STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid First Revisit survey to the survey conducted 07/17/2018 through 07/23/2018 was conducted 09/17/2018 through 09/19/2018. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. The census in this 174 certified bed facility was 159 at the time of the survey. The survey sample consisted of 20 resident reviews.	{F 000}	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws require it.	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to respect resident privacy for one resident, Resident #131, in a sample of 20 residents. For Resident #131, facility staff failed to knock before entering the resident room during an interview.	F 557	F 557 Respect, Dignity/Right to have Personal Property 1.An Ad-Hoc Quality Assurance /Performance Improvement (QAPI) meeting was held on 9-28-18. Resident # 131 was interviewed by the Director of Nursing (DON), and was asked if resident's privacy had been violated. Resident # 131 stated that resident's privacy had not been violated by staff not knocking before entering the resident's room. Resident #131 suffered no harm.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 10/7/18

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

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F 557	Continued From page 1 The findings included: On 09/18/2018 at 2:05 p.m., this surveyor was interviewing Resident #131 with the door to the resident room shut. During the interview, the door was opened without a preceding knock or call, and a facility staff member, RN B, entered the room. Upon seeing this surveyor, RN B stated "oops!" and knocked on the open door. RN B stood in the door for 1-2 seconds, until Resident #131 said "I'm with someone.", at which point RN B said "I'll come back later" and left the room, closing the door behind herself. On 9/19/2018 at 2:40 p.m., the Director of Nursing (DON) was asked about the expectation for staff entering residents' rooms when the door is closed. She stated: "I expect them to knock on the door and ask if they can come in". The Administrator and DON were informed of the findings at the end of day meeting on 09/19/2018. No new information was provided.	F 557	2. DON/designee conducted a Quality Review of staff to ensure they are knocking on doors prior to entering a resident's room to maintain the resident's privacy. Follow up was done based on findings. 3. DON/designee provided re-education to facility staff on regulation F557 with emphasis on knocking on doors prior to entering a resident's room to maintain the resident's privacy. 4.DON/designee to complete Quality Improvement monitoring of staff knocking on doors prior to entering a resident's room to maintain the resident's privacy. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Date of compliance: 10/30/18	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview the facility staff failed to accommodate the needs of 1 resident (Resident #122) of 20 residents in the survey sample.	F 558	F 558 Reasonable Accommodations Needs/Preferences 1. An Ad-Hoc QAPI meeting was held on 9-28-18. Resident #122 was interviewed by the DON to make sure resident was being offered blankets when requested. No further complaints by resident #122 were noted at that time. Resident #122 suffered no harm.	

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F 558	Continued From page 2 Resident #122 asked staff for an extra blanket on her bed because she was cold at night. Staff told her to ask for the blanket during another shift. The findings included: Resident #122, a 73 year old, was admitted to the facility on 8/17/18. Diagnoses included depression, hypertension, anemia, dysphagia, and hypothyroidism. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 8/31/18. Resident #122 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 9/19/18 at 9:00 a.m., Resident #122 stated that she needed another blanket for her bed because she was cold at night. She stated that she had been sleeping with her sweater on for the past week. When asked if she had notified staff that she was cold at night, she stated that she had informed Certified Nursing Assistant D (CNA D) that morning and asked for an extra blanket. Resident #122 stated that CNA D told her that she was probably cold because her bed was located under the air conditioning unit. CNA D told Resident #122 that she needed to ask staff on a different shift for a blanket. Certified Nursing Assistant C (CNA C) was in the hallway at this time. She was asked to help Resident #122 with an extra blanket. CNA C walked to the linen cart on Unit 4 to get a blanket. There were no blankets on the cart. Registered	F 558	2. DON/designee conducted a Quality Review of current residents to ensure they are being provided with blankets when requested. Follow up was done based on findings. 3.DON/designee provided re- education to facility staff on regulation F558 with emphasis on meeting the needs of residents by providing blankets to residents when requested. 4. DON/designee to complete Quality Improvement Monitoring of residents to ensure their requests for blankets are being met. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Date of compliance: 10/30/18	

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F 558	Continued From page 3 Nurse C (RN C) went to the laundry in the basement and got a blanket. She arranged it on the bed for Resident #122. Resident #122 told RN C that she had been sleeping in her sweater because she was cold at night. The Administrator, Director of Nursing and Corporate Nurse were notified of the issue at the end of day meeting on 9/19/18. COMPLAINT DEFICIENCY	F 558		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 1 resident (Resident # 105) in the survey sample of 20 residents, to facilitate a room change in an appropriate manner. For Resident #105, who had a diagnosis of	F 559	F 559 Choose/Be Notified of Room/Roommate Change 1. An Ad-Hoc QAPI meeting was held on 9/28/18. Resident #105 no longer resides at the facility. 2. DON/designee conducted a Quality Review of residents with room changes over a 30 day look back to ensure the room changes were done in an appropriate manner. Follow up was done based on findings. 3. DON/designee provided re-education to facility staff on regulation F559, with emphasis on ensuring room changes are done in an appropriate manner. 4. DON/designee to complete Quality Improvement Monitoring of room changes to ensure they are done in an appropriate manner. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

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F 559	Continued From page 4	F 559		

Paranoid Schizophrenia, the facility staff failed to prepare and follow up after transferring her from a double room to a Quad room with three new roommates.

The Findings included:

Resident #105 was a 72 year old who was admitted to the facility on 12/22/17. Resident #105's diagnoses included Paranoid Schizophrenia, Diabetes Mellitus-Type 2, Dementia without Behavioral Disturbance, Dysphasia Oropharyngeal Phase, Hypertension, and Hypothyroidism.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/12/18, coded Resident #105 as having a Brief Interview of Mental Status Score of 8, indicating moderate impairment in daily decision making ability. In addition, she was coded as having exhibited verbal behavioral symptoms. Resident #105 was not coded as having any physical or other behavioral symptoms, or any rejection of care.

On 9/19/18 at 2:00 P.M., an interview was conducted with the facility Administrator (Administration A). He stated that Resident #105 was transferred to the hospital on 8/1/18 due to several incidents of attacking other residents in the facility. He further stated that her room had been changed at her request after a verbal altercation on 2/20/18 with her roommate. The Administrator was unable to submit documentation of any incidents with other residents prior to 8/1/18. On 8/1/18 at approximately 11:00 P.M. Resident #105 was sent to the hospital for a psychiatric evaluation.

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F 559	Continued From page 5 The Administrator submitted a copy of an immediate discharge letter which was signed at 9:00 A.M. on 8/2/18, less that 12 hours after her transfer. On 9/19/18 at 3:00 P.M., an interview was conducted with the facility social worker (Employee B). She was unable to provide any documentation regarding involvement of her department in Resident #105's room change from room 315 B to 314 D. There was no documentation the Resident #105 had requested the change. There was no documentation that Resident #105 had been prepared for the room change. There was no documentation that Resident #105's new roommates had been prepared for her arrival. There was no documentation that there had been follow-up to determine how the residents involved were adjusting to the change. On 9/19/18, a review was conducted of Resident #105's clinical record, revealing her careplan. The careplan did not address the room change. On 8/1/18, the facility submitted a Facility Reported Incident which stated that Resident #105's roommate had accused Resident #105 of hitting her at an unspecified time during the past. The facility did not have documentation that an investigation had been conducted. No further information was submitted. Complaint Deficiency	F 559		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622	F 622 Transfer and Discharge Requirements Immediate 1. An Ad-Hoc QAPI meeting was held on 9/28/18. Resident # 105 no longer resides at the facility.	

