insmitting Bloodborne Communication" (2010) MedicalDevices/Safety/Alertsa (205, htm.) Inder: Use of Fingerstick and One Person Poses Risk bodborne Pathogens" (2010) Injectionsafety/Fingerstick—Demeters in a clinical setting for sons must be cleaned and						

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Event ID:8GEZ11

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PRINTED: 08/15/2017

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		495389	B, WING		<u> </u>		C 8/03/2017	
NAME OF I	PROVIDER OR SUPPLIER	,	· · · · · · · · · · · · · · · · · · ·	STF	REET ADDRESS, CITY, STATE, ZIP CODE		0103/2017	
ENVOY	OF WINCHESTER, LL	C	110 LAUCK DR WINCHESTER, VA 22603					
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F 443		ge 62 s made aware of the findings. on was provided by the end of	F 4	141				
	(CDC): "Blood gluc measure blood gluc possible, blood gluc assigned to an indiv shared. If blood glu the device should b after every use, per to prevent carry-ove agents. If the manu the device should be then it should not be	enters for Disease Control ose meters are devices that cose levels. Whenever cose meters should be ridual person and not be cose meters must be shared, e cleaned and disinfected manufacturer's instructions, or of blood and infectious if acturer does not specify how e cleaned and disinfected e shared. injectionsafety/blood-glucose-						
:	test strip and report Information obtained https://www.diabete	a small device that reads the s your blood sugar level. d from seducator.org/patient-resourc behaviors/aade7-self-care-be						
	other medications to also is used to prev- Improve survival aft Information obtained https://medilneplus.j tml	d from gov/drug nfo/meds/a684031.h						
	[3] Giipiziae EK is u	sed along with diet and					1	

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Event IO:8GEZ11

Facility ID: VA0123

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PRINTED: 08/15/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \cap 495389 08/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR ENVOY OF WINCHESTER, LLC WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (Xa) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 63 F 441 exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore. cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a684060.h [4] Lisinopril is used alone or in combination with other medications to treat high blood pressure. It is used in combination with other medications to treat heart failure. Lisinopril is also used to improve survival after a heart attack. Information obtained from https://medlineplus.gov/druglnfo/meds/a692051.h tml [5] Actos is used with a diet and exercise program and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood). Information obtained from https://medlineplus.gov/druginfo/meds/a699016.h

FORM CMS-z567(02-99) Previous Versions Obsolete

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Immune systems.

Information obtained from

i [8] Vitamin D3 helps your body absorb calcium.
Calclum Is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and

https://vsearch.nlm.nlh.gov/vivisimo/cgi-bin/query-

meta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=vitamin+d&_ga=2.19 2500842.1377447934.1502114951-734861906.1

