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 03/21/2019

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}	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 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid first revisit to the standard survey conducted 01/29/19 through 01/31/19, was conducted 03/20/19 through 03/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Two complaints were investigated during the survey. The census in this 174 certified bed facility was 166 at the time of the survey. The survey sample consisted of 19 resident reviews.	{F 000}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	{F 656}	F656 Develop/Implement Comprehensive Care Plan 1. Resident #1034 & #1144 suffered no adverse reactions from care plans not being patient centered or having measurable goals. Resident #1034 dementia/behavior care plan interventions updated to reflect the resident's current interventions based on the dementia dx. Resident # 1144 behavior care plan updated with a measureable objective/goal. 2. MDS/designee will review care plans for current residents in the facility with a focus to address cognition/dementia and ensure goals are measurable.	

RECEIVED
APR 08 2019
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/8/2019

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.

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 03/21/2019

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 656}	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to develop and implement a comprehensive person-centered careplan for two Residents (Resident #1034 & Resident #1144) in a survey sample of 19 residents. 1. For Resident #1034, the facility staff failed to develop a comprehensive and resident specific dementia careplan and failed to conduct the stated interventions. 2. For Resident #1144, the facility staff failed to develop a person centered comprehensive careplan with resident specific, measurable objectives and timeframes to meet the resident's needs.	{F 656}	3. ED/designee will re-educate the IDT to enter appropriate and specific interventions for residents with dementia and education for updating care plans with measurable objectives/goals with person centered care plans. 4. MDS/designee will conduct a quality monitoring on 20 residents weekly x 4 weeks for measureable goals/objectives related to behavior care plans and appropriate interventions related to dementia care plans. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 1 month for compliance and/or revisions. 5. Date of Compliance: 4/15/19	

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 03/21/2019

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 656}	Continued From page 2 The findings included: 1. For Resident #1034, the facility staff failed to develop a comprehensive and resident specific dementia careplan and failed to conduct the stated interventions. Resident #1034, was initially admitted to the facility on 8/16/18, with the most recent readmission on 10/12/18. Resident #1034 resided on the secure memory care unit. His diagnoses included but were not limited to: Peripheral Vascular Disease, MRSA (Methicillin-resistant staphylococcus aureus), open wound right lower leg, dementia without behavioral disturbance, chronic peripheral venous insufficiency, sepsis, cellulitis and major depressive disorder. Resident #1034's most recent MDS (minimum data set) (an assessment tool) was coded as a quarterly assessment, with an ARD (assessment reference date) of 2/2/19. The Resident was coded with a BIMS (Brief Interview for Mental Status) score of 6, indicating he was severely cognitively impaired. He required supervision for eating, hygiene, bathing and transfers. Review of the clinical record, including nursing notes, nursing assessments, MDS and careplan was conducted on 3/20/19 and 3/21/19. Resident # 1034's careplan read "the resident is an elopement risk/wanderer ( ) r/t (related to) wandering." [sic] The interventions read "Monitor location every (SPECIFY: 15/30/60)min) Document wandering behavior and attempted diversional interventions in behavior log. Provide	{F 656}		

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 03/21/2019

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 656)	Continued From page 3 structured activities: toileting, walking inside and outside." [sic] On 3/21/19 at 3:16pm, documentation of the resident's monitoring of location logs and behavior logs, as indicated in the careplan, were requested. Employee E stated, "I don't think he is on no safety checks, he is on the secure unit." [sic] On 3/21/19 at 3:25pm Employee E returned and stated, "there are no safety checks." Employee E then provided the March 2019 MAR (Medication Administration Record) page 7 of 9. Review of the March 2019 MAR revealed, 61 documentation entries that noted interventions 6 of the 61 opportunities, but failed to indicate the behavior the resident displayed when the staff provided interventions. The careplan was reviewed on 3/21/19 and read that Resident #1034 is an elopement risk. The careplan indicated an intervention to walk resident outside. This careplan intervention was not appropriate for Resident #1034, since he resides on a secure memory care unit. Review of the facility policy and procedure, titled "Plans of Care" dated 11/30/14, with a revision date of 9/25/17, read that the procedure was to, "review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each MDS assessment, and as needed." The policy read, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the	(F 656)		