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F 622	Continued From page 6 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622	2. Social Services/designee conducted a Quality Review of resident discharges over a 30 day look back to ensure the immediate discharges were facilitated appropriately and included adequate documentation and preparation. Follow up was done based on findings. 3. Regional Vice President of Operations (RVPO) provided education to the Executive Director (ED) on regulation F-622 with emphasis on facilitating discharges and ensuring adequate documentation and preparation is in place to support an immediate discharge. ED/designee provided education to the Interdisciplinary Team (IDT) on regulation F622 with emphasis on facilitating discharges and ensuring adequate documentation and preparation is in place to support an immediate discharge. 4. Social Services/designee to conduct Quality Improvement Monitoring of immediate discharges to ensure adequate documentation and preparation is in place to support the discharge. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

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F 622	Continued From page 7 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 8 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 1 resident (Resident # 105) in the survey sample of 20 residents, to facilitate an appropriate discharge. For Resident #105, who had a diagnosis of Paranoid Schizophrenia, the facility staff failed to facilitate adequate documentation, and preparation for an immediate discharge. The Findings included: Resident #105 was a 72 year old who was admitted to the facility on 12/22/17. Resident #105's diagnoses included Paranoid Schizophrenia, Diabetes Mellitus-Type 2, Dementia without Behavioral Disturbance, Dysphasia Oropharyngeal Phase, Hypertension, and Hypothyroidism. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/12/18, coded Resident #105 as having a Brief Interview of Mental Status Score of 8, indicating moderate impairment in daily decision making ability. In addition, she was coded as having exhibited verbal behavioral symptoms. Resident #105 was not coded as having any physical or other behavioral symptoms, or any rejection of care.	F 622		

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F 622	Continued From page 9 On 9/19/18 at 2:00 P.M., an interview was conducted with the facility Administrator (Administration A). He stated that Resident #105 was transferred to the hospital on 8/1/18 due to several incidents of attacking other residents in the facility. He further stated that her room had been changed at her request after a verbal altercation on 2/20/18 with her roommate. The Administrator was unable to submit documentation of any incidents with other residents prior to 8/1/18. On 8/1/18 at approximately 11:00 P.M., Resident #105 was sent to the hospital for a psychiatric evaluation. The Administrator submitted a copy of an immediate discharge letter which was signed at 9:00 A.M. on 8/2/18, less that 12 hours after her transfer. The facility had not received an evaluation of Resident #105's condition. There was no evidence that Resident #105's physician had documented a justification for an immediate discharge. In addition, the Administrator was unable to provide documentation that the discharge document had been delivered to resident # 105, or her guardian, or to the hospital. When asked for a copy of the facility policy on immediate discharge from the facility, the Administrator stated, "We don't have a specific policy, I just go by the regs." On 9/19/18 at 9:30 A.M., an interview was conducted with the complainant (Other C). She was Resident #105's social worker at the hospital. She stated that she was told by facility staff verbally that Resident #105 would be allowed to return to the facility one she had been evaluated, and stabilized. Once Resident #105 was ready for discharge from the hospital, the facility	F 622		

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F 622	Continued From page 10	F 622		

Administrator informed her via telephone that Resident #105 had been issued an immediate discharge on 8/2/18 at approximately 9:00 A.M. The social worker stated that neither she nor Resident #105's guardian had received a copy of the discharge, and that the facility refused to allow Resident #105 to return. The social worker further stated that Resident #105 was able to return the next day, but had to wait 30 days in the hospital until another nursing home bed became available at another facility.

On 9/19/18 at 3:00 P.M., an interview was conducted with the facility social worker (Employee B). She was unable to provide any documentation that Resident #105 had a history of physical altercations with other residents or staff. She was unable to provide any documentation regarding involvement of her department in Resident #105's room change from room 315 B to 314 D. There was no documentation the Resident #105 had requested the change. There was no documentation that Resident #105 had been prepared for the room change. There was no documentation that Resident #105's new roommates had been prepared for her arrival. There was no documentation that there had been follow-up to determine how the residents involved were adjusting to the change.

On 9/19/18, a review was conducted of Resident #105's clinical record, revealing her careplan. The careplan did not address physical altercations with other residents or staff. The care plan did not address Resident #105's room change.

On 8/1/18, the facility submitted a Facility Reported Incident which stated that Resident

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F 622	Continued From page 11 #105's roommate had accused Resident #105 of hitting her at an unspecified time during the past. The facility did not have documentation that an investigation had been conducted. No further information was submitted. Complaint Deficiency	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626	F 626 Permitting Residents to Return to Facility 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident # 105 no longer resides at the facility. 2. Executive Director/designee conducted a Quality Review of discharged residents over a 30 day look back to ensure residents are permitted to return to the facility when applicable. Follow up was done based on findings. 3. The RVPO provided education to the Executive Director (ED) on regulation F-626 with emphasis on permitting residents to return to the facility when applicable. The ED provided education to the IDT team on regulation F-626 with emphasis on permitting residents to return to the facility when applicable. 4. Social Services/designee to conduct Quality Monitoring of discharged residents to ensure they are permitted to return to the facility when applicable. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 12 § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 1 resident (Resident # 105) in the survey sample of 20 residents, to allow her to return to the facility after an hospital psychiatric evaluation. For Resident #105, who had a diagnosis of Paranoid Schizophrenia, the facility staff failed to allow her to return to the facility after an hospital psychiatric evaluation. The Findings included: Resident #105 was a 72 year old who was admitted to the facility on 12/22/17. Resident #105's diagnoses included Paranoid Schizophrenia, Diabetes Mellitus-Type 2, Dementia without Behavioral Disturbance, Dysphasia Oropharyngeal Phase, Hypertension, and Hypothyroidism. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/12/18, coded Resident #105 as having a Brief Interview of Mental Status Score of 8, indicating moderate impairment in daily decision making ability. In addition, she was coded as having exhibited verbal behavioral symptoms.	F 626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 13	F 626		

Resident #105 was not coded as having any physical or other behavioral symptoms, or any rejection of care.

On 9/19/18 at 2:00 P.M., an interview was conducted with the facility Administrator (Administration A). He stated that Resident #105 was transferred to the hospital on 8/1/18 due to several incidents of attacking other residents in the facility. He further stated that her room had been changed at her request after a verbal altercation on 2/20/18 with her roommate. The Administrator was unable to submit documentation of any incidents with other residents prior to 8/1/18. On 8/1/18 at approximately 11:00 P.M., Resident #105 was sent to the hospital for a psychiatric evaluation. The Administrator submitted a copy of an immediate discharge letter which was signed at 9:00 A.M. on 8/2/18, less that 12 hours after her transfer. The facility had not received an evaluation of Resident #105's condition. There was no evidence that Resident #105's physician had documented a justification for an immediate discharge. In addition, the Administrator was unable to provide documentation that the discharge document had been delivered to Resident # 105, or her guardian, or to the hospital.

When asked for a copy of the facility policy on immediate discharge from the facility, the Administrator stated, "We don't have a specific policy, I just go by the regs."

On 9/19/18 at 9:30 A.M., an interview was conducted with the complainant (Other C). She was Resident #105's social worker at the hospital. She stated that she was told by facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 14	F 626		

verbally that Resident #105 would be allowed to return to the facility one she had been evaluated, and stabilized. Once Resident #105 was ready for discharge from the hospital, the facility Administrator informed her via telephone that Resident #105 had been issued an immediate discharge on 8/2/18 at approximately 9:00 A.M. The social worker stated that neither she nor Resident #105's guardian had received a copy of the discharge, and that the facility refused to allow Resident #105 to return. The social worker further stated that Resident #105 was able to return the next day, but had to wait 30 days in the hospital until another nursing home bed became available at another facility.

On 9/19/18 at 3:00 P.M., an interview was conducted with the facility social worker (Employee B). She was unable to provide any documentation that Resident #105 had a history of physical altercations with other residents or staff. She was unable to provide any documentation regarding involvement of her department in Resident #105's room change from room 315 B to 314 D. There was no documentation the Resident #105 had requested the change. There was no documentation that Resident #105 had been prepared for the room change. There was no documentation that Resident #105's new roommates had been prepared for her arrival. There was no documentation that there had been follow-up to determine how the residents involved were adjusting to the change.