Event ID:8GE211

Facility ID: VA0123

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SEP 0 6 2017

"DIMINI

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/15/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		COM	E SURVEY PLETED
		495389	a. WING			•	i	03/2017
	PROVIDER OR SUPPLIER OF WINCHESTER, LL	С		110	REET ADDRESS, CITY, STATE LAUCK DR NCHESTER, VA 22603	E, ZIP CODE	1 30,	20/14/11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULI O THE APPROF	D BE	(X5) COMPLETION DATE
	[7] Ranexa is used medications to trea chest pain or press does not get enough information obtaine https://medlineplustml [8] Aspirin is used to people who have angina (of the heart does not the risk of death in or who have recent to prevent ischemic when a blood clot both brain) or mini-stroke the flow of blood to time) in people who or mini-stroke in the hemorrhagic stroke in the brain). Aspiricalled salicylates. If production of certal cause fever, pain, and information obtained the body to produce the body to produc	alone or with other t chronic angina (ongoing ure that is felt when the heart th oxygen). d from .gov/druginfo/meds/a606015.h o prevent heart attacks in ad a heart attack in the past or chest pain that occurs when get enough oxygen); to reduce people who are experiencing ly experienced a heart attack; c strokes (strokes that occur dlocks the flow of blood to the es (strokes that occur when the brain is blocked for a short or have had this type of stroke es past. Aspirin will not prevent es (strokes caused by bleeding in is in a group of medications it works by stopping the in natural substances that swelling, and blood clots, ad from .gov/druginfo/meds/a682878.h provides the iron needed by e red blood ceils. It is used to n-deficiency anemia, a rs when the body has too few ause of pregnancy, poor diet, r other medical problems.		441	RECI SEP 0	EIVED 6 2017 OLC		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/15/2017 APPROVED 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED		
		495389	B. WING	·		i	C 03/2017		
NAME OF I	ROVIDER OR SUPPLIER	0		STR	EET ADDRESS, CITY, STATE, ZIP C	CODE	03/2011		
ENVOY (OF WINCHESTER, LL	c	110 LAUCK DR WINCHESTER, VA 22603						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFIGIENCY)	SHOULD BE	COMPLETION DATE		
F 441	human insulin. Insu the insulin that is no and by helping mov other body tissues v also stops the livery information obtained https://medlineplus. tml [11] Metformin is us madications, including diabetes (condition use insulin normally control the amount information obtained https://medlineplus. tml [12] Diflucan is used including yeast infect throat, esophagus (to the stomach), ab- chest and waist), iur information obtained https://medlineplus. tml [13] Loratadine is us symptoms of hay fe other substances in information obtained https://medlineplus. tml [14] Oxybutynin is us	g-acting, man-made version of lin glargine works by replacing armally produced by the body e sugar from the blood into where it is used for energy. It from producing more sugar d from gov/druginfo/meds/a6D0027.h ed alone or with other ing insulin, to treat type 2 in which the body does not v and, therefore, cannot of sugar in the blood). If from gov/druginfo/meds/a696005.h et to treat fungal infections, ctions of the vagina, mouth, tube leading from the mouth domen (area between the ngs, blood, and other organs. If from gov/druginfo/meds/a690002.h ed to temporarily relieve the ver (allergy to pollen, dust, or the air) and other allergies. If from gov/druginfo/meds/a697038.h ed to treat overactive	F	441	SE	P 0 6 2017			
	bladder (a condition contract uncontrolla	in which the bladder muscles obly and cause frequent ed to urinate, and inability to			. VE	DHOLC			

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO: 0938-0391

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING	,	C 08/03/2017		
-	PROVIDER OR SUPPLIER DF WINCHESTER, LL		110	EET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR ICHESTER, VA 22603	1 0010012411		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 441	uncontrolled urinatioveractive bladder bladder muscles had information obtained https://medlineplustml [15] Multivitamin/micombination of vital sometimes have otherbs. They are also simply vitamins. Multivitamins. Multivitamins.	ontrol urgent, frequent, or ion in people who have (a condition in which the ave uncontrollable spasms).	F 441				
	when they cannot on nutrients from food. Information obtaine	or do not get enough of these					
	of human insulin. In replacing the insulir the body and by hel blood into other bod energy. It also stops more sugar. Information obtains	hort-acting, manmade version insulin aspart works by in that is normally produced by alping move sugar from the dy tissues where it is used for a sthe liver from producing ad from a gov/druginfo/meds/a605013.h					
F 465 SS=D	483.90(i)(5)	483.90(i)(5) BAFE/FUNCTIONAL/SANITARY/COMFORTABL		F Tag 465 1)The 6 ceiling tiles			
	(i) Other Environme			that were stained were replaced on 08/3/2017 by			
		ovide a safe, functional, ortable environment for		the maintenance director.			

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

PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

OTATEL (ENT DE DESIGNEMONES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495389	B. WING	C 08/03/2017
NAME OF PROVIDER OR SUPPLIER	## ## ## ## ## ## ## ## ## ## ## ## ##	STREET ADDRESS, CITY, STATE, ZI	
ENVOY OF WINCHESTER, LL	c	110 LAUCK DR WINCHESTER, VA 22603	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE COMPLETION HE APPROPRIATE DATE
applicable Federal, regulations, regardi and smoking safety non-smoking reside This REQUIREMEN by: Based on observat determined that the sanitary, and comforesidents, staff and resident hallways, (Six brown stained of the Gold, Red and (facility). The findings include A building tour was p.m. with OSM (oth director of maintenatiles were observed Outside room 22 the	the public. s, in accordance with State, and local laws and ng smoking, smoking areas, that also take into account ents. IT is not met as evidenced ion and staff interview it was facility staff failed to provide a rtable environment for the public on three of four Gold, Red and Green halls). eiling tiles were observed on Green resident hallways of the e: completed on 8/3/17 at 1:20 er staff member) #4, the ance. Six brown stained ceiling	F 465 2)Environmental rounds of by the Executive Director On 08/04/2017 to observe if any more of were stained, none found. 3) The maintenance director Educated on 08/4/2017 registained ceiling tiles to be reas soon as noted to be stain Executive Director to observationed ceiling tiles during or rounds in the facility month. 4) The results of the environ rounds will be taken to the for review and recommend to sustain substantial comp. 5) Compliance date: 09/05	eiling tiles d. or was garding eplaced ned. eve for any environmental nly. nmental QAPI meeting fations as needed
ceiling tile; outside to large brown stain woutside the "staff or ceiling tile and outsing tile. An interview was co	mately 5 inches round on the he oxygen storage closet a as observed on the ceiling tile; ly" closet there was a stained de room 43 there was a anducted on 8/3/17 at 1:35 er staff member) #4. OSM #4		CEIVED P 0 6 2017

