State of Virginia (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING VA0123 01/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR **ENVOY OF WINCHESTER, LLC** WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY)** F 000 **Initial Comments** F 000 An unannounced blennial State Licensure Inspection was conducted 01/07/20 through 01/09/20. One complaint (VA00047235 unsubstantiated with no deficiencies), was investigated during the survey. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 bed certified facility was 55 at the time of the survey. The survey sample consisted of 28 current resident reviews and 4 closed record reviews. F 001 Non Compliance F 001 The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-110. Management and administration, Cross reference to F623, F625 12VAC5-371-140. Policies and Procedures. Cross reference to F623, F625, F689, F695, F759, F760, F880 12VAC5-371-150. Resident Rights. Cross reference to F623, F625 12VAC5-371-180. Infection Control. Cross reference to F880 12VAC5-371-200. Director of nursing Cross reference to F759 and F760 12VAC5-371-210. Nurse staffing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU	LABORATORY DIRECTOR'S	OR PROVIDER/SUPPLYE	R REPRESENTATIVE'S	SIGNATURI
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Cross reference to F759 and F760

Electronically Signed

STATE FORM

9629

FXECUTIVE Director

(X6) DATE

If continuation sheet 1 of 2

S3RV1

State of Virginia

STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	SURVEY
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:		**************************************	COMPL	
		VA0123	B, WING		C 01/09/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.			
ENVOY O	F WINCHESTER, LLC	110 LAUC	K DR			
		<del></del>	TER, VA 2260	3	·	
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F 001	1 Continued From page 1					
	12VAC5-371-220. Qu Cross reference to F6	ality of Care 84, F695, F759, F760				
	12VAC5-371-250. Resident assessment and care planning. Cross reference to F684, F695					
	01000 101010100 10 1	,, 000				
	Care Planning 12VAC5-371-250 F ca	ross reference F657				
	Infection Control 12VAC5-371-180 B6	cross reference F880				
	Nursing Services 12VAC5-371-220 B c	ross reference Ff695				
	Resident Assessment 12VAC5-371-250 F,G	and Care Planning cross reference to F656				
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING				C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		- <b> </b>	110 1	EET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR CHESTER, VA 22603	1 0	1/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DE COMPLETION	
E 000	Initial Comments		Ε(	000			
F 000	An unannounced Emergency Preparedness survey was conducted 01/07/20 through 01/09/20. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. INITIAL COMMENTS  An unannounced Medicare/Medicaid standard		F	000		•	
	survey was conducted 01/09/20. One compl unsubstantiated with investigated during the required for compliand Federal Long Term Ca	d 01/07/20 through aint (VA00047235- no deficiencies), was e survey. Corrections are be with 42 CFR Part 483 are requirements and guilations for the Licensure The Life Safety Code					
F 550 SS=D	at the time of the survicensisted of 28 current closed record reviews Resident Rights/Exerc	ise of Rights	F 5	50			
	self-determination, and access to persons and	ht to a dignified existence, d communication with and					
ABORATORY	with respect and dignit resident in a manner a promotes maintenance her quality of life, reco	must treat each resident ty and care for each and in an environment that or enhancement of his or gnizing each resident's  UPPLIER REPRESENTATIVE'S SIGNATURE					
		The Theoreti Alive o algival URE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any deliciency statement ending with an affertsk (\*) 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.

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

Event ID: TTUI11

Facility ID: VA0123

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI	TPLE CONSTRUCTI	ION	(X3) DATE SURVEY COMPLETED
		496389	B. WNG			C
	ROVIDER OR SUPPLIER  F WINCHESTER, LLC  SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	110 LAUCK DR WINCHESTER		01/09/2020 (X6)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	< (EA	ACH CORRECTIVE ACTION SHOULD BI SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 550	access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless of the resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fact resident can exercise interference, coercion from the facility.  §483.10(b)(2) The resident can exercise interference, coercion from the facility.  §483.10(b)(2) The resident from the facility in the facility staff failed to particular failed to particular failed to particular failed to particular failed fai	ity must protect and the resident.  cility must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.  of Rights.  of Rights.  of Rights.  of the facility and as a citizen ted States.  cility must ensure that the his or her rights without and discrimination, or reprisal sident has the right to be oercion, discrimination, and try in exercising his or her orted by the facility in the rights as required under this  is not met as evidenced and, resident interview, staff ament review and clinical determined that facility staff sident's dignity for one of 32 y sample, Resident # 6. The rovide privacy for Resident ton bag and urine inside the		2. R pr ca ti 3. St ar Se 02 4. Th ca re co wh or M fin	desident #6 had a dignity is heir catheter bag on 1/8/2 desidents with catheter bag otential to be effected. Note at the term of the farme, the farme, the farme of the term o	gs have the o additional cility at this catheter care of Clinical by lete the or any o ensure times a w up based the facilities ality ied based on

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/31/2020 M APPROVED
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE	O. 0938-0391 E SURVEY PLETED
		495389	B. WING			C /09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		10074040
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
F 550	Continued From page	2	F 58	50		
	not limited to: heart fa disease and high chol Resident # 6's most reset), a quarterly asses (assessment reference Resident # 6 as scorir interview for mental standard for the being cognit decisions. Resident # limited assistance of activities of daily living Bowel" coded Resider incontinence of bladder On 01/07/20 at 1:17 prom from the hallway collection bag hanging of the bed. Observation bag failed to evidence collection bag and unit was visible from the heart of the continence of bladder of the ped. Observation bag failed to evidence collection bag and unit was visible from the heart of the continence of bladder of the ped. On 01/07/20 at 2:46 promote the continence of bladder of the ped.	ses that included but were allure, stage 4 kidney lesterol.  secent MDS (minimum data assment with an ARD se date) of 10/22/19, coded and a 14 on the brief tatus (BIMS) of a score of 0 tively intact for making dally to the staff member for g. Section H "Bladder and ant # 6 as occasional er and continent of bowel.  The continent of the continent				
	collection bag hanging of the bed. Observation	g on the right lower portion on of the catheter collection a privacy bag over the				

was visible from the hallway.

collection bag and urine inside the collection bag

On 01/07/20 at approximately 4:10 p.m., during an Interview with Resident # 6, the resident was

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	MEDICAID SERVICES					O. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		495389	B. WNG	i		C 01/09/2020		
NAME OF P	ROVIDER OR SUPPLIER			Ts	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	10912020	
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	·ΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ON SHOULD BE COMPLET HE APPROPRIATE DATE		
F 550	When asked how it m stated, "I wouldn't like The POS [physician's signed by the physicial" 6 documented, "Fol measures."  The comprehensive of dated of 01/06/2020 at 1:0 conducted with LPN [4. When asked about collection bag for Resident's bladder and When informed of the 4 stated that the cath have been placed in a if it was dignified for a collection bag to be v # 4 stated no.  On 01/09/2020 at 11: conducted with ASM member] # 2, director Resident # 6's cathetic covered. When informobservations ASM # 2 issue for Resident #6 been covered."	vation of the catheter visible from the hallway. hade them feel, Resident # 6 e everyone to be watching it."  order sheet] dated and an on 12/27/19 for Resident ley catheter for comfort  care plan for Resident # 6 failed to evidence care and liling catheter.  O p.m., an interview was licensed practical nurse] # t the care of a catheter sident #6, LPN # 4 stated, "It off the floor, below the d placed in a privacy bag." habove observations LPN # eter collection bag should a privacy bag. When asked a resident's catheter isible from the hallway LPN  14 a.m., an interview was [administrative staff of nursing, regarding are collection bag not being med of the above 2 agreed it was a dignity and stated, "it should have	F	550				
:		ector and ASM # 2, director regional director of clinical						

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NAMEOFP	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 7 7 7	
					10 LAUCK DR		,
ENVOYO	F WINCHESTER, LLC						
					VINCHESTER, VA 22603		
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F 550							
F 550			F	550			
<b> </b>	services and LPN # 5	traveling MDS coordinator,					
	were made aware of the findings.						
							1
	No further information	was provided prior to exit.					
F 623		Before Transfer/Discharge	-	000			
SS=D	CFR(s): 483.15(c)(3)-		Г	623			
00-0	οι πια <i>μ.</i> που, ισιοχοή-	(0)(0)					
	§483.15(c)(3) Notice	hoforo transfor					
	Before a facility trans						
	resident, the facility m	unt			,		
	(i) Notify the resident						
		ne transfer or discharge and	İ			ļ	
	the reasons for the m	te transfer of discharge and					
		r they understand. The					
	facility must send a co						
	representative of the					ŀ	
	Long-Term Care Omb						
	(ii) Record the reason	is for the transfer or					
	discharge in the resid	ent's medical record in					
		graph (c)(2) of this section;	1			ļ	
	and						
		ce the items described in					
	paragraph (c)(5) of th	is section.					
	6483 15/0\/A\ Timin-	of the retire					
	§483.15(c)(4) Timing	or the notice.  I in paragraphs (c)(4)(ii) and					l l
	(c)(8) of this eastion is	the notice of transfer				-	
	(c)(o) or uns section, t	the notice of transfer or					
	made by the facility of	der this section must be					
	recident to tree-terms	t least 30 days before the					
	resident is transferred	or uischarged.					]
	hofore from the	ide as soon as practicable					İ
	before transfer or disc	charge when-	1	1			
	(A) The safety of Indiv	riduals in the facility would					
		paragraph (c)(1)(i)(C) of		1			
	this section;					1	
	(p) The health of indiv	iduals in the facility would					
	be endangered, unde	r paragraph (c)(1)(i)(D) of		l			
	this section;			İ			