On 9/19/18, a review was conducted of Resident #105's clinical record, revealing her careplan. The careplan did not address physical altercations with other residents or staff. The care plan did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 15 address Resident #105's room change. On 8/1/18, the facility submitted a Facility Reported Incident which stated that Resident #105's roommate had accused Resident #105 of hitting her at an unspecified time during the past. The facility did not have documentation that an investigation had been conducted. No further information was submitted. Complaint Deficiency {F 684} Quality of Care SS=D CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure the highest level of practicable well being for 1 resident (Resident #137) of 20 residents in the survey sample. For Resident #137, the facility failed to provide an appropriate object to manage chewing behaviors. Rather than provide the chew device recommended by the speech therapist, the facility staff provided a clothing protector for the resident to chew.	F 626	F 684 Quality of Care 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident # 137 suffered no harm. The resident's physician does not desire for her to have a chewing device at this time. The Resident will engaged in more group activities {F 684 and one to one activities to divert her from chewing on non-food items. 2. DON/designee conducted a Quality Review of residents with chewing behaviors to ensure that an appropriate plan of care is in place and it is being followed. Follow up was done based on findings. 3. DON/designee provided re-education to facility staff on regulation F684 with emphasis on ensuring residents with chewing behaviors have an appropriate plan of care in place and it is being followed. 4. DON/designee to complete Quality Improvement Monitoring on residents with chewing behaviors to ensure the plan of care is appropriate and is being followed. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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{F 684}	Continued From page 16	{F 684}		

The findings included:

Resident #137, a 64 year old, was admitted to the facility on 9/4/17. Her diagnoses included dementia, dysphagia, and oral fixation. Resident had her own teeth.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/24/18. Resident #137 was coded with severely impaired cognitive skills. She required extensive assistance with activities of daily living and was coded as a 4/2 (total dependence, one person assistance) for eating.

On 9/18/18 at 1:20 p.m., Resident #137 was observed in her room. She was seated in her wheelchair. Certified Nursing Assistant A (CNA A) was standing next to the resident singing and speaking to the resident. Resident #137 did not converse, but could provide one word answers to specific questions. Resident #137 wore a clothing protector made from wash cloth type material. The clothing protector was the full length of her torso. Resident #137 was observed to bite/ chew at the end of her finger tip. CNA A was asked if she was assigned to Resident #137. She stated that she was the sitter. When asked if she was assigned as a 1:1 sitter, CNA A stated yes. CNA A stated that facility staff were to supervise Resident #137 at all times while the resident was awake. CNA A felt that the residents chewing behavior was worse in the afternoon than in the morning.

While observing Resident #137, her lunch tray was delivered. Resident #137's diet order was a mechanical soft diet with puree meats. The foods on the tray were consistent with the diet order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 17	{F 684}		

Certified Nursing Assistant B (CNA B) fed Resident #137. In between each bite of food, Resident #137 grabbed the clothing protector with her fist and put it into her mouth. CNA B stated that it was usual behavior for Resident #137 to put the clothing protector in her mouth. When asked if she usually fed Resident #137, CNA B stated she fed Resident #137 when the resident was assigned to her as part of her daily assignment. She stated that Resident #137 was assigned to her that day.

Resident #137 was observed again on 9/19/18 at 8:45 a.m. She was seated in the unit dining room waiting for breakfast. CNA A was with the resident. Resident #137 alternated between chewing on her shirt and biting at the end of her finger tips. CNA A stated that she was waiting on someone to bring a clothing protector. Once CNA A put the clothing protector on Resident #137, the resident began to chew on the clothing protector. Shortly after, the breakfast tray was delivered and CNA A began to feed Resident #137.

On 7/30/18, the Nurse Practitioner assessed Resident #137 and competed a progress note. The staff concern was listed as "F/U (follow up) PICA." The note also read "I am here to follow up on this resident labs & medication therapy for ongoing PICA. I found this resident in the hallway eating on her shirt." The Assessment section read "2) PICA: unstable Will continue to monitor labs and medications reviewed. (Doctor name) is now aware."

Directly next to the above documentation regarding Pica, the doctor (Admin E) wrote the following note on 7/30/18 "MD (doctor) Addendum- Pt (patient) has Advanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 18	{F 684}		

Alzheimer's disease with an oral fixation and is chewing on multiple objects. 1-will correct Mg (magnesium) 2-will order speech evaluation 3-Patient is unable to participate with history or treatment plan and thus will not benefit from psychiatry and neurology consult 4-Add SSRI Zoloft 25 mg (milligram) QHS (every night) to attempt to reduce behavior."

After 7/30/18, there are no other progress notes from Admin E in the clinical record.

On 7/30/18, Admin E hand wrote a telephone order for "Speech Therapy Evaluation" and "Add Zoloft 25 mg QHS for Oral fixation and Advanced Alzheimer's".

The Speech Therapist (ST) completed the "ST Discharge Summary" on 8/4/18. The dates of service were documented as 7/18/18- 8/3/18. The Short-Term Goals read "Patient will demonstrate safe oral manipulation of a non nutritive resistive chewing device (i.e. Chewy Tube, Y-Chew, Etc) for up to 15 minutes without s/s aspiration, gagging or distress." It was documented that on 7/31/18 Resident #137 could use the chewing device "45+ minutes safe tolerance x 1 observation". Upon discharge on 8/3/18, it was documented that Resident #137 could use the chewing device "45+ minutes safe tolerance x 1 observation." The Short Term Goals "comments" section read, "Trials discontinued per DON (Director of Nursing)".

The Long-Term Goals read "Patient will demonstrate a reduced risk of ingesting inedible objects and inflicting self harm via safe use of a non-nutritive resistive chewing device between meals." Upon discharge on 8/3/18, it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 19	{F 684}		

documented that "ST recommendation for non-nutritive resistive chewing device completed 'Ark's Y-chew' with extensive written and verbal education and training completed to all caregivers." The Long Term Goals "comments" section read, "Device and ST discontinued per DON".

The ST Discharge Summary "Summary of Care" section read "Summary of Skilled Services Provided: Dysphagia management therapy to determine a safe and effective intervention to decrease frequency of inappropriate chewing behaviors due to PICA. Devices trialed were obtained from "Performance Health Professional Rehabilitation Equipment and Supplies 2018" catalog and can be referenced on page 433. Devices obtained included #565825 'Super Chewy Tube' and #081566272 'Blue Y-Chews'. The Super Chewy Tube was determined not to be an appropriate option for this patient due to the small size and flexibility of the device that increased risk of choking. The 'Y-Chew' was determined to be a viable candidate for this patient to assist in oral exploration and to provide sensory exploration as the device is more rigid and is designed to easily reach the back molar area and has textured durable surfaces."

"Patient Progress and Response to Treatment: ST recommendations were submitted for the Ark Y-Chew resistive chewing device. Patient had demonstrated safe tolerance of this device for 45+ minutes during ST observation with no wear or tear observed on the device. Extensive written and verbal education was provided for safety instructions (located in chart as well as provided to unit manager, DON, and DOR) including; 1. Providing device to patient between meals, when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 20	{F 684}		

out of bed and when in line of sight supervision by caregivers. 2. Caregivers to hand the device to the patient, not to place the device in her mouth. #. Caregivers to remove the device when the patient was not alert and/or when she was out of line of sight supervision. 4. Caregivers to check device for wear and tear at the end of each shift. 5. Caregivers to clean device per manufacturer recommendations (handbook placed in hard chart) at the end of each shift. 6. Oral care to be completed x2/day in am and pm. 7. Caregivers to notify SLP (speech therapist) immediately with observed safety concerns, wear and tear on device and other concerns."

"Upon completion of ST recommendations, the device was removed from the patient by the DON. ST provided verbal rationale for the safety of this device when patient is under appropriate level of supervision and reviewed all safety instructions which were then again provided in writing. Further trials were recommended by ST under supervision of the SLP for further risk assessment. DON requested that device not be used as an intervention at this time due to risk of potential patient harm and choking."