stated, "I just got some new tiles in and I'll replace them. I was doing some work up there (indicating the stained tile outside the oxygen storage

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	E SURVEY
		40 5 3 0 0			W-basher		C
44.00 m. i		495389	B. WING			08/	03/2017
	PROVIDER OR SUPPLIER OF WINCHESTER, LL	C		1101	ÉET ADDRESS. CITY. STATE. ZIP COOE LAUCK DR ICHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(K5) COMPLETION OATE
F 465	Continued From pa	ge 68	F 4	-65			
	member) #1, the ad	.m. ASM (administrative staff Iministrator and ASM #2, the vere made aware of the					
	483.70(i)(1)(5) RES	on was provided prior to exit. ETE/ACCURATE/ACCESSIB	F 5	i14	F Tag 514 1)Resident #4's Medical Record is		
	 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- 				unable to be corrected however resident's medical record going forward will be maintain accurately .Resident's #7 clinical documentation was removed on	i	
	(i) Complete;				08/2/17 and placed in the correct		
	(ii) Accurately docur	mented;			medical record.		
	(iii) Readily accessil	ole; and			Quality review completed by DCS/designee of medical record		
	(îv) Systematically o	rganized			s for current Residents for		
	(5) The medical rec	ord must contain-			completeness. Incomplete records corrected if possible, per		
	(i) Sufficient informa	ition to identify the resident;			regulatory standards. Quality review conducted		
	(ii) A record of the re	esident's assessments;			by DCS/designee on current		
	(iii) The comprehent provided;	sive plan of care and services			resident's medical records to ensure that residents records are in the correct		:
	(iv) The results of ar and resident review determinations cond				residents clinical record.		

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PRINTED: 08/15/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING	:		Ç
NAME DE I	PROVIDER OR SUPPLIER	493309	D. WING		TREET ADRIGOS CITY OTLITE TIP CORP.	08/03/2017
					TREET ADDRESS. CITY, STATE, ZIP CODE IP LAUCK DR	
ENVOY	OF WINCHESTER, LL	C		l	/INCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 514	Continued From pa	ge 69	F 5	514	3) Education provided to	
	A.A. Film on indicated and account				clinical staff by the DCS on 08/30/17	7
	professional's progr	se's, and other licensed		,		
professional's progre		eas notes, and			in regards to complete and accurate documentation.	
		ology and other diagnostic			Education given to the Medical reco	rde
		required under §483.50.			Clerk by the Executive Director	
	this requirements	NT is not met as evidenced			on 08/04/17 on ensuring that the	
	2	ion, staff interview, clinical			correct record is filed in the correct	
	record review, and facility document review, it was determined that the facility staff failed to				resident's clinical record.	
		and accurate clinical record nts in the survey sample;			10 % of current	
	Residents #4 and #				resident's clinical records	
					to be reviewed by the DCS/	
		off failed to document a pain			designee monthly to ensure	
	assessment for Res	dent #4, including (a pain scale), quality			records are complete and	
	descriptors of pain,				accurate. Staff will be re-educated	
		al interventions attempted ration of pain medication,			if indicated.	
	and/or post-adminis	tration follow up assessment April 2017, 20 occasions in			4) The plan of correction and	•
		sions in June 2017, and 9			Clinical record reviews will be	
	occasions in July 20				Discussed by the Executive	
	سرس پارو، س بسیست و				Director during the QAPI	
		failed to document the eekly vital signs in Resident			Committee Meeting Monthly	
		or 2 weeks in April 2017, and			The Committee will recommend	
	4 weeks each for the	e months of May 2017, June			needed revisions to the plan	
	2017, and July 2017	, -			to sustain substantial compliance.	Ť
		inical record contained				
	documents that belo	onged to another resident.			5) Compliance date: 09/05/2017	
	The findings include	t .				