STATEMENT OF DEFICIENCIES	//4\	AVON 141 B		AALATALATAL		7. U330-U331	
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495389	B. WING				C <b>(09/2020</b>	
NAME OF PROVIDER OR SUPPLIER		L	RT	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	UDIZUZU	
ENVOY OF WINCHESTER, LLC			11	0 LAUGK DR INCHESTER, VA 22603			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X6) COMPLETION DATE	
allow a more immediate under paragraph (c)(1) (D) An immediate trans required by the resider under paragraph (c)(1) (E) A resident has not days.  §483.15(c)(5) Contents notice specified in paramust include the follow (i) The reason for trans (ii) The effective date of (iii) The location to whi transferred or discharg (iv) A statement of the including the name, and and telephone number receives such requests to obtain an appeal for completing the form an hearing request; (v) The name, address telephone number of the Long-Term Care Ombut (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and advidevelopmental disabilities and Bill of Rights Act of codified at 42 U.S.C. 1 (vii) For nursing facility	Ith improves sufficiently to the transfer or discharge, (i)(i)(B) of this section; sfer or discharge is not's urgent medical needs, (ii)(A) of this section; or resided in the facility for 30 as of the notice. The written agraph (c)(3) of this section wing: asfer or discharge; of transfer or discharge; ich the resident is ged; resident's appeal rights, address (mailing and email), or of the entity which is; and information on how im and assistance in and submitting the appeal is (mailing and email) and the Office of the State udsman; residents with intellectual sabilities or related in and email address and the agency responsible for rocacy of individuals with ties established under Part al Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and or residents with a mental abilities, the mailing and	F	F6	<ol> <li>On 1/9/2020 written notificated sent to Resident Representated Ombudsman for resident #6</li> <li>All residents who transfer fracility have the potential to effected. Transfer/discharge review was completed on 1/6 for all discharges since 1/1/2 Follow-up based on findings</li> <li>Nursing staff re-educated on transfer notice and social was re-educated on notifying the Representative and Ombude transfer by the DCS/designe 2/15/2020.</li> <li>DCS/designee to complete the transfer/discharge quality many discharges to ensure comaintained weekly for four Follow up based on findings reported to the facilities momeeting. Quality Monitoriated modified based on findings.</li> <li>Date of compliance 2/15/20</li> </ol>	tive and 5. om the be quality /23/202 2020. c. n issuing orker ste Reside sman of the by the monitor mpliand weeks. c and onthly Cong scheooles.	the aff ent for ce is	

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		495389	B, WING			1	C 01/09/2020	
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ENVOYO	F WINCHESTER, LLC			1				
	OLD MARKET OF			<u> </u>	VINCHESTER, VA 22603			
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F 623	Continued From page	s &		000				
	, •		r	623				
	agency responsible for	or the protection and als with a mental disorder						
	Actablished under the	Protection and Advocacy						
	for Mentally III Individ	uals Act.						
	\$493 45(a)(6) Ohan							
	§483.15(c)(6) Change							
	effecting the transfer	ne notice changes prior to or discharge, the facility						
	must undate the recir	or discridinge, the racility			v			
	must update the recipients of the notice as soon as practicable once the updated information becomes available.							
	§483.15(c)(8) Notice	In advance of facility closure						
	In the case of facility	closure, the individual who is						
	the administrator of the	ne facility must provide						
	written notification pri	or to the impending closure		i				
	to the State Survey A	gency, the Office of the						
	State Long-Term Care	o Ombudsman, residents of						
	the facility, and the re	sldent representatives, as						
	well as the plan for th	e transfer and adequate						
	relocation of the resid	ents, as required at §						
	483.70(I),   This DEO! !!DEMENT	· la wat and						
	by:	ls not met as evidenced					•	
	Based on staff intervi	lew facility document			ĺ			
	review, and clinical re	cord review it was						
		icility staff failed to provide						
	the resident represent	tative and Ombudsman with						
	the required written no							
		residents in the survey						
		. The facility staff failed to						
	evidence that a writte	n notification of a hospital						
	transfer for Resident	#65 on 12/10/19, was						
	provided to the reside	nt representative and						
	Ombudsman,							
	The findings include:							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WNG			ł	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	01/	/09/2020
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F 623	Continued From page 7		F	623			
	12/9/19. Diagnoses in to, brain cancer, apha obesity, alcohol abust Due to the short amore in the facility prior to the facility prior to the facility prior to the facility prior to the facility prior to the facility and admission nursing documented the resident operson, place and the facility operson, place and the facility operson, place and the facility operson, place and the facility operson, place and the facility operson, place and the facility operson, place and the facility operson, place and the facility operson operson, place and the facility operson	ent was alert and oriented ime.  I record revealed that the ospital on 12/10/19 and did y. The record revealed a 2/11/19 that documented, nedical history of GBM me of brain (2)), seizure  I (urinary tract infection) comy for GBM resection is of syncope, altered nificant cognitive decline e underwent IV cs, continue steroid, Vimpat oncology group for got transferred to SNF of PT/OT (physical onal therapy) and 24 hour er had erratic behavior with not safe for her and other nt to ER (emergency room) admission."					
		er - the Director of Social that she usually sends a					

		MEDIO/NO OLIVIOLO				OMP M	<u>J. 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		`		C /09/2020	
NAME OF P	ROVIDER OR SUPPLIER			1 8	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	70372020	
ENVOY O	F WINCHESTER, LLC			1	110 LAUCK DR WINCHESTER, VA 22603			
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F 623	notice to the family at the Ombudsman. Os Resident #65 she did ombudsman notice for stated she missed do A review of a "Notice Policy For residents thospital" form that Os but did not in this cas.  The purpose of this leafter careful consider sent to an acute care. The transfer was necessand (his/her) medical this facility. (Resident (name of hospital and Notice of Bed Hold P.  You are being sent to are a Medicaid/Medicadmitted to the hospital and whatever your paymoursing home is paid are in the hospital, the someone else into you may have the rig is available in a semi-home as long as you provided by this nursing Medicaid, you are elichome services.)  If the nursing home is did not services.	and the same notice is sent to SM #1 stated that for not have the family and or this hospital transfer. She sing it.  of Transfer and Bed Hold ransferring to ED or SM #1 stated she sends out the documented:  etter is to inform you that ration, (resident name) was sended center on (date), essary for (his/her) welfare inceds could not be met in at name) was transferred to diaddress.)  olicy:  the hospital today. If you care resident and you are tal, Virginia Medicaid and	F	623				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B, WING			1	C
NAME OF P	ROVIDER OR SUPPLIER		15: 11110	STREET ADDRESS, CITY, STATE, ZIP COI	Œ	] 01/	/09/2020
ENVOY 0	F WINCHESTER, LLC			110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 623	Bed Hold:  If you wish to hold your hospitalization, your hospitalization, your hold it you would not be able is if:  1. The level of care of (facility)  2. The patient is judged anger to themselves and the coutstanding payment which they are responsible.  On 1/08/20 03:59 PM (Licensed Practical Nopaper work provided transfer, LPN #2 state [medication] list, bed form, SBAR (Situation Recommendation) for Resuscitate). When document this informationspital, LPN #2 state the transfer form or mosent."	e the hospital - nt to appeal a complaint an appeal or a complaint  ur bed at (facility) during you will be responsible to pay at the facilities per diem the bed, the only reason that a to be admitted to (facility)  equired is not provided at ged by the physician to be of a or others, a time of readmission has an to the nursing home for naible.  I, in an interview with LPN #2 urse), when asked about the to the hospital for a resident ed, "Facesheet, med hold, care plan, transfer n, Background, Assessment, rm, and DNR (Do Not asked where staff ation provided to the ed, "Usually documented on take a note of what was  record revealed the	F	623			
	"Nursing Home to Ho	spital Transfer Form" dated lid not document that written					