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 03/21/2019

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 656}	Continued From page 4 extent practicable and updated in accordance with state and federal regulatory requirements." The Administrator and DON (Director of Nursing) made aware of the findings on 3/21/19 during the end of day debriefing. No further information was provided. 2. For Resident #1144, the facility staff failed to develop a person centered comprehensive careplan with resident specific, measurable objectives and timeframes to meet the resident's needs. Resident #1144, an 68 year old female, was admitted to the facility on 12/29/17. Her diagnoses included but were not limited to: type 2 diabetes, unspecified psychosis, UTI (urinary tract infection), history of falling, hyperlipidemia, other lack of coordination, difficulty in walking, muscle weakness, dysphagia, hypertension and chronic viral hepatitis C. Resident #1144's, most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/16/19 was coded as an annual assessment. Resident #1144 was coded as having a BIMS (brief interview for memory status) score of 3 indicating severe cognitive impairment. She was also coded as requiring extensive assistance of one staff member for transfers and dressing. Personal hygiene and bathing was coded as being totally dependent on one staff member. Resident #1144, was coded as always being incontinent for bowel and bladder.	{F 656}		

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 03/21/2019

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 656}	Continued From page 5 On 3/21/19, during a review of Resident #1144's careplan with a revision date of 3/20/19, the careplan stated "(Resident #1144's name) has potential a behavior problem r/t (related to) Dementia, psychosis...." [sic]. The goal for this focus area stated, "(Resident #1144's name) will have minimal risk for negative outcome r/t behaviors" "by review date." Resident #1144, had a careplan with a revision date of 1/18/19 that stated "(Resident #1144's name) has bowel incontinence r/t (related to) immobility." The goal for this focus area stated "The resident will have less than two episodes of incontinence per day through the review date." Resident #1144's MDS with an ARD of 1/16/19 and MDS with an ARD of 10/30/18, was coded that Resident #1144, was always incontinent of bowel and bladder. On 3/21/19 at 2:28pm, during an interview with the Administrator and Director of Nursing (DON), the DON, Employee B, stated, "careplans are updated and reviewed quarterly with each assessment." When the careplan goal for the behavioral careplan was read, and Employees A & Employee B were asked how they would measure this goal, Employee B stated "its broad, you can't measure minimal." On 3/21/19 at 6:34pm, Employee E brought a careplan for Resident #1144 with a goal that read, "(Resident #1144's name) will have less than 2 episodes of behaviors such as (reaching for items, that is not there, wandering, confusion, verbal and aggressive behavior towards others, refusing care, cursing, combative) by review date." When Employee E was asked, "Does this mean this wasn't measurable the reason it was	{F 656}		

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 03/21/2019

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 656)	Continued From page 6 changed?" Employee E replied "I reckon so." The Administrator and DON were informed of the failure to develop and implement a comprehonsive person-centered careplan with a measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs on 3/21/19 at approximately 2:30pm. No further information was provided.	(F 656)		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure safe sanitary food	F 812	F 812 Food Procurement, Storage/ Prepare/Serve-Sanitary 1. Residents #1027, #1049, & #1072 were not adversely affected by improper food handling. Employee J, employee I, employee E and employee L were educated on the proper handling of the food and was directed to sanitize hands between serving food to each resident and not touching food during the preparation of meals. 2. DON/designee will conduct quality monitoring rounds to ensure sanitation is maintained during food handling, tray delivery, and meal preparation. 3. DON/designee will re-educate employees J, I, E, and L on sanitation during meal service, not touching food during meal preparation, and handling of plates during meal time. 4. DON/designee will conduct quality monitoring review during meal service to ensure proper food handling and sanitation is maintained 3 x week for 4 weeks. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 1 month for compliance and/or revisions. 5. Date of Compliance: 4/15/2019	