"ST to discharge as this time with continued recommendation for use of this non-nutritive device under caregiver supervision following the safety instructions as listed above per nursing discretion. No other non-nutritive chewing devices are recommended by ST."

"Recommend continuation of mechanical soft diet textures with pureed meats and thin liquids with assistance to feed non finger food items. Caregivers to ensure patient is sitting upright and alert during meals Caregivers to offer 1 finger

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 21	{F 684}		

food at a time at meals. Caregivers to ensure slow rate of intake, appropriate bite size and that patient remains upright at least 30 min after meals. Recommend that caregivers provide appropriate snacks between meals and that all inedible objects are removed from patient's reach and from her immediate vicinity at all times (i.e. items from carts or counter tops that the resident is sitting beside and maintain appropriate distance between resident and other residents in the dining room and hallways)."

NOTE: The diet recommended on 8/4/18 is the same diet order Resident #137 has during the standard survey.

On 7/31/18, the ST wrote her recommendations on a telephone order sheet. The recommendations read "1. ST refortification; Continue Speech Therapy x 2 visits x 1 week." and "2. ST recommendation: "Ark's Y-chew" chewing device between meals as tolerated." The word VOID was written through the Ark's Y-chew recommendation.

On 9/19/18 at 9:10 a.m., an interview was conducted with the ST. The ST stated she had a physician order to complete the consult. She stated that she writes her recommendations on a telephone order sheet and the nurse takes the orders off the chart. The ST was notified that someone had written the word VOID on the recommendation for the Y-Chew. When asked if she had voided her own recommendation, the ST stated no. It was reviewed with the ST that her note documented that the DON discontinued the speech therapy trials and the DON also discontinued the use of the Y-Chew. When asked why the DON discontinued the use of the Y-chew,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 22	{F 684}		

the ST stated that the DON had observed Resident #137 with the Y portion of the chew inserted in her mouth. She stated that the DON felt the Y-chew was a choking hazard. When asked if the DON who had discontinued the Y-Chew was the new DON or previous DON, ST stated it was the new DON. The ST was asked if she had any interaction with the physician (ADMIN E) regarding Resident #137's care. The ST stated no. The ST stated that all communication regarding the resident had been with nursing.

On 9/19/18 at 2:15 p.m., an interview was conducted with the DON. When asked what the survey team should see as related to the management of Resident #137's chewing behaviors, the DON stated that the resident was to have 1:1 supervision when she was awake. She stated that the importance of the supervision was to ensure that Resident #137 did not get a hold of anything that was a choking hazard. When asked why she had discontinued the Y-chew device, the DON stated that she had concerns that the Y-chew was a choking hazard. When asked if Resident #137 was being supervised (as per ST written instruction) at the time she (DON) had observed the resident with the Y-Chew, the DON stated no. When asked for the start date of the 1:1 supervision of Resident #137, the DON stated she did not know. When asked if the physician was notified or involved in the decision to not use the Y-Chew, the DON stated that the physician was aware. It was reviewed with the DON that there was no nursing notes documenting any communication between nursing and the physician regarding the ST recommendations or the physician's decision not to use the Y-Chew. It was also reviewed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 23 there was no documentation by the physician or the Nurse Practitioner regarding the ST recommendation to use the Y-Chew. When asked if she wrote VOID on the ST telephone order for the Y-Chew, the DON stated no. When asked if she knew who voided the recommendation, the DON stated no. When asked who is the most qualified health professional to identify an appropriate, safe device for chewing behaviors and oral fixation behaviors, the DON stated it was the responsibility of the Speech Therapist. The DON was asked who had decided to use the clothing protector in substitution for the Y-Chew. The DON stated that the clothing protector was put into place so that Resident #137 did not chew on her clothing. After the interview, the DON brought Corporate Nurse D in to speak with the survey team. Corporate Nurse D brought in a light blue Y-Chew and the product instructions. She stated this was not the actual Y-Chew provided to Resident #137 but it was the same model. Corporate Nurse D stated that the product instruction she had now were the same as those left in the resident chart by ST. Corporate Nurse D stated that the Y-Chew was small and they thought Resident #137 would choke on it or bite through the material. The product instructions indicated the Y-Chews were made with different firmness. The product recommended for Resident #137 was of the least firm material. When asked if the nursing staff had talked with ST about using a Y-Chew with increased firmness, the DON and Corporate Nurse D stated no. It was reviewed that the ST assessed the resident for the safe use of the product and provided instructions regarding use, including that the resident needed to be	{F 684}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 24 supervised when using the Y-Chew. Corporate Nurse D and the DON stated that they disagreed with the ST recommendations to use the Y-Chew. When asked if chewing on a clothing protector was an acceptable alternative to the Y-Chew, Corporate Nurse D stated that the clothing protector is not being used in place of the Y-Chew but rather used to protect Resident #137's clothing. She stated that the clothing often became wet from saliva. Corporate Nurse D stated that when Resident #137 was sitting idle, she goes to work on her shirt. Corporate Nurse D stated that when Resident #137 is engaged in activity she does not chew. She said that the facility was managing her oral fixation though divisional activity using an activities volunteer. Lastly, Corporate Nurse D stated that Resident #137 is not on 1:1 supervision, rather she is to be closely observed by staff within a distance of a few feet. During the meeting, Resident #137's physician (Admin E) entered the room. Admin E stated that he did not feel that Resident #137 had a pica condition, rather she had a severe oral fixation. It was reviewed with Admin E that this change in diagnosis was documented in a consult note completed by the psychiatric nurse practitioner on 9/4/18. It is noted that Admin E initialed the psychiatric nurse practitioner's consult note on 9/16/18. It was reviewed with Admin E that the change in diagnosis was not documented in any progress note written by him or the Nurse Practitioner. It was reviewed with Admin E that the only documentation by him in the clinical record was the addendum he included on the Nurse Practitioner 7/30/18 note.	{F 684}		

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	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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{F 684}	Continued From page 25 When asked why he ordered a speech consult, Admin E stated that he thought that Resident #137's oral fixation could be managed by a dietary focus. He stated he didn't want to use a device (the Y-Chew) because it was a chocking risk. It is unclear whether Admin E observed Resident #137 using the Y-Chew. Admin E also stated that there was a safety concern with Resident #137 chewing on her hand or possibly choking on an object. It was reviewed with Admin E that there was no progress note documenting any of the information he had shared with the survey team during the interview. When asked how the nursing staff knew that he did not want to use the Y-Chew, Admin E stated that he did not communicate in a note, rather he told staff verbally. When asked if he ever spoke directly with the ST about Resident #137, he stated no- all communication was through the nurses. After the interview with the DON, Admin E and Corporate Nurse D, Resident #137 was observed in divisional activities by Surveyor #1 along with Corporate Nurse D. Resident #137 was chewing on her shirt and was not wearing a clothing protector. Corporate Nurse D asked Resident #137 a question. The resident stopped chewing on her shirt to give a one word answer. The Resident went back to chewing immediately after the one word answer until a second question was asked. The Resident answered again with one word, then continued chewing fingers and shirt immediately after each answer. The psychiatric nurse practitioner assessed Resident #137. The date of service was documented as 9/4/18 and the practitioner signed the document 10 days later on 9/14/18. The progress note read, "Resident eating/ chewing	{F 684}		

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	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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{F 684}	Continued From page 26	{F 684}		

non-food items since admission; Mg (magnesium) chronically low and may be contributing to her chewing/ hunger. Medical following and consulted regarding a possible nutritional deficit or electrolyte deficiency. MD (doctor) following electrolytes. Her nutritional needs seem to be met. She has advanced dementia with severe cognitive impairments making her child-like. It seems her chewing is more consistent with oral fixation found in young children. It is not consistent with a compulsion or PICA. The undersigned and several nurses observe her responding to the 'rooting reflex' that is stimulated when the corner of her mouth or cheek is stroked. She moves her open mouth looking for food in response. She does this repeatedly. She does admit during the interview that she is anxious and worried."