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1.a. Resident #4 was admitted to the facility on

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PRINTED: 08/15/2017 FORM APPROVED OMB NO 0938-0301

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	(X3) DATI COM	U938-U391 E SURVEY PLETED
		495389	B. WING			1	Charles
	PROVIDER OR SUPPLIER OF WINCHESTER, LL	3		110	REET ADDRESS, CITY, STATE, ZIP CODE D LAUCK DR INCHESTER, VA 22603	1 00/	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	with the diagnoses of palsy, insomnia, low spasticity, depression delusional disorder, The most recent MI quarterly assessme Reference Date) of coded as being mode make daily life decisions possible 15 on the Electronia Mental Status) examing the status of the clinic for Hydrocodone-Acting (milligrams), takeneeded for pain. The updated monthly via A review of the clinic (Medication Administing May 2017, June 2017, and 9 of these administration 2017, all 20 of the all 17 of the administration of the administration of the recomponents include assessment of the recomposition of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents include assessment of the recomponents included assessment of	ded most recently on 1/13/17 of but not limited to cerebral of blood pressure, hypertonia on, arthritis, anxiety, paranoia, and osteoporosis. DS (Minimum Data Set) was a not with an ARD (Assessment 5/16/17. Resident #4 was derately impaired in ability to sions, scoring an 11 out of a BIMS (Brief Interview for n. Resident #4 was coded as for bathing; extensive care for and hygiene; supervision for athent of bowel and bladder. The lab every 6 hours as the date of this order was a 30 day prescription renewal. The resident was are on 29 occasions in April In May 2017, 17 occasions in becasions in July 2017. Of the resident was are on 29 occasions in April In May 2017, 17 occasions in becasions in July 2017. Of the 19 times in April dministrations in May 2017, trations in June 2017, and all ons in July 2017 did not the necessary ain management. Missing d pre-administration	F	514			

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Event ID:8GEZ11

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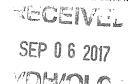
		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 08/15/2 FORM APPROV MB NO. 0938-0	VED.
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B, WING	·		C 08/03/2017	,
NAME OF F	PROVIDER OR SUPPLIER	AN W PARTIES IN THE SELECTION A. S. A.	· .	}	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2037	
ENVOY	OF WINCHESTER, LL	C		1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCE) TO THE APPROI DEFICIENCY)	D B@ COMPLET	
F 514	Continued From pa	ge 71	F	514		Sample of the Control	
	•	sment of the resident's pain,				•	
	conducted with LPN #11. She stated that about the location a that non-pharmacolattempted. LPN #11 the resident afterwal assessment and folion the back of the N	m., an interview was I (Licensed Practical Nurse) at she does ask the resident and intensity of her pain, and ogical interventions are 1 stated she follows up with rds. She stated that the low up should be documented IAR and on the pain flow ted, "We don't always nould."					
	conducted with RN stated that she asks on a scale 0-10, locanon-pharmacological about documenting #7 stated, "I don't the On 8/3/17 at approx (Director of Nursing Staff (ASM) #2) was No further information the survey. References; [1] Norce is hydrocological about documenting the survey.	imately 2:00 p.m., the DON - Administrative Corporate made aware of the findings, on was provided by the end of done in combination with is used to relieve pain.					
							;