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 03/21/2019

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 812	Continued From page 7 service for 4 Residents (#1027, #1049, #1072 and all Residents in first floor dining area) in a survey sample of 19 Residents. 1. For Resident # 1027 the facility staff touched Resident's food without using gloves. 2. For Resident # 1049 the facility staff touched Resident's food without using gloves. 3. For all residents in one of two facility dining rooms, a dining aide failed to wash hands with soap and water prior to donning gloves and plating food in a food service area. 4. For Resident #1072, the facility staff member served a plate of food with his thumb on the top of the plate and nearly touching the food on the plate. The findings include: Resident # 1027 is a 69 year-old man admitted to the facility on 12/6/18 with diagnoses of but not limited to Renal insufficiency, Hypokaleimia, Schizophrenia, Bipolar disorder and Asthma, and seizure disorder. On 3/20/19 at 1:15 PM the tray service for lunch began on the 400 hall. Resident Aide (employee K) was observed buttering roll for Resident using bare hands. She did not have gloves on or use the fork and knife to cut an butter the bread. On 3/21/19 at 5:00 an interview was condcucted with the Assistant Director of Nursing (ADON/employee E). The ADON was asked what the expectation was for handling Resident's	F 812		

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 03/21/2019

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 812	Continued From page 8 food. The ADON stated " I expect the staff to wash their hands and ensure all Residents hand are clean, then provide them with clothing protectors if they choose, and then pass the trays to those who don't need assistance first making sure that all the Residents at one table eat together." The ADON also stated that you cannot touch the surface of the plate or the rim of the plate. When asked about buttering bread she stated "You cannot touch the Resident's food without gloves." A policy of food service hand hygiene and related practices was requested however the facility only provided the "Hand Hygiene" Policy and Procedure dated 9/6/16 revised 8/29/17. The document address hand washing and use of gel based hand sanitizers but does not address food service practices. At the end of day meeting on 3/21/19 at 6:45 PM the Administrator and DON were made aware and no further information was provided. 2. For Resident # 1049 the facility staff touched Resident's food without using gloves. Resident #1049 a 79 year-old woman admitted to the facility on 9/1/17 with diagnoses of but not limited to Heart Failure, Hypertension, Diabetes, Depression, and Dementia - Alzheimer's Type. On 3/20/19 at 1:15 PM the tray service for lunch began on the 400 hall. (Certified Nurses Assistant) CNA A was observed buttering roll for Resident using bare hands. She did not have gloves on or use the fork and knife to cut an	F 812		

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 03/21/2019

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 812	Continued From page 9 butter the bread. On 3/21/19 at 5:00 an interview was condcucted with the Assistant Director of Nursing (ADON/employee E). The ADON was asked what the expectation was for handling Resident's food. The ADON stated " I expect the staff to wash their hands and ensure all Residents hand are clean, then provide them with clothing protectors if they choose, and then pass the trays to those who don't need assistance first making sure that all the Residents at one table eat together." The ADON also stated that you cannot touch the surface of the plate or the rim of the plate. When asked about buttering bread she stated "You cannot touch the Resident's food without gloves." A policy of food service hand hygiene and related practices was requested however the facility only provided the "Hand Hygiene" Policy and Procedure dated 9/6/16 revised 8/29/17. The document address hand washing and use of gel based hand sanitizers but does not address food service practices At the end of day meeting on 3/21/19 at 6:45 PM the Administrator and DON were made aware and no further information was provided. 3. For all residents in one of two facility dining rooms, a dining aide failed to wash hands with soap and water prior to donning gloves and plating food in a food service area. On 03/20/2019 at approximately 12:30 PM,	F 812		