The psychiatric nurse practitioner documented in the "Past Psychiatric History" section "Zoloft 25 mg (milligram) added 7/30/19 (sic) per medical". She recommended an increase in Zoloft from 25 milligrams to 50 milligrams per day. According to Resident #137's September 2018 Medication Administration Record (MAR), the resident was already taking 50 mg of Zoloft at the time she was assessed by the psychiatric nurse practitioner. According to the MAR, the Zoloft 50 mg was started on 8/14/18. The physician wrote done on the progress note, with a signature and date of 9/16/18.

The nurse practitioner notes documented the following observations of Resident #137:

8/1/18 "I found this resident @ the nurses station chewing on her shirt."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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{F 684}	Continued From page 27 8/22/18 "was found at the nursing station" "She currently has pica and is chewing on her clothing" 8/29/18 "was found at the nursing station" "She currently has pica and is chewing on her clothing" 8/31/18 "usually found at the nurses station for close observation" "She currently has pica and is chewing on her clothing" Resident #137's care plan was reviewed. The Focus revised on 9/15/18 read, "(Resident name) has actual/ potential for impaired or inappropriate behaviors/ mood r/t (related to) risk for exposing self r/t (related to) consistently chewing and eating non eatable materials. AEB (as evidenced by): Chews on shirts, hands, etc. Behavior is not easily redirected does not make eye contact dx (diagnosis): Cataracts- nonsurgical candidate dx (diagnosis) Advanced Alz (Alzheimer's disease) dementia, GAD." The Goal read, "(Resident) will have interventions in place to minimize injury from eating non edible objects through next review." The Interventions included: anticipate and address resident needs, approach resident in a calm manner, introduce self when providing care, monitor environment for nonfood items and remove as needed, psychiatry consult as needed, redirect inappropriate behaviors as needed, staff to offer/ assist resident to wear clothing protector. Another Focus read, "(resident) is dependent on staff for activities, cognitive stimulation, social interactions r/t (related to) behaviors (puts objects in mouth) impaired visual acuity." One of the interventions dated 9/15/18 read, "Volunteer to provide 1:1 for divisional activities when	{F 684}		

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	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 684}	Continued From page 28 available." On 9/19/18 at the end of day meeting, the Administrator, DON and Corporate Nurse D were notified of the concerns regarding Resident #137.	{F 684}		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #116's Foley catheter was immediately secured by the nurse on 9-19-18, so that the tubing was not touching the floor. Resident #116 suffered no harm. 2. DON/designee conducted a Quality Review of current resident's with Foley catheters to ensure the tubing was not touching the floor. Follow up was based on findings. 3. DON/designee provided re-education to facility licensed staff on regulation F-690 with emphasis on ensuring Foley catheter tubing is not touching the floor. 4. DON/designee to complete Quality Improvement Monitoring on residents with Foley catheters to ensure they are not touching the floor. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 29	F 690		

ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility documentation review the facility failed to maintain a catheter in a manner to prevent the spread of infection for 1 resident (Resident #116) of 20 residents in the survey sample.

Resident #116's Foley catheter tubing was observed on the floor on two occasions.

The findings included:

Resident #116, a 64 year old, was admitted to the facility on 7/11/18. Diagnoses included peripheral vascular disease, dysphagia, hypertension and advanced nephropathy.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 6/15/18. Resident #116 was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment and required extensive assistance with activities of daily living.

Resident #116 had a physician order dated 7/12/18 for a suprapubic catheter due to advanced nephropathy.

On 9/19/18 at 8:35 a.m., Resident #116 was observed seated in a wheelchair in the Unit 1 hallway. He self propelled himself down the hallway and into his room. His catheter tubing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 30	F 690		

dragged on the floor under the wheelchair. At this time, Licensed Practical Nurse C (LPN C) was passing medications outside of Resident #116's room. She was asked to identify Resident #116 by name.

On 9/19/18 at 9:40 a.m., LPN C continued to pass medications on the same hall. Resident #116 was observed to leave his room and self propel down the hallway to the dining room with his catheter tubing dragged on the floor under the wheelchair.

On 9/19/18 at 10:30 a.m., Resident #116 was in his room. Corporate Nurse D was asked to observe the resident, specifically the Foley catheter tubing. Corporate Nurse D stated that the tubing is not supposed to be on the ground. She stated that because the resident is short the wheelchair sits low. She stated that she would have therapy look at the chair.

On 9/19/18 at 10:40 a.m., The Director of Nursing stated that the catheter tubing should be below the bladder and off the floor. She reported that five residents with Foley catheters had urinary tract infections in September 2018.

The facility policy dated 9/1/17 titled "Urinary Tract Infections (Catheter Associated), Guidelines for Preventing" read "Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor."