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i .		MICHICAID SEVAICES	<del></del>			<u>OMB NO</u>	<u>), 0938-0391</u>
STATEMENT ( AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		496389	B. WING		·	1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER		<del></del>		STREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY O	F WINCHESTER, LLC				110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	nursing or social work that written notification resident representative. A review of the facility Notification & Rights to "Notice Before Transfers or discharge must: *Notify the resident reasons for the meand manner they undo send a copy of the notice of the State Ombudsman; *Recort transfer or discharge is record. Timing of the or discharge must be resident is transferred when:An Immediate required by the resident needsNotices must practicable before transfer or discharge must be resident is transferred when:An Immediate required by the residencedsNotices must practicable before transfer to the ombude can be sent when pra residents on a month!	mbudsman.  If record failed to reveal any cer notes that documented in was provided to the re and Ombudsman.  If policy, "Transfer/Discharge to Appeal" documented, sfer: Before a center is a resident the center dent and resident ine transfer or discharge and ove in writing (in a language erstand); "The Center must attice to a representative of a Long-Term Care of the reasons for the in the resident's medical in Notice: Notice of transfer made 30 days prior to a or discharged except in the resident's medical in the resident's medical in the resident's medical in the resident's medical in the resident's medical in the resident's medical in the resident's urgent medical in the second as a list of y basis"  ASM #1 (Administrative decutive Director) and ASM raing) were made aware of ear information was provided	F	623			
	References:						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		495389	B, WING			C 01/09/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	L	
ENVOY O	F WINCHESTER, LLC				10 LAUCK DR Vinchester, va 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Vimpat - is used to	o treat selzures,	F	323			
	tml	ov/druginfo/meds/a609028.h					
	<ol> <li>Glioblastoma is a malignant (cancerous) bra tumor that develops from a specific type of bra cell called an astrocyte. This information was obtained from the website:</li> </ol>						
	https://rarediseases.ir ioblastoma	nfo.nih.gov/diseases/2491/gl					
F 625 SS=D	Notice of Bed Hold Po CFR(s): 483.15(d)(1)(	olicy Before/Upon Trnsfr (2)	F	325			
	§483.15(d) Notice of I	bed-hold policy and return-					
	nursing facility transfet the resident goes on t	provide written information to					
	<ul><li>any, during which the return and resume refacility;</li><li>(ii) The reserve bed p</li></ul>	ayment policy in the state					
	paragraph (e)(1) of the resident to return; and	y's policies regarding ch must be consistent with is section, permitting a					
	of this section.	ld notice upon transfer. At					
l			j .			1	[ ]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495389	B. WING			1	Compan
	OVIDER OR SUPPLIER WINCHESTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603			1 0.17	09/2020
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	facility must provide to resident representative specifies the duration described in paragraphis REQUIREMENT by:  Based on staff intervand facility document that the facility staff falled notice upon a horesidents in the surve The facility staff falled notice was provided to transfer on 12/10/19.  The findings include:  Resident #65 was ad 12/9/19. Diagnoses in to, brain cancer, apha obesity, alcohol abus Due to the short amo in the facility prior to the (Minimum Data Set) accompleted. The admit and admission nursing documented the resident went to the resident went to the facility prior to the completed of the clinical resident went to the facility prior to the person, place and the resident went to the facility prior to the same and admission nursing documented the resident went to the facility prior to the same and current of the facility prior to the same and admission nursing documented the resident went to the facility prior to the facility prior to the same and current of the facility prior to the facility prior	apeutic leave, a nursing of the resident and the re written notice which of the bed-hold policy wh (d)(1) of this section.  Is not met as evidenced lew, clinical record review, review, it was determined alled to provide a written bed espital transfer for 1 of 36 y sample; Resident #65. It to evidence that a bed hold apon Resident #65's hospital mitted to the facility on included, but are not limited asia, convulsions, epilepsy, e, and adult failure to thrive, unt of time, the resident was the hospital transfer the MDS assessment had not been ssion nursing assessment g note dated 12/9/19, dent was alert and oriented	F	625	<ol> <li>On 1/9/2020 written notisent to Resident Represe resident #65.</li> <li>All residents who transfer facility have the potential effected. Transfer/dischareview was completed or for all discharges since 1/Follow-up based on findin</li> <li>Nursing staff re-educated transfer notice and social re-educated on notifying Representative and Omb transfer by the DCS/desig 2/15/2020.</li> <li>DCS/designee to complet transfer/discharge quality any discharges to ensure maintained weekly for fo Follow up based on findin reported to the facilities meeting. Quality Monito modified based on findin</li> <li>Date of compliance 2/15/</li> </ol>	r from the f	for he lity 020 ling the staff ident of or for ince is

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<u> </u>		NEDIONID SERVICES				OM	B NO. 0938-0391
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F 625	admitted with diagnos mental status with sig and possibly UTI. Sh (intravenous) antibioti (1) and follow up with immunotherapy. She (skilled nursing facility therapy and occupation nursing care. She late combative nature and residents, she was se for psych (psychiatric).  On 1/08/20 03:59 PM (Licensed Practical Netransfers to the hospit to the hospit to the hospit al, LPN # [medication] llst, bed if form, SBAR (Situation Recommendation) for Resuscitate)." When document the paper whospital, LPN #2 state the transfer form or m sent."  Review of the clinical "Nursing Home to Hospit 1/2/10/19. This form dhold notice was provice resident representative."	is of syncope, altered nificant cognitive decline e underwent IV cs, continue steroid, Vimpat oncology group for got transferred to SNF of for PT/OT (physical onal therapy) and 24 hour er had erratic behavior with not safe for her and other nit to ER (emergency room) admission."  In an interview with LPN #2 crse), regarding residents al and the paper work sent 2 stated, "Facesheet, med nold, care plan, transfer and DNR (Do Not asked where staff work provided to the d, "Usually documented on ake a note of what was record revealed the spital Transfer Form" dated led to the resident and or e.  I record failed to reveal any er notes that documented the trepresentative on	F	625			
			1				1 1

STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		496389	B. WING			C 01/09/2020	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	<u> </u>	<del>09</del> /2020
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F 625	#1 (Other Staff Memb. Services), she stated notice to the family are the Ombudsman. The information about beef for Resident #65 she ombudsman notice for stated she missed do A review of a "Notice Policy For residents to generating OSM #1 stated she is case, documented:  The purpose of this leafter careful consider sent to an acute care The transfer was neces and (his/her) medical this facility. (Residen (name of hospital and Notice of Bed Hold Pour are being sent to are a Medicald/Medicadmitted to the hospital and Medicare does not pay Whatever your paymoursing home is paid are in the hospital, the someone else into you may have the rig is available in a semi-	in an interview with OSM per - the Director of Social that she usually sends a nd the same notice is sent to is form also contained it holds. OSM #1 stated that did not have the family and or this hospital transfer. She ing it.  of Transfer and Bed Hold ransferring to ED ent] or hospital" form that ends out but did not in this  etter is to inform you that ation, (resident name) was medical center on (date), essary for (his/her) welfare needs could not be met in it name) was transferred to it address.)  olicy:  the hospital today. If you care resident and you are tal, Virginia Medicaid and	F	625			

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	RCVIDER OR SUPPLIER F WINCHESTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		10 LAUCK DR	, V	0012020
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F 625	provided by this nursi Medicaid, you are elig home services.)  If the nursing home d first available bed in a you are ready to leave You have the You may also file For help in filing a Bed Hold:  If you wish to hold you your hospitalization, y privately for the room rate. Once you hold it you would not be able is if: 1. The level of care r (facility) 2. The patient is judg danger to themselves 3. The resident at the outstanding payment which they are respon  A review of the facility Notification & Right to criteria for the provision to the prov	ng home (and, if you are on gible for Medicaid nursing  oes not readmit you to the a semi-private room when e the hospital - right to appeal a complaint an appeal or a complaint  ur bed at (facility) during you will be responsible to pay at the facilities per diem the bed, the only reason that a to be admitted to (facility)  equired is not provided at ged by the physician to be of a or others. If time of readmission has an to the nursinghorne for naible.  If policy, "Transfer/Discharge of Appeal" did not include any on of a written Bed Hold  If, ASM #1 (Administrative executive Director) and ASM ursing) were made aware of ter information was provided	F	625			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49538 <del>9</del>	B. WING				00/2020
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F 625	tml  2. Glioblastoma is a n tumor that develops fi cell called an astrocyt obtained from the wel	o treat selzures.  from  ov/druginfo/meds/a609028.h  nalignant (cancerous) brain rom a specific type of brain e. This Information was	F	625			
F 655 SS≖D	Planning §483.21(a) Baseline (§483.21(a)(1) The fact implement a baseline that includes the instruction of the factive and personant that meet professional the baseline care plated (i) Be developed with admission.  (ii) Include the minimula necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.	ive Person-Centered Care Care Plans illity must develop and care plan for each resident uctions needed to provide centered care of the resident I standards of quality care, n must- n 48 hours of a resident's um healthcare information care for a resident ed to- on admission orders, endation, if applicable.	F	655			