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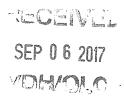
		AND HUMAN SERVICES & MEDICAID SERVICES					FORM.	08/15/2017 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	O	(X3) DATE	0938-0391 SURVEY PLETED
		495389	B. WING				0876 0876	03/ 2017
NAME OF	PROVIDER OR SUPPLIER			STF	EET ADDRESS, CITY, STATE, ZIP (CODE	00/	JULEUII
ENVOY	of winchester, ll	c ·	İ		LAUCK DR NCHESTER, VA 22603.			٠.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD EAPPROPE	BE	(X5) COMPLETION DATE
	physician ordered w #4's clinical record if 4 weeks each for th 2017, and July 2017 Review of the clinical dated 11/11/16 for " Wednesday." A rev staff failed to docum weekly vital signs in weeks in April 2017 months of May 2017 On 8/3/17 at 11:15 a #4, she stated they documented in the r times, they (vital sig- unit logbook which or residents as well. It logbook is not part of (vital signs) would in resident's clinical re On 8/3/17 at approx (Director of Nursing Staff (ASM) #2) was No further information the survey. According to "Fundal Incredibly Easy Lipp Philadelphia PA pag Is a highly significant is a fundamental fea- records are legally vand comprehensive communicated effect	failed to document the veekly vital signs in Resident for 2 weeks in April 2017, and e months of May 2017, June 7. all record revealed an order Weekly Vitals every fiew of the MAR revealed that nent the physician ordered the clinical record for 2, and 4 weeks each for the 7, June 2017, and July 2017. a.m., in an interview with LPN (vital signs) should be record. LPN #4 stated many ins) will be documented on a contains information for other LPN #4 stated the unit of the clinical record, and they of get logged into each cord. cimately 2:00 p.m., the DON - Administrative Corporate is made aware of the findings on was provided by the end of eamentals of Nursing Made sincott Williams and Wilkins, see 23: Nursing documentation at its use since documentation at the said, and need to be accurate	F	514				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/15/2017 APPROVED
STATEMENT	of deficiencies Forrection	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY PLETED
	·	495389	B. WING	i			C /03/2017
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
ENVOY	OF WINCHESTER, LL	Ċ			10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	quality of care may do not realize that we record can produce care that is provided health care team." 2. Resident # 7's cli documents that belonger that is provided health care team." 2. Resident # 7's cli documents that belonger that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions that inclusions gastroesophageal with an ARD (asses 7/10/17 coded the residual that an ARD (asses 7/10/17 coded the residual that inclusions that inc	of patient and family care, not be possible. Many nurses what they document or fall to an enormous effect on the d by other members of the mical record contained onged to another resident. Idmitted to the facility on 1/3/05 readmitted on 11/22/16 with reded but were not limited to: lis (1), depression, reflux disease (2), anxiety, and Resident # 7's most recent a set) a quarterly assessment sment reference date) of resident as scoring a 15 on the ental status (BIMS) of a score that Resident # 7 was Resident # 7's clinical record, and to another resident were lent # 7's record. On 8/2/17 at 10:20 a.m. with restaff member) # 1, the oncern was shared. ASM # 1	F	514			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION	1	. 0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	ING _		COM	PLETED
		495389	B. WING			1	C (03/2017
NAME OF F	PROVIDER OR SUPPLIER		1 <u></u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		03/2017
ENVOY (OF WINCHESTER, LL	c			0 LAUCK DR		
(X4) ID	ATS YGAMMI(S	TEMENT OF DEFICIENCIES	· · · · · · · · · · · · · · · · · · ·	٠,٠	INCHESTER, VA 22603	***************************************	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From pa	ae 74	; 	, 514		,	
•	records are maintai	ned in accordance with		117			•
		e standards to provide rate information on each					i
:	resident for continu	ity of care. The clinical record					
:		nation to identify the resident the resident;					
•	the plan of care and	l services; the results of			•		
		ening; and progress notes inge toward achieving the care					
;	plan objectives. In	addition, the resident's clinical		;			
	record shall be read	tily accessible and hized to facilitate retrieving		1			,
	and complling inforr	mation. All information					
		ident's clinical record, rm or storage method, shall					
:	be considered confi	dential. The facility has the		:			
		clinical record, but the steeted right of information.					
į	The propose of the	clinical record is to document					
		sident's plan of care and to if communication among					
		onals involved in this care"					
and distance	According to "Funda	amental Nursing Skills and		:			
	Concepts": Eighth	edition, Chapter 3, pg. 36	•				:
		are setting requires accurate mentation: The medical					
	record is a legal dod	cumentRecords must be	· :				
	timely, objective, ac legible"	curate, complete and	•				
							:
	No further information	on was provided prior to exit.					:
!	References:				•		
		Makes your bones weak and					
!	more likely to break	. This information was					

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obtained from the website:

https://www.nlm.nih.gov/medlineplus/osteoporosi

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495389	8. WING			C	
NAME OF PROVIDER OR SUPPLIER ENVOY OF WINCHESTER, LLC				110	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	_08	3/03/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)			HOULD BE COMPLETION	
ti ()	contents to leak, or and irritate it. This is the website: attps://www.nlm.nih 3) Bipolar disorder manic-depressive illicates unusual shift evels, and the abilit bymptoms of bipola hey are different frowns that everyone ime. This informativebsite:	eal reflux disease — Stomach reflux, into the esophagus information was obtained from gov/medlineplus/gerd.html.	F	514:			

FORM CMS-2587(02-99) Previous Versions Obsolete

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