Potter and Perry. (2005). Fundamentals of Nursing (pp 1348). 6th edition., provided the following guidance on maintaining a closed drainage system for catheterization, "After inserting an indwelling catheter, the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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F 690	Continued From page 31 maintains a closed urinary drainage system to minimize the risk of infection. Urinary drainage bags are plastic and can hold about 1000 to 1500 ml (milliliter) of urine. The bag should hang on the bed frame or wheelchair without touching the floor." The Administrator, Director of Nursing and Corporate Nurse were notified of the catheter issue at the end of day meeting on 9/19/18.	F 690		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	{F 755}	F755 Pharmacy Services/ Procedures/ Pharmacist/Records 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #1126's controlled medication prescriptions were removed from the medical record by the licensed nurse, and were marked to indicate they were no longer valid. Resident #1114's inhaler was immediately discarded by the licensed nurse. The licensed nurse immediately re-ordered the inhaler from the pharmacy which was received from the pharmacy STAT. Resident #1114's inhaler was dated upon opening by the licensed nurse. Residents #1126 and #1114 suffered no harm. 2. DON/designee conducted a Quality Review of current residents' active medical record to ensure controlled medication prescriptions in the record are marked to indicate they were no longer valid. The DON/designee reviewed current residents opened inhalers to ensure if opened they are properly dated. Follow up was done based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 32 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, facility staff failed to secure controlled medication prescriptions and failed to date opened medications, for 2 residents, Resident #1126 and Resident #1114, in a sample of 20 residents. 1. For Resident #1126, the facility failed to dispose of hard prescriptions for Tramadol, a narcotic painkiller, Vimpat, a seizure medication, Keflex, and antibiotic, and Lyrica, a neuropathic painkiller. 2. The facility failed to date when Resident #1114's medication was opened, in order to determine when the medication has expired. The Findings included: 1. For Resident #1126, the facility failed to dispose of hard prescriptions for Tramadol, a narcotic painkiller, Vimpat, a seizure medication, Keflex, and antibiotic, and Lyrica, a neuropathic painkiller. On 09/19/2018, a review of Resident #1126's chart was conducted. In the section of the chart labeled "Orders", there were multiple signed prescriptions. These prescriptions included 2 for Tramadol, 1 for Vimpat, 1 for Keflex, and 1 for Lyrica. The prescriptions had no strikethroughs,	{F 755}	3. DON/designee provided re-education to licensed nurses on regulation F755 with emphasis on marking residents' controlled medication prescriptions to indicate they are no longer valid, and dating inhalers upon opening. 4. DON/designee to complete Quality Improvement monitoring to ensure controlled medication prescriptions are marked to indicate they are no longer valid. DON/designee to also complete Quality Improvement monitoring to ensure opened inhalers are dated. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 33 VOID marks, or other indications that they were used or no longer valid. The facility was asked to provide their policy on handling of controlled substance prescriptions. The facility provided a single typed sheet entitled "Policy #/Title 4.3 New Orders for Schedule III-V Controlled Substances." Under the heading "Procedure", item #2 states: "2. After faxing the Schedule III-V Controlled Substance Prescription to the Pharmacy, Facility Staff should deface the original prescription to ensure it cannot be re-used by writing the following on the face of the [sic] 2.1 Name and signature of the nurse faxing the prescription 2.2 The Phrase: 'FAXED TO PHARMACY' 2.3 Date and time the prescription was faxed" The Administrator and Director of Nursing were made aware of the findings at the end of day meeting on 09/19/2018. No further information was provided. 2. The facility failed to date when Resident #1114's medication was opened, in order to determine when the medication has expired. Resident #1114 was admitted to the facility on 6/21/2018 with diagnoses of Chronic Obstructive Pulmonary Disease and Acute Lower Respiratory Infection. His most recent Minimum Data Set (MDS) is a Quarterly assessment dated 8/10/2018. This MDS showed that Resident #114 was cognitively intact, did not have shortness of breath with activities of daily living, and received both oxygen and physical therapy services.	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 34 At 8:30 on 9/19/2018, this surveyor inspected the medication cart for the 200 hall. A medication box for Symbicort 160 mcg/Formoterol Fumarate dehydrate 4.5 mcg inhalation aerosol was noted to be opened. The foil pouch was empty and inside the box, along with the inhalation dispenser. This dispenser was without notation regarding the date the foil pouch was opened. The dispenser did not have a resident's name, room number, or any other identifying notation. The dispenser did have the original manufacturer labeling on the internal medication canister for batch and final expiration date. The external box had a Pharmacy label indicating the resident's name, dispensed date, the date a refill was available, and the manufacturer information. In summary, Resident #1114 had a container for his inhaler. The container had prescribing information, but the inhaler itself had been removed from the internal packaging and had no identifying information on it other than drug name and manufacturer expiration. LPN A was passing medications with this medication cart. When shown the container and asked what the process was for dating/labeling medications when opened, LPN A stated "I am agency, and this is my first day. I can go get the policy for you. I was taught to date meds when I opened them." The surveyor spoke instead to Administration C, who was also standing by the medication cart. When asked what the facility policy was for dating or labeling medications when opened, Administration C stated "We follow pharmacy guidelines."	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 755}	Continued From page 35 At 9:30 on 9/19/2018, the surveyor located Administration A and asked "What is the company or facility policy for opening, dating, and labeling medications?" Administration A stated again that pharmacy guidelines were to be followed. When questioned again, Administration A would not identify a facility policy/procedure. She provided the surveyor with a document labeled Omnicare Drug Information SYMBICORT 160-4.5 MCG INHALER. Page 5 of this 6 page document states: STORAGE ...Discard the inhaler 3 months after you remove it from the original foil package or after all the doses have been used, whichever comes first. Administration A also provided a document titled "Omnicare LTC Facility Pharmacy Services and Procedures Manual, Policy # 5.3 Storage and Expirations of Medications, Biologicals, Syringes and Needles. This document states: 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. In conclusion, if the actual inhaler is not dated when the original packaging is removed, staff do not know when the 3 month period of use has ended, and cannot comply with pharmacy guidelines for discarding expired medications. At 12:00 PM, Administration A showed the surveyor two boxes of inhalers for resident #1114. She stated that the inhaler discovered by the	{F 755}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 755}	Continued From page 36 surveyor was in fact unused. She showed the surveyor the second inhaler, which had an attached pharmacy label which could be dated by staff when the original packaging was opened. She also stated that she was "following up" with the pharmacy to determine when the process for including an internal label changed. Administration A was asked what would stop an employed or agency nurse from using the unlabeled inhaler, and she did not answer. No further information was provided prior to survey.	{F 755}		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756	F 756 Drug Regimen Review 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #107 no longer resides at the facility. 2. DON/designee conducted a Quality Review of physicians' orders to ensure transcription to the Medication Administration Record (MAR) was accurate. Follow up was done based on findings. 3. DON/designee provided re-education to licensed nurses on regulation F756 and transcribing physician's orders accurately to the MAR. 4. DON/designee to complete Quality Improvement monitoring of physicians' orders to ensure accurate transcription to the MAR. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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F 756	Continued From page 37 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed for 1 resident (Resident #107) of 20 residents in the survey sample to identify a medication error during the Monthly Medication Review (MMR). For Resident #107, a MMR was conducted on 7/29/18. The pharmacist did not identify that scheduled Lorazepam was administered twice daily since 7/14/18 without a physician order. The findings included: Resident #107, a 77 year old, was admitted to the facility on 7/11/18. Diagnoses included dementia with behaviors, reflux, hypertension, and lung cancer. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/25/18. Resident #107 was coded with severe cognitive impairment and required supervision for all activities of daily	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 38	F 756		

living except for hygiene for which she required extensive assistance.

Resident #107's closed record was reviewed as part of a complaint investigation conducted during the survey. One of the complaint allegations read, "She seemed very heavily medicated."

The July 2018 MAR included a handwritten order dated 7/13/18 for Lorazepam 0.5 milligram (mg) by mouth every 12 hours PRN (as needed) due to anxiety. The "PRN" was scribbled out. The medication was administered twice daily from 7/14/18 to 7/31/18.

The August 2018 MAR included two orders for Lorazepam. The first was a printed order dated 7/13/18 for Lorazepam 0.5 mg every 12 hours as needed. The medication was never administered.

The second was a handwritten order dated 8/1/18 for Lorazepam 0.5 mg by mouth every 12 hours. This medication was documented as having been administered twice a day from 8/1/18- 8/6/18.

The August 2018 physician order sheet, signed by the physician but not dated, included a PRN order for Lorazepam. It did not include a scheduled order for Lorazepam.

No physician order for scheduled Lorazepam was located in the clinical record. On 7/19/18 at 5:00 p.m., Corporate Nurse D provided a copy of the script for PRN Lorazepam that she had just received from the pharmacy. She stated that the pharmacy did not have an order for scheduled Lorazepam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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F 756	Continued From page 39 In total, Resident #107 was administered Lorazepam twice daily from 7/14/18 to 8/6/18 without a physician order. The pharmacist conducted the Monthly Medication Review (MMR) on 7/29/18. The pharmacist wrote a recommendation on 7/29/18 using the "Consultation Report" form. This form was located in the clinical record. The recommendation read, "(resident) had a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg **NOTE: CMS requires stop date/ documentation despite patient status" "Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period, and the duration for the PRN order." The pharmacist did not identify during the 7/29/18 MMR that Resident #107 was receiving a scheduled dose of Lorazepam without a physician order. COMPLAINT DEFICIENCY	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757	F 757 Drug Regimen is Free from Unnecessary Drugs 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #107 no longer resides at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

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F 757	Continued From page 40 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed for 1 resident (Resident #107) of 20 residents in the survey sample was free from unnecessary medications. For Resident #107, the facility administered Haloperidol and Lorazepam (both antipsychotic medications) without physician orders for either medication. Haloperidol was administered without an appropriate diagnosis. The findings included: Resident #107, a 77 year old, was admitted to the facility on 7/11/18. Diagnoses included dementia with behaviors, reflux, hypertension, and lung cancer. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/25/18. Resident #107 was coded with severe cognitive impairment and required supervision for all activities of daily	F 757	2. DON/designee conducted a Quality Review of physicians' orders to ensure transcription to the Medication Administration Record (MAR) is accurate and each medication includes an indication for use or diagnosis. Follow up was done based on findings. 3. DON/designee provided re-education to licensed nurses on regulation F757 with emphasis on accurate transcription of physicians' orders to the MAR, as well as, ensuring that each medication has an indication for use or diagnosis. 4. DON/designee to complete Quality Improvement Monitoring of physicians' orders to ensure accurate medication transcription to the MAR along with an indication for use or diagnosis for each medication. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 41	F 757		

living except for hygiene for which she required extensive assistance.

Resident #107's closed record was reviewed as part of a complaint investigation conducted during the survey. One of the complaint allegations read, "She seemed very heavily medicated."