	OT ON MEDIONIAL O	MEDIONID OFICEO			·		OMD M	7. 0936-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI. A. BUILD		CONSTRU	CTION	(X3) DATE SURVEY COMPLETED			
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ENVOY O	F WINCHESTER, LLC		110 LAUCK DR							
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<del>~</del>	<del>~</del>	· · · · · · · · · · · · · · · · · · ·	_							
F 655	F 655 Continued From page 17			655						
	comprehensive care plan in place of the baseline			Į						
	care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).		l							
				,	F655			*		
					1.	The baseline care plan for	resider	nt #163		
						was updated to include in	centive			
	§483.21(a)(3) The facility must provide the					spirometer on 1/8/2020.				
		resentative with a summary			3	Audit of base line care pla	ne to ái	neuro		
		plan that includes but is not			۷.	·				
	limited to:	ca the				they include incentive spir	ometer	was		
	(i) The initial goals of					completed by 1/10/2020.	No oth	er		
	dietary instructions.	resident's medications and				findings were noted.				
	(iii) Any services and	I treatments to be			2	Nursing staff will be re-ed	uratad	hy the		
		acility and personnel acting			3,	<del>-</del>		·		
	on behalf of the facilit	ty.				DCS/designee on including	incent	ave		
	(iv) Any updated infor	mation based on the details				spirometer and other med	lical			
		care plan, as necessary.	-			equipment on the care pla	ın bv			
		is not met as evidenced				2/15/2020.	•			
	by:	iew, facility document				, ,				
	review, and clinical re		1.		4.	The DCS/designee to com	plete tr	ne care		
		acility staff failed to develop				plan quality monitor for a	ny resid	lents		
		for the use of an incentive				with incentive spirometer	s and o	ther		
		of 32 residents in the				·				
	survey sample, Resid	lent # 163,				medical equipment to ens				
						compliance is maintained	weekly	tor		
	The findings include:					four weeks. Follow up ba	sed on			
	Resident # 163 wees	admitted to the facility on				findings and reported to t	he facil	ities		
	Resident # 163 was admitted to the facility on 01/03/2020 with diagnoses that included but were not limited to high blood pressure and chronic obstructive pulmonary disease [2].  The most recent MDS (minimum data set),			į		monthly QAPI meeting. C				
				•		•				
						Monitoring schedule mod	itied ba	ised on		
			1			findings.				
					5.		2020.			
	1	not due at the time of the								
	l survev.		1		I					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			EY 0
		495389	B. WING			C 01/09/20	120
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE 110 LAUCK DR WINCHESTER, VA 22603	, ZIP CODE	VIVOZA	12.0
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F 655	The facility's "Admiss dated 01/03/2020 for in part, "Cognition: Al Under "Communication Understood and Understood and Procand/or observation."  On 01/07/20 at 1:49 to 4:05 p.m., observation over-the-bed table respirometer.  On 01/08/20 at 8:25 are Resident # 163's over incentive spirometer.  The POS [physician's 01/01/2020 through 0 physician on 01/04/2 to evidence documer incentive spirometer.  The facility's baselined dated 01/03/2020 fail documentation for the spirometer.  On 01/08/20 at 8:30 conducted with Residual the incention of 163 stated sometime.  On 01/08/2020 at 1:0 conducted with LPN	ion Data Collection" sheet Resident # 163 documented ert, Oriented to Person." on" it documented, "Usually erstands." Under mented, "Special edures: None per history  o.m., at 2:43 p.m., and at ns of Resident # 163's vealed an incentive  a.m., an observation of r-the-bed table revealed an  s order sheet] dated 01/31/2020, signed by the 020 for Resident # 163 failed intation for the use of an  e care plan for Resident 163 led to evidence e use of an incentive  a.m., during an interview dent # 163, when asked if ve spirometer, Resident #	F 6				
	use of the incentive s	spirometer, LPN # 4 reviewed in for Resident # 163 and					

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC			S1 11	TREET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603	1 01/	09/2020
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F 655	stated that they could On 01/08/20 at 1:43 p conducted with LPN a coordinator. LPN # 5 physician order for Re spirometer. LPN # 5 spoken to Resident # that Resident # 163 w the incentive spirome would obtain a physic needed] use of an inc update the plan of ca On 01/08/2020 at app 5 provided this surve 163's revised baselin care plan documente [Respiratory] Functio incentive spirometer  The facility policy "Pla part the following: "Pl implement an Individe baseline care plan wi that includes, but not on admission orders, orders, therapy servic PASARR [Preadmiss Review] recommend other areas needed to the resident that mee care to ensure that the appropriately until the care is completed."  On 01/08/2020 at app (administrative staff re	not locate one.  D.m., an interview was \$\frac{1}{2}\$, traveling MDS a stated there was no esident \$\frac{1}{2}\$ 163's incentive further stated that they had a 163's nurse practitioner and would benefit from the use of ster. LPN \$\frac{1}{2}\$ 5 stated they clarify order for prn [as centive spirometer and re.  Droximately 2:00 p.m., LPN \$\frac{1}{2}\$ yor with a copy of Resident \$\frac{1}{2}\$ e care plan. The baseline \$\frac{1}{2}\$, "Altered Cardiac/Resping. Encourage use of PRN (as needed) \$1/8/20"."  The procedure: Develop and utilized-Person-Centered thin \$4\$ hours of admission limited to, initial goals based physician orders, dietary	F	655			

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F 655	3, regional director of 5 traveling MDS coor the findings.	e 20 clinical services and LPN # dinator, were made aware of n was provided prior to exit.	F	655			
	healthy after surgery illness, such as pneu obtained from the we	nelp you keep your lungs or when you have a lung monia. This information was bsite: ov/ency/patientinstructions/0					
F 656 SS=D	can lead to shortness was obtained from th https://www.nlm.nih.g Develop/Implement (	ov/medlineplus/copd.html. Comprehensive Care Plan	F	656			
·	implement a comprei care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identifi assessment. The cor describe the following (i) The services that or maintain the resid- physical, mental, and required under §483, (ii) Any services that	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's il mental and psychosocial fied in the comprehensive apprehensive care plan must					

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F 656	provided due to the re under §483.10, includ treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wit resident's representa (A) The resident's go desired outcomes.  (B) The resident's profuture discharge. Fact whether the resident's profuture discharge. Fact whether the resident's community was assessed local contact agencies entities, for this purportice, requirements set for section.  This REQUIREMEN' by:  Based on observation interview, staff interview, staff interview and facility document that the facility staff implement the comp 32 residents in the s #47, 41, 61, 37, 3, a care plan for Reside documentation for as facility staff failed to incentive spirometer Resident #41's compaltered respiratory si	esident's exercise of rights ling the right to refuse 3.10(c)(6). 6.10(c)(6).	F	656	1. The care plan for resident updated to include incent on 1/8/2020. The care plat #41 was updated to include diagnosis of diabetes and on 1/8/2020. Resident #6 scoop mattress and falls in interventions and the scowas added to the resident 1/8/2020. The oxygen flowers and falls in the nurse to physician or on 1/8/2020. Oxygen sate to be documented on resident #37s care were in the policy on medication of blood pressure medication of blood pressure medication was updated to reflect on 1/8/2020.	ive spire n for re le the interver i1 was is nats as i op matt ts care p w rate i adjuste dered fle uration i ident M respons e-educa adminis tion on or reside	ometer sident ntions sued fall ress olan on for d by ow rate evels AR and lible for lated on tration ent #47

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495389	B, WING				C
NAME OF P	ROVIDER OR SUPPLIER	770000	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	09/2020
ENVOY O	F WINCHESTER, LLC			i i	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X5) COMPLETION DATE
F 658	and services of the rediabetes. The facility intervention of a scood #61's comprehensive determined was a redfall on 12/29/19; and for the use of fall mat. The facility staff failed comprehensive care blood pressure medic facility staff failed to it Resident #25's compadministration of oxy.  The findings include:  1. Resident #47 was 12/13/2019 with diag were not limited to expneumonia (2) and codisease (3).  Resident #47's most set), an admission as (assessment reference Resident #47 as scood assessment for ment of 0 - 15, 15- being codaily decisions. Sect documented Resider therapy while a resident was conducted to the control of the section	esident's disease process of staff falled to include an up mattress on Resident care plan that the facility quired intervention, after a failed to follow the care plan is after a fall on 12/29/19. It to implement the plan for the administration of eations to Resident #37. The implement resident #37 and rehensive care plan for the gen.  admitted to the facility moses, that included but ingestive heart failure (1), heronic obstructive pulmonary recent MDS (minimum data issessment with an ARD ce date) of 12/19/19, coded ing a 15 on the staff all status (BIMS) of a score ognitively intact for making ilon O of the MDS at #47 as receiving oxygenent of the facility.	F	656		eter, dia ons, scoo on ordere leted by sident's tresses w no other oservatio it reflect omplete ased on medicat ompleted he policy on is foll o based of educated ometer, o	betes op d with vas r on of d on d for y on lowed on

NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 23 asked about the oxygen, Resident #47 stated that she doot used it recently but it was there in case she felt that she needed it.  The order summary report dated 01/01/20 through 01/31/20 documented, "12/14/19 Oxygen saturations) > (greater than) 92%."  The MAR (medication administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A, BUILDING COMPLETED			
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL TAG  F 656  Continued From page 23 asked about the oxygen, Resident #47 stated that she did not use it currently. Resident #47 stated that she used her oxygen when she first came into the facility in the middle of December but had not used it recently but it was there in case she felt that she needed it.  The order summary report dated 01/01/20 through 01/31/20 documented, "12/14/19 Oxygen @ (at) 2 (two) LPM (liters per minute) via (by way of) N/C (nesal cannula) to maintain sats (oxygen saturations) > (greater than) 92%."  The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.								
### Clarifying oxygen usage on the care plan, and administering oxygen and blood pressure medication per the plan of care by 2/15/2020 on implementing fall mats and scoop mattresses as care planned by the DCS/designee.  #### The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47 failed to evidence documentation of oxygen for Resident #47. Teiled to evidence documentation of oxygen for Resident #47. Teiled to evidence documentation of oxygen for Resident #47. Teiled to evidence documentation of oxygen for Resident #47.			495389	B. WING _			01/	09/2020
FREFIX TAG  (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 23  asked about the oxygen, Resident #47 stated that she did not use it currently. Resident #47 stated that she used her oxygen when she first came into the facility in the middle of December but had not used it recently but it was there in case she feit that she needed it.  The order summary report dated 01/01/20 through 01/31/20 documented, "12/14/19 Oxygen @ (at) 2 (two) LPM (liters per minute) via (by way of) N/C (nasal cannula) to maintain sats (oxygen saturations) > (greater than) 92%."  The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen to said oxygen usage to dated oxygen usage to					110 LAU	CK DR		
asked about the oxygen, Resident #47 stated that she did not use it currently. Resident #47 stated that she used her oxygen when she first came into the facility in the middle of December but had not used it recently but it was there in case she felt that she needed it.  The order summary report dated 01/01/20 through 01/31/20 documented, "12/14/19 Oxygen @ (at) 2 (two) LPM (liters per minute) via (by way of) N/C (nasal cannula) to maintain sats (oxygen saturations) > (greater than) 92%."  The MAR (medication administration record) dated "December 2019," and "January 2020" for Resident #47 failed to evidence documentation of oxygen for Resident #47.  The TAR (treatment administration record) dated "01/01/20-01/31/20" failed to evidence documentation of oxygen for Resident #47.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
The baseline care plan dated "12/15/19" for Resident #47 documented "Altered Cardiac/Resp. (respiratory) functioning)". Under "Interventions:" it documented in part, "O2 (oxygen) therapy as ordered, Monitor O2 saturation as ordered," The baseline care plan further documented, "Below are signatures and dates signifying the final review of the baseline care plan with transition to the Comprehensive Care Plan," signed by [Name of registered nurse] and [Name of Resident #47], dated "12/30/19."  The baseline care plan further documented in part, "This baseline care plan will be effective until the development of the Comprehensive Care Plan, which will supersede the baseline care plan. This document will remain a part of the resident's	F 656	asked about the oxygshe did not use it currently into the facility in the not used it recently be feit that she needed it.  The order summary rethrough 01/31/20 doc @ (at) 2 (two) LPM (tof) N/C (nasal cannul saturations) > (greated the facility of the MAR (medication dated "December 20 Resident #47 failed to oxygen for Resident "01/01/20-01/31/20" documentation of oxygen the baseline care plan kers in the facility of the facil	ten, Resident #47 stated that rently. Resident #47 stated rently. Resident #47 stated rently. Resident #47 stated rently. Resident #47 stated rently. Resident #47 stated rently. Resident #47 stated rently. Resident #47 stated rently. Resident #41.  The baseline care plan review of the baseline ion to the Comprehensive years will be effective until he Comprehensive Care plan.	F6	4.	plan, and administering oxyg blood pressure medication professore by 2/15/2020 by the DCS/designee. An in-service will be conducted by 2/15/20 implementing fall mats and s mattresses as care planned by DCS/designee.  The DCS/designee to comple plan quality monitor for any with incentive spirometer, fascoop mattresses, diabetes dand interventions, blood presented interventions and oxygen usage ensure compliance is maintain weekly for four weeks. Follow on findings and reported to the monthly QAPI meeting. Qual Monitoring schedule modified findings.	en and er the p for staff 220 on coop by the te the c resident Il mats, liagnosi ssure ge to ined w up ba he facil lity d based	are ts s

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMP	
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	<u> </u>	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	permanent record."  The comprehensive of failed to evidence douse of oxygen.  On 1/08/20 at 04:00 producted with LPN when asked the purp#2 stated that it lets yithe patient. When as completed, LPN #2 shave baseline care pand then the MDS (nupdate them. LPN # orders are received of interventions are addicated with LPN coordinator. When a comprehensive care used to drive the plat When asked if oxygen comprehensive care stated that it should oxygen is ordered at resident's room should LPN #6 stated, "Yes care plan for Reside administration as ne did not see one in the Conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator. When a conducted with LPN coordinator.	care plan for Resident #47 cumentation for as needed  p.m., an interview was (licensed practical nurse) #2. cose of the care plan, LPN you know how to take care of sked when care plans are stated that new admissions lans completed in 24 hours ninimum data set) staff 2 stated that when new or changes occur that new sted to the care plan. When sid to the care plan. When sid be on the comprehensive ated that it should.  m., an interview was #6, MDS (minimum data set) saked the purpose of the plan, LPN #6 stated that it is n of care of the resident. en should be on the plan for a resident, LPN #6 be. When asked if the nd available for use in the sld It still be on the care plan ." When asked about the nt #47 for oxygen eded, LPN #6 stated that she e record for Resident #47.  m., an interview was	F	656			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI	E SURVEY PLETED
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC			S'	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR /INCHESTER, VA 22603	<u> </u>	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	that they are good for comprehensive care is stated that when the completed it supersed and it is kept on the reafterwards.  On 01/09/20 at approximate request was made by (administrative staff or director for the facility implementing the care.  On 01/20/20 at approximate request was made by (administrative staff or director for the facility implementing the care.  On 01/20/20 at approximate request was made by (administrative staff or nursing stated that the Lippincott, and Potter practice.  The facility policy "Pla 11/30/2014; Revision documented in part, "I plan of care for each or measurable objectives resident's medical, nurpsychosocial needs the comprehensive assess.  According to Potter, P Griffin. (2005). Fundar Editlon, St. Louis, Monursing care plan is a also serves as a document's nursing care to care team. It is made ready reference for nursing car	21 days or until the colan is completed. LPN #5 comprehensive care plan is cles the baseline care plan accord as a reference eximately 12:30 p.m., a written list to ASM nember) #1, the executive policy on developing and a plan.  Eximately 1:30 p.m., ASM nember) #2, the director of a facility uses their policies, & Perry as their standard of the color of the color of the color of the facility uses their standard of the color of the	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495389	B. WING			1	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC	40000	5, 71110	S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR NINCHESTER, VA 22603	01/	09/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)			(X6) COMPLETION OATE
F 656	director, ASM #2, the the regional director of (licensed practical nu coordinator were made on 1/9/20 at approximation (administrative staff in director of clinical ser "Physician's Interim/T Resident #47, which of (discontinue) O2 (oxymedication) & (and) It dated "1/8/20, 1610 (provided a copy of the Resident #47 as doct No further information Reference:  1. Congestive heart for the heart can't pump body's needs. This I from the website: https://medlineplus.go.  2. Prieumonia - An ir lungs. This information website: https://medlineplus.go.  3. Chronic obstructive (COPD) is a disease breath that can lead to information was obtain https://www.nlm.nih.go.  2a. The facility staff for Incentive Spirometer.	director of nursing, ASM #3, of clinical services and LPN rse) #5, the travelling MDS de aware of the findings.  Inately 8:00 a.m., ASM nember) #3, the regional vices provided a copy of elephone Orders" for documented, "DC gen), Duonebs (nebulizer S (incentive spirometer)" 4:10 p.m.)." ASM #3 also to baseline care plan for amented above.  In was provided prior to exit.  Inateliure is a condition in which enough blood to meet the information was obtained by/heartfailure.html  Infection in one or both of the in was obtained from the ineplus.gov/pneumonia.html.  In pulmonary disease that makes it difficult to one shortness of breath. This ined from the website: gov/medlineplus/copd.html.  In alled to include the use of an include the use of	F	656			