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 03/21/2019

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 812	Continued From page 10 Employee J was observed entering the dining room holding tray cards and a writing tool. Employee J approached each table in the dining room reviewing menu preferences with each resident and writing each resident's choice on each tray card. Employee J then donned gloves after she applied an antimicrobial gel to her hands from a dispenser on the wall. Employee J then uncovered the food on a portable steam table in the corner of the dining room, dispensed food portions on the plates according to resident preference, and placed them on the holding shelf. Other dining staff members then took a plate and tray card to each resident. On 03/21/2019 at approximately 5:00 PM, an interview with Employee E was conducted. When asked about the expectation for hand hygiene when assisting residents with their food, Employee E stated staff should "wash their hands with soap and water" and for as long as it takes to sing "the happy birthday song." When asked about serving food in the dining room, Employee E stated staff delivering the meal to each resident should not wear gloves but hold the plate on the bottom and "not have fingers on the top of the plate." The policy for Food Services hand hygiene was requested. The facility staff presented Dining Services Policies for "Meal Distribution" and "Food: Preparation." For the "Meal Distribution" policy, procedure #5 documented, "For point-of-service dining, the Dining Services department staff, under the supervision of a licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient." Procedure #6 documented,	F 812		

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 03/21/2019

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 812	Continued From page 11 "Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining." For the "Food: Preparation" policy, procedure #1 documented, "All staff will practice proper hand washing techniques and glove use." The policies did not specify proper hand hygiene practices of utilizing soap and water when plating food in food service areas. On 03/21/2019 at approximately 6:45 PM, the Administrator and DON were notified of concerns. 4. For Resident #1072, the facility staff member served a plate of food with his thumb on the top of the plate and nearly touching the food on the plate. Resident #1072, a 63-year old female, was admitted to the facility on 04/07/2018. Diagnoses include but not limited to type 2 diabetes with diabetic peripheral angiopathy with gangrene, peripheral vascular disease, and heart failure. Resident #1072's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 02/16/2019 and was coded as a quarterly assessment. Resident #1072 was coded for a Brief Interview of Mental Status (BIMS) of 15 out of possible 15 indicative of intact cognition. Functional status for eating and personal hygiene were coded as requiring supervision and encouragement from staff. On 03/20/2019 at approximately 12:30 PM, Employee J was observed entering the dining room holding tray cards and a writing tool. Employee J approached each table in the dining	F 812		

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 03/21/2019

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 812	Continued From page 12 room reviewing menu preferences with each resident and writing each resident's choice on each tray card. Employee J then donned gloves after she applied an antimicrobial gel to her hands from a dispenser on the wall. Employee J then uncovered the food on a portable steam table in the corner of the dining room, dispensed food portions on the plates according to resident preference, and placed them on the holding shelf. Other dining staff members then took a plate and tray card to each resident. On 03/20/2019 at approximately 12:45 PM, Employee I was observed lifting a plate and meal card from the holding shelf. Employee I was holding the plate of food with his thumb on the top of the plate near Resident #1072's food and then delivering the plate and meal card to Resident #1072. The meal card that was placed on the table next to the plate had Resident #1072's name, room number, and diet (Regular diet) on it. On 03/21/2019 at approximately 5:00 PM, an interview with Employee E was conducted. When asked about the expectation for hand hygiene when assisting residents with their food, Employee E stated staff should "wash their hands with soap and water" and for as long as it takes to sing "the happy birthday song." When asked about serving food in the dining room, Employee E stated staff delivering the meal to each resident should not wear gloves but hold the plate on the bottom and "not have fingers on the top of the plate." The policy for Food Services hand hygiene was requested. The facility staff presented Dining Services Policies for "Meal Distribution" and "Food: Preparation." For the "Meal Distribution" policy,	F 812		