HALOPERIDOL:
Resident #107's signed admission orders dated 7/11/18 included the medication Haloperidol 0.3 milliliters (ml) by mouth daily for dementia. According to the July 2018 Medication Administration Record (MAR) the Haloperidol was administered from 7/11/18- 7/16/18. A handwritten note on the MAR read, "discontinued on 7/17/18."

Included in the record was a handwritten note on a full sheet of paper with a date/ time stamp and fax number printed at the top. The note read, "(doctor name) can we discontinue Haloperidol 2 mg/ ml oral concentrate and can we start Lorazepam 0.5 mg (milligram) by mouth R/T (related to) behavioral issue" Below this was handwritten "DC (discontinue Haldol) with the physician signature and the date 7/13/18.

The August 2018 physician order sheet, signed by the physician but not dated, included Haloperidol that included the handwritten note "D/Cd (discontinued) 7/13/18" written through the order.

The Haloperidol was discontinued on 7/13/18 per the handwritten doctor note. It was discontinued from the July 2018 MAR on 7/16/18, three days later. According to the August 2018 MAR, the Haloperidol was administered from 8/1/18-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 42	F 757		

8/6/18. The Haloperidol was administered on six occasions in the month of August without a physician order. The Haloperidol was administered a total of nine occasions after it was discontinued.

In addition to being administered with out a physician order, dementia is not an appropriate diagnosis to justify the use of the medication. The following information regarding Haloperidol use was accessed on 9/20/18 at 11:58 p.m. at the website https://medlineplus.gov/druginfo/meds/a682180.html

Haloperidol Black Box warning:
"Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as haloperidol have an increased chance of death during treatment.

Haloperidol is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia. Talk to the doctor who prescribed this medication if you, a family member, or someone you care for has dementia and is taking haloperidol. For more information, visit the FDA website: http://www.fda.gov/Drugs"

During the afternoon of 9/19/18, Corporate Nurse D was asked if dementia was an appropriate diagnosis to support the use of Haloperidol. She stated no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 43 LORAZEPAM: The July 2018 MAR included a handwritten order dated 7/13/18 for Lorazepam 0.5 milligram (mg) by mouth every 12 hours PRN (as needed) due to anxiety. The "PRN" was scribbled out. The medication was administered twice daily from 7/14/18 to 7/31/18. The August 2018 MAR included two orders for Lorazepam. The first was a printed order dated 7/13/18 for Lorazepam 0.5 mg every 12 hours as needed. The medication was never administered. The second was a handwritten order dated 8/1/18 for Lorazepam 0.5 mg by mouth every 12 hours. This medication was documented as having been administered twice a day from 8/1/18- 8/6/18. The August 2018 physician order sheet, signed by the physician but not dated, included a PRN order for Lorazepam. It did not include a scheduled order for Lorazepam. No physician order for scheduled Lorazepam was located in the clinical record. In total, Resident #107 was administered Lorazepam twice daily from 7/14/18 to 8/6/18 without a physician order. The pharmacist conducted the Monthly Medication Review (MMR) on 7/29/18. The pharmacist wrote a recommendation on 7/29/18 using the "Consultation Report" form. This form was located in the clinical record. The recommendation read, "(resident) had a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg **NOTE: CMS requires stop date/ documentation despite patient status"	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 44	F 757		

"Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period, and the duration for the PRN order."

It was not identified by the pharmacist during the 7/29/18 MMR that Resident #107 was receiving a scheduled dose of Lorazepam without a physician order.

On 7/19/18 at 5:00 p.m., Corporate Nurse D provided a copy of the script for PRN Lorazepam that she had just received from the pharmacy. She stated that the pharmacy did not have an order for scheduled Lorazepam. She stated that the Haloperidol was restarted without a physician order. When asked if physician orders were supposed to be completed on a piece of paper such that was done with the faxed note between the facility staff and the physician with the Haloperidol, she shook her head no.

In summary, Resident #107 was administered Haloperidol without an appropriate supporting diagnosis and without a physician order. She was administered scheduled Lorazepam twice daily from 7/14/18 to 8/6/18 without a physician order.

The Administrator, Director of Nursing and Corporate Nurse D were notified of the unnecessary medications at the end of day meeting on 9/19/18.

COMPLAINT DEFICIENCY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758 SS=D	Continued From page 45 Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758 F 758	F 758 Free from unnecessary Psychotropic Meds 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #107 no longer resides at the facility. 2. DON/designee conducted a Quality Review of PRN (as needed) psychotropic medication orders to ensure they have a stop date that does not exceed 14 days, an include an indication for use. Follow up was done based on findings. 3. DON/designee provided re-education to the facility's physicians and licensed nurses on regulation F758 with emphasis on ensuring PRN (as needed) psychotropic medication orders have a stop date that does not exceed 14 days, and include an indication for use. 4. DON/designee to complete a Quality Improvement Monitoring on PRN (as needed) psychotropic medication orders to ensure they have a stop date that does not exceed 14 days and include an indication for use. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 46	F 758		

prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed for 1 resident (Resident #107) of 20 residents in the survey sample was free from unnecessary PRN (as needed) psychotropic medications.

For Resident #107, the PRN Lorazepam order was effective longer than 14 days, did not include a stop date and did not include indications for use.

The findings included:

Resident #107, a 77 year old, was admitted to the facility on 7/11/18. Diagnoses included dementia with behaviors, reflux, hypertension, and lung cancer. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/25/18. Resident #107 was coded with severe cognitive impairment and required supervision for all activities of daily living except for hygiene for which she required extensive assistance.

Resident #107's closed record was reviewed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 47	F 758		

part of a complaint investigation conducted during the survey. One of the complaint allegations read, "She seemed very heavily medicated."

On 7/19/18 at 5:00 p.m., Corporate Nurse D provided a copy of the script for PRN Lorazepam dated 7/13/18 that she had just received from the pharmacy. The script included a dosage but did not indicate indications for use.

The July 2018 MAR included a handwritten order dated 7/13/18 for Lorazepam 0.5 milligram (mg) by mouth every 12 hours PRN (as needed) due to anxiety. The "PRN" was scribbled out. The medication was administered twice daily from 7/14/18 to 7/31/18.

The August 2018 MAR included a PRN order for Lorazepam. The order dated 7/13/18 was printed on the MAR and read, Lorazepam 0.5 mg every 12 hours as needed. The medication was never administered.

The August 2018 physician order sheet, signed by the physician but not dated, included a PRN order for Lorazepam. This order did not include indications for use.

The pharmacist conducted the Monthly Medication Review (MMR) on 7/29/18. The pharmacist wrote a recommendation on 7/29/18 using the "Consultation Report" form. This form was located in the clinical record. The recommendation read, "(resident) had a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg **NOTE: CMS requires stop date/ documentation despite patient status" "Recommendation: Please discontinue PRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	R-C 09/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 48 Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period, and the duration for the PRN order." Using the Consultation Report, the physician declined the recommendation and wrote "dx (diagnosis) Anxiety" and signed/ dated the form on 8/16/18, 10 days after the resident was discharged from the facility. The Administrator, Director of Nursing and Corporate Nurse D were notified of the issue with the PRN antipsychotic medication at the end of day meeting on 9/19/18.	F 758		
F 760 SS=E	COMPLAINT DEFICIENCY Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed for 1 resident (Resident #107) of 20 residents in the survey sample was free from significant medication errors. For Resident #107, the facility administered Haloperidol and Lorazepam (both antipsychotic medications) without physician orders for either medication.	F 760	F 760 Residents are Free of Significant Med Errors 1. An Ad-HOC QAPI meeting was held on 9/28/18. Resident #107 no longer resides at the facility. 2. DON/designee conducted a Quality Review of medication administration on all shifts to ensure medications are administered per physicians' orders. Follow up was done based on findings.	