1		A, BUILDI		CONSTRUCTION		SURVEY PLETED
	495389	B. WING.				C /09/2020
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC			11	REET ADDRESS, CITY, STATE, ZIP CODE 0 Lauck dr Inchester, va 22603	, <u>, , , , , , , , , , , , , , , , , , </u>	0012020
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	INT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Resident #41 was admitted 8/7/19; diagnoses include, I hydrocephalus, psychotic d cancer with removal of kidh defibrillator, high blood presidabetes, bipolar disorder, situsion, and cerebral palsy. (Minimum Data Set) with an Reference Date) of 12/21/11 as being cognitively intact in life decisions. The resident requiring extensive care for dressing, and transfers; sugand hygiene; and was incorbladder.  A review of the facility policy documented, "Develop a of care for each resident that measurable objectives and resident's medical, nursing, psychosocial needs that are comprehensive assessment Person Centered plan of ca not limited to the following: and needs; Services to attait resident's highest practicable and psychosocial well-being.  A review of the comprehens revealed one dated 1/7/20 fe has altered respiratory staturit (related to) Wheezing," Treveal the use of the Incentification.	d to the facility on but are not limited to, disorder, right kidney ney, cardiac ssure, atrial fibrillation, spinal stenosis with The quarterly MDS in ARD (Assessment 19 coded the resident in ability to make daily it was coded as r bathing, toileting, pervision for eating intinent of bowel and  by, "Plans of Care" a comprehensive plan iat includes I timetables to meet the i, mental and e identified in the itThe individualized are may include but is Resident's strengths ain or maintain the ble physical, mental, g"  sive care plan for "(Resident #41) us/difficulty breathing This care plan failed to tive Spirometer.	F	656			

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		I CONDUCTIVIOES				OMR M	<i>J.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;	(X2) MUI A. BUILL		E CONSTRUCTION		E SURVEY PLETED
		495389	B. WING				C /09/2020
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200200	W 153351 M 1 Park			1	110 LAUCK DR		
ENVOYO	f winchester, llc			1	NINCHESTER, VA 22603		
(X4) ID	TO VOLAMANIE	ATEMENT OF DEFICIENCIES	T	·	<del></del>		<del></del>
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F 656	Continued From page	28		656			
		ncentive Spirometer was		000			
	observed on the over	had table					
	20001100 011 (10 010)	bod table.					
	On 1/08/20 at 8:52 At	VI. the resident was					
	observed inn bed. Th	ne Incentive Spirometer					
	remained as previous	ly observed.					
	On 1/08/20 at 1:00 Pt	M, the Resident #41 was					
	observed, and an inte	erview was conducted. The					
	over bed table was ac	cross the resident. The					
	incentive spirometer v	was on the table. Resident					<b>!</b>
	#41 stated that he has	s used it on occasion,					ļ
	On 1/8/20 at 1:07 PM	In an Interview with RN #1					
		he stated that there should					
	be an order for the us	e of the Incentive					
•		ated that the residents					
	"come in with them fro	om the hospital."					
	On 1/8/19 at 4:04 PM	, during in an interview with					
	LPN #2 (Licensed Pre	actical Nurse), when asked					
	about the purpose of	a comprehensive care plan,					
	LPN #2 stated, "so the	at we know how to take care					***************************************
	of the patient." When	asked if a resident's					
	be care planned, LPN	s, medications, etc., should					
	ne care planned, LFN	#2 Stated, " Yes,"	1				
	On 1/8/19 at 3:13 PM	, in an interview with RN #1,					
	she stated that it (Ince	entive Spirometer) should					
	have been care plann	ed when he came back					
		it on 12/28/19. RN #1					
	stated that he would b	enefit from using it since he					
	has been treated for r	espiratory issues since				Í	
<u> </u>	1/6/20.						
	On 1/8/20 at 5:50 PM	, ASM #1 (Administrative					
,	Staff Member - the Ex	recutive Director) and ASM				j	
	#2 (the Director of Nu	rsing) were made aware of				·	
	the findings. No furth	er information was provided	1				

STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION		SURVEY PLETED
		495389	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	L.		STI	REET ADDRESS, CITY, STATE, ZIP CODE	01	/09/2020
ENVOY O	F WINCHESTER, LLC				DLAUCK DR NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 656	Continued From page by the end of the surv		F	356			
	2b. The facility staff factoring comprehensive care parties the Resident #41's dis	ailed to develop the plan for care and services of sease process of diabetes.					
	On 1/08/20 at 8:52 Al Nurse) was observed administering the folk Resident #41:	preparing and		- Anna Carlo			
	Clonidine (1) 0.1 mg (milligrams), 1 tablet Metoprolol (2) 100 mg, 1 tablet Metformin (3) 500 mg, 1 tablet Depakote (4) ER (extended release) 500 mg, 1 tablet						
	Accupril (5) 20 mg, 1 Folic Acid (6) 1 mg, 1 Azithromycin (7) 250 Prednisone (8) 20 mg Mucinex (9) 600 mg,	tablet mg, 1 tablet <sub>I</sub> , 1 tablet		T Y THAT PHANCE AND THE ACTION			
	were also noted as be	the following medications bing ordered but were not stered to Resident #41:					
	Multivitamin (10), 1 ta Vitamin D (11) 25 mcç daily. Glimepiride (12) 4 mg	g (micrograms) (1000 units),					
	relation to the residen	not administered as no documented		***************************************			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		495389	B. WNG				3
NAME OF PROVIDER OR SUPPLIER ENVOY OF WINCHESTER, LLC		430303	D. YANG	S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	<u>  01/</u>	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	provision of care and resident's diabetes.  On 1/8/20 at 4:04 PM (Licensed Practical Numbers of a compressated, "so that we kny patient." When asketreatments, medication planned, LPN #2 stated.  On 1/9/20 at 1:07 PM Staff Member - the Employer of Note of the Sumber of	I, in an interview with LPN #2 lurse), when asked about the hensive care plan, LPN #2 now how to take care of the dif a resident's conditions, ons, etc., should be care ed, "Yes."  If, ASM #1 (Administrative executive Director) and ASM cursing) were made aware of her information was provided eyey.  If to treat high blood  If from ov/druginfo/meds/a682243.h  If the different diabetes from ov/druginfo/meds/a682864.h  If the different diabetes from ov/druginfo/meds/a696005.h  If the different disorder disorder with the disorder disorder disorder with the disorder dis	F	656			

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			SURVEY PLETED
		495389	B. WING			į	C
ENVOY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIF 110 LAUCK DR WINCHESTER, VA 22603	CODE	1 01	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
F 656	Continued From page		F	356			
	Information obtained	o treat high blood pressure. from ov/druginfo/meds/a692026.h	THE STATE OF THE S				
	Folic Acid - helps to cells. Information obtained the https://medlineplus.go.						
	7. Azithromycin - is a Information obtained i https://medlineplus.go	n antibiotic. from v/druginfo/meds/a697037.h				:	
	changing the way the Information obtained f	es swelling and redness by immune system works. From works/druginfo/meds/a601102.ht	***************************************				
	Information obtained f	o relleve chest congestion. rom v/druginfo/meds/a682494.h					
	keep you in good heal Information obtained f https://www.webmd.co	to poor diet, certain egnancy. Vitamins are ks of the body and help th.				A. I. V. Marting Fig. 1. and T. Miller (Martin) and M. Miller (Marti	,
		ns are substances that					