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 03/21/2019

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 812	Continued From page 13 procedure #5 documented, "For point-of-service dining, the Dining Services department staff, under the supervision of a licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient." Procedure #6 documented, "Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining." For the "Food: Preparation" policy, procedure #1 documented, "All staff will practice proper hand washing techniques and glove use." The policies did not specify proper practices to prevent bare hands from coming in contact with food during food distribution. On 03/21/2019 at approximately 5:45 PM, the Administrator and DON were notified of findings. On 03/21/2019 at approximately 6:45 PM, the DON presented a handwritten statement from Employee L dated 03/21/2019 that documented, "Attestation - Lunch Meal 03/20/2019 - Yesterday, during lunch fine dining services, I witnessed [Employee I] touch the rim of a resident's plate when serving the resident. I immediately called him over to me and did on-the-spot education that included not touching the rim of the resident's plate during serving. [Employee I] did not touch anymore rims of any other plates after education for the remaining duration of the lunch meal on my observation." The DON also presented an "Education In-service Attendance Record" dated 03/21/2019 at 6:15 PM. The Summary of the Training Session documented, "Discussed hand sanitization during meal pass. Staff must use hand sanitizer in between each tray pass. Hands must be placed under plate without fingers	F 812		

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 03/21/2019

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 812	Continued From page 14 touching the rim of plates, cups, or bowls. Staff will not touch food using fork or knive (sic) to place or cut food." The document listed three staff members including Employee I.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable.to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842	F842 Resident Records-Identifiable information 1. Resident #1025 suffered no adverse reactions from medical record not being updated timely. A late entry was added to electronic medical record from a previous contact with ombudsman. 2.Social services director/designee will complete a quality review of all residents who had scheduled care plan meeting from February 2019 to current to ensure current residents had social notes within the past 90 days. The documentation will be updated to reflect social service visits. 3. ED/designee will re-educate the IDT on entering documentation timely at the time of the care plan meetings. 4. SSD/designee will conduct a quality review 1 x weekly of residents who have had care plan meetings to ensure social services notes are entered timely for 4 weeks. Quality improvement monitoring findings to be reported to the QAPI committee for a period of 1 month for compliance and/or revisions. 5. Date Of Compliance: 4/15/2019	

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 03/21/2019

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 842	Continued From page 15 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation, and in the course of a complaint investigation, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident	F 842		

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 03/21/2019

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 842	Continued From page 16 #1025) in a sample size of 19 residents. The findings included: Resident #1025, a 53-year old male, was admitted to the facility on 01/20/2017. Diagnoses include but not limited to hyperlipidemia, atrial fibrillation, paraplegia, cystostomy, absence of left upper limb above elbow, muscle weakness, and abnormal posture. Resident #1025's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 01/25/2019 and was coded as an annual assessment. Resident #1025 was coded for a Brief Interview of Mental Status (BIMS) of 15 out of possible 15 indicative of intact cognition. Functional status for locomotion in wheelchair both on and off unit were coded as requiring supervision from staff. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Functional status for transfers between surfaces were coded as total dependence on staff. On 03/20/2019 at approximately 1:20 PM, an interview with Resident #1025 was conducted. When asked about going out into the community, Resident #1025 stated he used to go out in to the community but since the new administrator, he is not allowed into the community. Resident #1025 stated the administrator "blocked the doorway" and said I can no longer go out of the facility and she did not give me a reason. Resident #1025 stated he is able to go to the bank down the street and the assistant administrator accompanies him. Resident #1025 stated he needs to request a few days in advance to schedule a time to go the bank when the	F 842		

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 03/21/2019

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 842	Continued From page 17 assistant administrator is available to accompany him. Resident #1025 stated he would occasionally like to go outside or go to the store independently. On 03/20/2019 at approximately 1:40 PM, the clinical record (paper chart) was reviewed. Under the Social Services tab, there were two pages entitled, "Interdisciplinary Progress Notes." One page had an entry dated 11/20/2019 and documented, "[Resident] met with Activities and Social Service to discuss his mobility assessment. Resident is alert and oriented and able to make his needs known. Resident stated he enjoys going out in the community to go out to eat. Staff will continue to encourage [Resident] to participate in group activities." This handwritten narrative was approximately 1/3 of a page long and the rest of the document was blank. The second page was an interdisciplinary progress note dated 11/25/2018, written by a social worker no longer employed at the facility, and documented, "Psychosocial well being: Social services met with resident. Resident is upset he can't go outside w/o (without) supervision. Social Services explained that this was to ensure he was safe. Resident would like to transfer." This handwritten narrative was approximately 1/4 of a page long and the rest of the document was blank. A copy of both pages was obtained. On 03/21/2019 at 10:15 AM, an interview with the facility's social worker, Employee G was conducted. Employee G had started working for the facility 2 months ago. Employee G stated she met with Resident #1025 and completed a MDS	F 842		