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F 760	Continued From page 49 The findings included: Resident #107, a 77 year old, was admitted to the facility on 7/11/18. Diagnoses included dementia with behaviors, reflux, hypertension, and lung cancer. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 7/25/18. Resident #107 was coded with severe cognitive impairment and required supervision for all activities of daily living except for hygiene for which she required extensive assistance. Resident #107's closed record was reviewed as part of a complaint investigation conducted during the survey. One of the complaint allegations read, "She seemed very heavily medicated." HALOPERIDOL: Resident #107's signed admission orders dated 7/11/18 included the medication Haloperidol 0.3 milliliters (ml) by mouth daily for dementia. According to the July 2018 Medication Administration Record (MAR) the Haloperidol was administered from 7/11/18-7/16/18. A handwritten note on the MAR read, "discontinued on 7/17/18." Included in the record was a handwritten note on a full sheet of paper with a date/ time stamp and fax number printed at the top. The note read, "(doctor name) can we discontinue Haloperidol 2 mg/ ml oral concentrate and can we start Lorazepam 0.5 mg (milligram) by mouth R/T (related to) behavioral issue" Below this was handwritten "DC (discontinue Haldol) with the physician signature and the date 7/13/18. The August 2018 physician order sheet, signed	F 760	3. DON/designee provided re-education to licensed nurses on regulation F-760 and administration of medications per physicians' orders. 4. DON/designee to complete Quality Improvement monitoring of medication administration per physicians' orders. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of compliance: 10/30/18	

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F 760	Continued From page 50	F 760		

by the physician but not dated, included Haloperidol that included the handwritten note "D/Cd (discontinued) 7/13/18" written through the order.

The Haloperidol was discontinued on 7/13/18 per the handwritten doctor note. It was discontinued from the July 2018 MAR on 7/16/18, three days later. According to the August 2018 MAR, the Haloperidol was administered from 8/1/18-8/6/18. The Haloperidol was administered on six occasions in the month of August without a physician order. The Haloperidol was administered a total of nine occasions after it was discontinued.

LORAZEPAM:
The July 2018 MAR included a handwritten order dated 7/13/18 for Lorazepam 0.5 milligram (mg) by mouth every 12 hours PRN (as needed) due to anxiety. The "PRN" was scribbled out. The medication was administered twice daily from 7/14/18 to 7/31/18.

The August 2018 MAR included two orders for Lorazepam. The first was a printed order dated 7/13/18 for Lorazepam 0.5 mg every 12 hours as needed. The medication was never administered.

The second was a handwritten order dated 8/1/18 for Lorazepam 0.5 mg by mouth every 12 hours. This medication was documented as having been administered twice a day from 8/1/18- 8/6/18.

The August 2018 physician order sheet, signed by the physician but not dated, included a PRN order for Lorazepam. It did not include a scheduled order for Lorazepam.

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F 760	Continued From page 51 No physician order for scheduled Lorazepam was located in the clinical record. In total, Resident #107 was administered Lorazepam twice daily from 7/14/18 to 8/6/18 without a physician order. The pharmacist conducted the Monthly Medication Review (MMR) on 7/29/18. The pharmacist wrote a recommendation on 7/29/18 using the "Consultation Report" form. This form was located in the clinical record. The recommendation read, "(resident) had a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg **NOTE: CMS requires stop date/ documentation despite patient status" "Recommendation: Please discontinue PRN Lorazepam. If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period, and the duration for the PRN order." It was not identified by the pharmacist during the 7/29/18 MMR that Resident #107 was receiving a scheduled dose of Lorazepam without a physician order. On 7/19/18 at 5:00 p.m., Corporate Nurse D provided a copy of the script for PRN Lorazepam that she had just received from the pharmacy. She stated that the pharmacy did not have an order for scheduled Lorazepam. She stated that the Haloperidol was restarted without a physician order. When asked if physician orders were supposed to be completed on a piece of paper such that was done with the faxed note between the facility staff and the physician with the	F 760		

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F 760	Continued From page 52 Haloperidol, she shook her head no. In summary, Resident #107 was administered Haloperidol without a physician order. She was administered scheduled Lorazepam twice daily from 7/14/18 to 8/6/18 without a physician order. The Administrator, Director of Nursing and Corporate Nurse D were notified of the significant medication errors at the end of day meeting on 9/19/18. COMPLAINT DEFICIENCY	F 760		
{F 921} SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview and facility documentation, the facility failed to provide safe, functional, sanitary, and comfortable environment for Residents. The facility failed to provide an environment that is clean, comfortable and sanitary in the following areas; furniture in disrepair, drywall exposed, broken, damaged or stained ceiling tiles, restrooms out of order and strong urine odor in a shower room. The findings include: On 9/19/2018 during a tour of the facility the facility was noted to have several areas in	{F 921}	F921 Safe/Functional/Sanitary/Comfortable Environment 1. An Ad-HOC QAPI meeting was held on 9/28/18. Broken furniture in rooms 404, 409, and 310 was replaced. Bathrooms in rooms 308 and 310 received needed repairs and were placed back in service. Room 313 was repaired. Nurse's station on the locked unit was repaired and has no torn or chipped edges on the counter. Ceiling tile in room 407 was replaced. Ceiling tile outside room 315 was replaced. Displaced tiles in room 320 were replaced. Ceiling tiles in room 408 were replaced on. Ceiling tiles across from room 408 were replaced. Exposed drywall in room 407 behind bed B was repaired. Bathroom wall in room 400 was repaired. Bathroom wall in room 408 was repaired. Residents suffered no harm.	

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{F 921}	Continued From page 53 disrepair unsafe and or unsanitary. 1. Broken furniture in rooms - 404, 409, 310, 2. Bathrooms in rooms 310 and 308 were out of order. 3. Room 313's bathroom door was broken with wood putty exposed. 4. Nurses station on the locked unit had torn and chipped edges on counter. 5. The shower room on unit 3 had strong smell of urine and standing water on floor where drain was clogged. 6. Ceiling tiles that were broken, damaged, or wet from leaking roof in room 407, middle of 400's hall, on the memory care (locked unit), room 315 outside of door in hallway, in room 320 displaced tiles in bathroom, in room 408 (cracked and bulging ceiling tiles), and in the alcove across from room 408 (bulging ceiling tiles). 7. Room 407 had exposed drywall behind B Bed, 8. Room 400's bathroom walls had water damage, peeling paint, and unpainted plaster above windows. 9. Room 408's bathroom wall had peeling paint and separating drywall 10. Room 414's bathroom had no threshold on floor and the flooring was raised at entrance. On 9/19/2018 at 4:30 PM, an interview was	{F 921}	2. Executive Director/designee conducted a Quality Review of resident rooms, care, and common areas facility wide to ensure Safe/Functional/Sanitary/Comfortable Environment is maintained. Follow up was done based on findings. 3. DON/designee re-educated facility staff on regulation F-921 with emphasis on reporting furniture in disrepair, drywall exposed, damaged or stained ceiling tiles, restrooms out of order, and strong urine odors in shower rooms and documenting them in the maintenance log. The ED re-educated the Maintenance Director and Maintenance Assistants on reviewing the maintenance log with appropriate follow up and documentation. 4. ED/designee to conduct Quality Improvement monitoring of facility to ensure furniture is in good repair, drywall is not exposed, ceiling tiles are not damaged or stained, restrooms are in working order, and shower rooms do not have strong urine odors. ED/designee to also conduct Quality Improvement monitoring of the maintenance log to ensure follow up with documentation of identified issues. Monitoring will be conducted 3 x weekly for 1 month, and then quarterly, as needed. Findings to be reported to QAPI Committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 1. Date of compliance: 10/30/18	

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{F 921}	Continued From page 54 conducted with the Administrator who stated that he had ordered new furniture and he had hired two extra people to perform repairs in the building. He also stated he was not aware of the urine odor but would get housekeeping to check on it. He also stated maintenance was working on the out of order bathrooms. The Administrator submitted receipts from supply companies for furniture he ordered dated 9/13/2018. No further information was provided.	{F 921}		