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STATEMENT ( AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495389	B. WNG	•		1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	10012020
				1	110 LAUGK DR		
ENVOYO	f winchester, llc						
				l v	NINCHESTER, VA 22603		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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ino	NEGOLATORI OK	LOC IDENTIFTING INFORMATION)	TAG	1	CROSS-REFERENCED TO THE APPROPRI	ATE.	DATE
					DEFICIENCY)		
F 656	Continued From page	32	F	656			1
	your body needs to a	row and develop normally.			***		
	Vitamin D helps your	hody absorb calcium					
	Calcium is one of the	main building blocks of	į.				
	bone, A lack of vitami	n D can load to hone					
	diseases such as act	eoporosis or rickets. Vitamin					
	Distance a role in w	our nerve, muscle, and	-				
	immune systems.	our nerve, muscie, and					
	Information obtained	<b>r</b>					
	https://medlineplus.go	ov/vitamind.html					
	4= =0						
	12. Glimepiride - is u	sed to treat diabetes.					
_	Information obtained t						
	https://medlineplus.go	ov/druginfo/meds/a696016.h					
	tml			ĺ			1
	3. The facility staff fail	ed to include an intervention					
	of a scoop mattress of	n Resident #61's					
	comprehensive care p	olan that the facility					
	determined was a reg	ulred intervention, after a					}
	fall on 12/29/19: and f	alled to follow the care plan					
	for the use of fall mate	s after a fall on 12/29/19.					
	THE STATE OF THE PROPERTY OF	aller a fall off 12/20/18.		- 1			
	Resident #61 was adr	nitted to the facility as	-			1	
<b>'</b>	12/23/10: disappear in	nclude but are not limited to,		***************************************			
	dementia with habavia	ricide but are not limited to,		ĺ			
	dementia Mitt DeliaMi	ors, panic disorder, thyroid					
	disorder, restless leg,	anxiety disorder, high blood					
	pressure and delirium	. The admission / 5-day					
	MINIMUM Data	Set) assessment with an		1			
	AKD (Assessment Re	ference Date) of 12/29/19					
	coded the resident as	being severely impaired in					
	ability to make daily lif	e decisions. The resident		1			
	was coded as requirin	g total care for bathing.		l		ļ	
	hyglene, toileting, and	eating; extensive		- Landanian Company		į	
	assistance for ambula	tion and transfers; and was					
	coded as incontinent of	of bowel and bladder.					
ļ		CONTRACTOR OF STATES	1				
	A review of the clinical	record revealed a nurse's		ĺ			
	note dated 12/29/19 a	t 6:30 AM that documented.				ļ	

STATEMENT AND PLAN OI	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495389	B. WNG			l .	C
NAME OF P	ROVIDER OR SUPPLIER	40000	10,11110	,	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020
ENVOY Q	F WINCHESTER, LLC			1 .	110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	"Resident yelling out" sitting position. MAE" well), vital signs obtain checks initiated. NP is and RP (responsible) and RP (responsible). A review of a fall investocumented that the go to the bathroom but the documented that the go to the bathroom but the discuss/review reside sitting on (R) (right) si position. No injuries, med [medication] review recommendations at the discussion of t	"help me!" Found on floor in W (moves all extremities ned, neuro (neurological) (nurse practitioner), son, party) notified."  stigation dated 12/29/19 resident stated she had to at did not ask for help.  eam (IDT) meeting note nented, "IDT met to nit's fall on 12/29/19. Found de of bed in floor in sitting B+B (bowel and bladder), ew. No further his time."  eam meeting note dated IDT met to discuss/review alling last 30 days. B+B, er recommendations at this eam meeting note dated IDT met to discuss/review nere was no fall noted on the IDT note dated 1/3/20). If floor beside bed. No oop mattress. No further	F	656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

MAKE OF PROVIDER OR SUPPLIER

ENVOY OF WINCHESTER, LLC

(X1) PROVIDER STATEMENT OF DEFICIENCIES WINCHESTER, LLC

PRINTED: 01/31/2020

FORM APPROVED

(X2) MULTIPLE CONSTRUCTION

A BUILDING

C

B, WING

STREET ADDRESS, CITY, STATE, ZIP CODE

110 LAUCK DR

WINCHESTER, VA 22603

(X4) ID

PROVIDER'S PLAN OF CORRECTION

(X5)

PRINTED: 01/31/2020

FORM APPROVED

OMB NO, 0938-0391

(X3) DATE SURVEY

COMPLETED

C

WINCHESTER, VA 22603

	· · · · · · · · · · · · · · · · · · ·				U1/(	09/2020
IAME OF PI	ROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE		
ENVOY OF WINCHESTER, LLC			1	10 LAUCK DR		
HYUT U	r windings fer, elu		1	WINCHESTER, VA 22603		
0411.45	ON HALADY OTHER LEVEL OF COMMENT		1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETK DATE
F 656	Continued From page 34		F 656			
	fall with no injury r/t (related to) poor balance, poor communication/comprehension." This care plan included the intervention, dated 12/30/19 for "Fall mats on both sides of bed." The care plan did not include any intervention for the care plan.	OT .				
	did not include any intervention for the scoop mattress.					
	On 1/09/20 at 10:46 AM, LPN #3 (Licensed Practical Nurse) was asked about the fall mats and scoop mattress for Resident #61. She state that she was not aware the resident was to have fall mate and a second part that she	•			***************************************	
	fall mats and a scoop mattress. At this time, she checked on Resident #61 and verified that there were no fall mats or scoop mattress in place. When asked about implementing these interventions, LPN #3 stated, "They should have					
	been implemented as soon as it was decided shaded them." When asked about updating and following the care plan for these interventions, LPN #3 stated, "They should have been	16				
	care-planned and the care plan followed for them."				1	
	On 1/9/20 at 1:07 PM, ASM #1 (Administrative Staff Member - the Executive Director) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided	f			***************************************	
	by the end of the survey.				***************************************	٠
	4. The facility staff failed to implement the comprehensive care plan for the administration blood pressure medications to Resident #37.	of			***************************************	
	Resident #37 was admitted to the facility on 12/10/19; diagnoses include but are not limited an encephalopathy, heart disease, dysphagia, diabetes, atrial flutter, abdominal aortic aneurysm, high blood pressure, cardiac	ю,			fore-mind of the second contract contra	

STATEMENT ( AND PLAN OR	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495389	B. WING			I	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			'	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	1 01	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 656	pacemaker, and pneu 5-day MDS (Minimum an ARD (Assessment 12/17/19 coded the recognitively impaired in decisions. The reside total care for bathing assistance for transfe was independent for a bowel and bladder.  A review of the compressident #37 revealer "(Resident #37 revealer "(Resident #37) has a rft (related to) CVA (co CAD (coronary artery (hypertension - high be (hyperlipidemia). This intervention, dated 1/6 meds [medications] a Cn 1/08/20 at 9:08 All Nurse) was observed the following medication Allopurinol (1) 100 mg Atenolol (2) 25 mg, 3 only prepared 1 tablet Eliquis (3) 2.5 mg, 1 to Multivitamin (4), 1 tab Vitamin D3 (5), 1000 units.  On 1/8/19 at 3:27 PM RN#1, when asked at medication administral	Imonia. The admission / In Data Set) assessment with Reference Date) of Resident as significantly In ability to make daily life ent was coded as requiring and toileting; extensive rs, dressing, and hygiene; reating; and incontinent of Interest of the se	F	656	3		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MUL A, BUILD		(X3) DATE SURVEY COMPLETED		
		495389	B. WNG		С		
NAME OF P	ROVIDER OR SUPPLIER	430303	S. VVIIVO		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Review of the clinical physician's orders do was to receive three the Atenolol. RN #1 only during the observation. On 1/09/20 at 9:54 Al with RN #1, when ask Atenolol, RN #1 state know him that well." comprehensive care in the administration of medication, RN #1 staff Member - the Example 1:07 PM Staff Member 1:07 PM Staff Member 1:07 PM Staff Member 1:07 PM Staff	record and medications, the cumented that the resident ablets (75 mg) of the administered one tablet n.  M, in a follow up interview ked about the dose of the d, "I don't know. I don't When asked if the plan was implemented for his blood pressure	F	656			
	the findings. No furth by the end of the survive References:  1. Allopurinol is used Information obtained https://medlineplus.grtml  2. Atenolol is used to Information obtained https://medlineplus.grtml  3. Eliquis is used to clots in people with a Information obtained	ler information was provided /ey.  I to treat gout, from ov/druginfo/meds/a682673.h  o treat high blood pressure, from ov/druginfo/meds/a684031.h  prevent strokes and blood trial fibrillation.					

STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495389	B. WING			I	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CO 110 LAUCK DR WINCHESTER, VA 22603		1 01/	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	4. Multivitamin - used deficiency due to pood during pregnancy. Vit blocks of the body an health. Information obtained https://www.webmd.co.// 8/multivitamin-oral/multivitamins-oral/detalls  5. Vitamin D - Vitami body needs to grow a Vitamin D helps your Calcium is one of the bone. A lack of vitami diseases such as osted D also has a role in yimmune systems. Information obtained https://medlineplus.go.//medline	It to treat or prevent vitamin or diet, certain illnesses, or amins are important building dhelp keep you in good from om/drugs/2/drug-18820-903 aultivitamins-includes-prenata in a are substances that your and develop normally, body absorb calcium, main building blocks of in D can lead to bone apporosis or rickets. Vitamin our nerve, muscle, and from ov/vitamind.html led to implement resident # are plan for the gen. in an individual in an and alimonary disease [1].  ecent MDS (minimum data assment with an ARD are date) of 09/26/19, coded and a 12 on the staff al status (BIMS) of a score		656			