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 03/21/2019

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 842	Continued From page 18 (Minimum Data Set) assessment shortly after beginning her employment with the facility. Employee G also stated she is working with the ombudsman to get Resident #1025's section 8 reinstated. Employee G stated that when that occurs, she will be responsible to find another place to live for Resident #1025 and obtain home health services for him. A copy of all Social Services notes was requested. On 03/21/2019 at approximately 10:45 AM, the Director of Nursing (DON) presented a copy of the two pages entitled, "Interdisciplinary Progress Notes" that were observed on the clinical record paper chart. However, the copy with the entry dated 11/20/2019 now had two more entries. One entry dated 2/5/19 documented, "Social worker spoke with ombudsman regarding [Resident] discharge to community Section 8 paperwork. She stated she was assisting him in reinstating his Section 8 and for social worker to look for emails from [service provider]." A second entry dated 3/4/19 documented, "Social worker spoke with ombudsman who provided information that she would be meeting with an attorney for [Resident]." On 03/21/2019 at approximately 1:15 PM, Employee D, the Assistant Director of Nursing (ADON), clarified that the facility switched to electronic clinical record documentation in December 2018 and that staff now documents in the electronic clinical record. On 03/21/2019 at approximately 2:00 PM, an interview with the Administrator and Employee G was conducted. When asked about documentation process, Employee G stated that she keeps "soft files" (notes that are not in clinical	F 842		

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 03/21/2019

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 842	Continued From page 19 record) on residents. When asked about the two entries on the page in Resident #1025's clinical record paper chart that were not there yesterday, Employee G stated she 'basically transcribed from my notes I keep" and went on to say she was told they needed to be in the chart so she wrote them. When asked if the information she transcribed is a part of the clinical record, she stated, "I guess it would be." When asked when the entries were made, the Administrator stated, "Recently." Employee G also stated she wrote a late entry in the electronic clinical record today. A copy of that documentation was requested. On 03/21/2019 at approximately 3:00 PM, the facility staff provided a copy of an electronic progress note created by Employee G dated 03/21/2019 at 9:06 AM. It documented, "Late entry SW (social worker) met with ombudsman [name] to discuss members (sic) section 8 voucher progress and the lack of correspondence received from [service provider] regarding the member. [Ombudsman name] explained that she has requested information regarding and is now taking the needed steps to assist [Resident #1025] in regaining his Section 8 voucher." The facility "Policies and Procedures" document for Social Services was provided by the facility staff. In section 5, it stated "As a member of the interdisciplinary team, Social Services will participate in planning the overall care of the resident including: a. Completing Social Services History and Psychosocial Assessments on admission. b. Completing periodic reviews of the assessment as necessary, but at least once quarterly and documenting progress in Social Services progress notes."	F 842		

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 03/21/2019

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 842	Continued From page 20 According to Perry & Potter, eighth edition, chapter 26 on documentation, it states, "Regardless whether documentation is entered electronically or on paper, as a member of the healthcare team you communicate information about patients in an accurate, timely, and effective manner. The quality of patient care depends on your ability to communicate with other members of the health care team. All health care providers require the same information about patients to develop an organized, comprehensive plan of care" (Perry & Potter, 2013, p. 348). On 03/21/2019 at approximately 6:45 PM, the Administrator and DON were notified of findings and they offered no further information or documentation.	F 842		