CTATE LACATE		CAL SOCIATION OF TAXABLE	T				<i>).</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		SURVEY PLETED
		495389	B. WING			į.	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	I Alinaizaza	
					10 LAUCK DR		
ENVOY O	f winchester, llc			1	VINCHESTER, VA 22603		
NA 15	CHANACO	ATTUCK OF OFFICE VOICE		ب	<del></del>		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	<b>=</b>	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
'							
F 656	Continued From page	<del>3</del> 8	F	656			
	Programs" coded Res	sident # 3 for the use of					
	oxygen.						
					***		
	On 01/07/2020 at app	proximately 3:15 P.m., an					
		ent # 3 revealed they were					
		oxygen by nasal cannula					
		en concentrator that was					]
	running. Observation	of the oxygen flow meter					
	on the oxygen concer	ntrator revealed a flow rate					1
	of one-and-a-half liter	s per minute.					
	On 01/09/2020 at 40.	20 am an abanamation of					
	Resident # 3 revealer	39 a.m., an observation of d they were lying in bed	1				
	receiving overage	rasal cannula connected to					
	an oxygen concentral		ŀ				·
	Observation of the ox	tygen flow meter on the					
	oxygen concentrator	revealed a flow rate of					
·	one-and-a-half liters p						
	The POS [physician's	order sheet] dated					
		11/31/2020 and signed by the					
	physician on 1/7/2020	0 for Resident #3					
		19 Oxygen at 2L [two liters					
	per minute) via [by] na	asal cannula every shift."					
	T						
	ine comprehensive o	are plan for Resident # 3					
	with a revision date of	f 12/31/2018 documented,					
	SOB of training to 1	) has shortness of breath					
	Date Initiated 12/31/2	ecreased lung expansion.					
	12/31/2018," Under "	.v.io. Revision on Interventions" it					
		Oxygen setting: O2 [oxygen]					
	2L via NC [nasal can	nulal. Date initiated					]
	12/31/2018. Revision						
		·· · · · · · · · · · · · · · ·					
	On 01/08/2020 at 1:0	0 p.m., an Interview was					
		licensed practical nurse]#					
		scribe the procedure for					
	reading the oxygen, fi	low rate meter on an oxygen					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTIONS		(X3) DATE SURVEY COMPLETED	
		495389	B. WING			) c	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		] 01/	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 656	concentrator, LPN # eye level with the me pass through the mic asked to read the flor oxygen concentrator, meter, LPN # 4 state at one-and-a-half lite what the flow rate sh two-liter's per-minute the flow rate on the c reviewing Resident # plan for oxygen, LPN plan was being imple On 01/08/2020 at api (administrative staff r director and ASM # 2 3, regional director of 5 traveling MDS coor the findings. No further information References: [1] Disease that make can lead to shortness was obtained from th https://www.nlm.nih.g 6. The facility staff fai 25's comprehensive of administration of oxyg Resident # 25 was ac 11/20/2019 with diagn not limited to respirat breath and chronic of [1].	4 stated, "You should be at ster and the liter line should lide of the ball. LPN # 4 was w meter on Resident # 3's  After looking at the flow d the oxygen flow rate was rs per minute. When asked ould be, LPN # 4 stated  LPN # 4 then readjusted oxygen concentrator. After 3's comprehensive care # 4 was asked if the care mented. LPN # 4 stated no.  Proximately 5:50 p.m., ASM nember) # 1, the executive director of nursing, ASM # f clinical services and LPN # dinator, were made aware of the was provided prior to exit.  The sit difficult to breath that the of breath. This information is website; pov/medlineplus/copd.html.  Ited to implement resident # care plan for the	F	356			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

1		VEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER		<u>.</u>	T	STREET ADDRESS CITY STATE 7D CODE	1 01.	/09/2020
			STREET ADDRESS, CITY, STATE, ZIP CODE		110 LAUCK DR		
ENVOY O	F WINCHESTER, LLC				WINCHESTER, VA 22603		•
44410	OLD MANAGEMENT OF		<del></del>				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION		(X6) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)	-	
·						<del></del>	
F 656	Continued From page	40	F	65	6		
	set), a quarterly asse	ssment with an ARD					
	(assessment reference	e date) of 11/29/19, coded					
	Resident # 25 as scor						
		al status (BIMS) of a score					
	of 0 - 15, 14- being co	gnitively intact for making					
	daily decisions. Resid	dent # 25 was coded as					
	requiring extensive as	ssistance of one staff					
	member for activities	of daily living. Section O					
	"Special Treatments,	Procedures and Programs"					
	coded Resident # 25	for the use of oxygen.					
	On 01/07/00 at 4:05						
	Resident #25 reveale	o.m., an observation of					
	an oxygen concentrat	asal cannula connected to					
	Observation of the flo	w meter on the oxygen			-		
	concentrator revealed	an oxygen flow rate set at					
	three-and-a-half liters	ner minute					
	THE WALL OF STREET	por mariato.					
	On 01/07/20 at 2:45 p	.m., an observation of					
	Resident #25 revealed	d they were in bed receiving					
	oxygen by nasal cann	ula connected to an oxygen					
	concentrator that was	running. Observation of					
	the flow meter on the						
	revealed an oxygen fl						
	three-and-a-half liters	per minute.					
	On 01/07/00 at 4:00						
	On 01/07/20 at 4:05 p	.m., an observation of					
	Resident #25 revealed						
	an oxygen concentrat	asal cannula connected to					
	Observation of the flor	or that was running. w meter on the oxygen					
	Concentrator revealed	w meter on the oxygen an oxygen flow rate set at			***************************************		
	three-and-a-half liters	ner minute					
		hor mando.					
	On 01/08/20 at 8:30 a	.m., an observation of					[
	Resident #25 revealed	d the resident in bed					
	receiving oxygen by n	asal cannula connected to					<b> </b>
	an oxygen concentrate						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	
		496389	B. WNG				С
NAME OF D	ROVIDER OR SUPPLIER	49000	0. 741140			01/	09/2020
	F WINCHESTER, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 Lauck dr Vinchester, Va. 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	concentrator revealed three-and-a-half liters The POS [physician's 01/01/2020 through 0 physician on 1/7/2020 documented, "12/17/liters per minute] via   continuous every shift saturation] [2] greater The comprehensive of with a revision date of "Focus: [Resident # 2 Failure. Revision Date of "Interventions" it doct setting: O2 [oxygen] of Revision on 12/03/20 On 01/08/2020 at application of the procedure for reading on an oxygen concentional nurse] # 4. In procedure for reading on an oxygen concentional nurse in the procedure for reading on an oxygen concentional pass through the should pass throug	ow meter on the oxygen of an oxygen flow rate set at a per minute.  sorder sheet] dated 21/31/2020 and signed by the O for Resident # 3 19 Oxygen @ [at] 4L [four [by] nasal cannula it to maintain SPO2 (oxygen r than 90%."  care plan for Resident # 25 f 12/03/2019 documented, E5] has Congestive Heart te: 12/03/2019." Under umented in part, "Oxygen via NC [nasal cannula] at 4L, 19."  proximately 1:00 p.m., an atted with LPN [licensed When asked to describe the of the oxygen, flow rate meter attrator, LPN # 4 stated, "You will with the meter and the liter ugh the middle of the ball, oread the flow meter on en concentrator. After eter, LPN # 4 stated the at three-and-a-half liters per what the flow rate should ur-liter's per-minute. LPN # flow rate on the oxygen eviewing Resident # 25's plan for oxygen, LPN # 4 plan was being	F	656			
	Implemented, LPN#	4 stated no.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		496389	B, WING					
ENVOY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		110 LAUCK DR	017	oo; Lond	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657 SS=D	On 01/08/2020 at app (administrative staff m director and ASM # 2, 3, regional director of 5 traveling MDS coord the findings.  No further information References: [1] Disease that make can lead to shortness was obtained from the https://www.nlm.nih.g Care Plan Timing and CFR(s): 483.21(b)(2)(2) §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse alde with resident. (D) A member of food (E) To the extent practite resident and the manual control of the resident and the manual control of the explanation must it.	proximately 5:50 p.m., ASM member) # 1, the executive director of nursing, ASM # clinical services and LPN # dinator, were made aware of a was provided prior to exit.  It was provided prior to exit.  It is it difficult to breath that of breath. This information is exebsite: ov/medlineplus/copd.html.  It Revision (i)-(iii)  In the provided prior to exit.  It days after completion of exessment.  It is days after completion of exessment.  It is existent it is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.  It is a completion of exessment.		656				
	not practicable for the resident's care plan.	resentative is determined development of the staff or professionals in						

F 657  Continued From page 43 disciplines as determined by the resident,  F 657  Continued From page 43  Cross-referenced to the appropriate Deficiency)		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 43  disciplines as determined by the resident,  TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  WINCHESTER, VA 22603  (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  F 657  Continued From page 43  disciplines as determined by the resident's needs or as requested by the resident,			495389	B, WING			1	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 43 disciplines as determined by the resident's needs or as requested by the resident,				l	S 1	10 LAUCK DR	<u>  01/</u>	/09/2020
disciplines as determined by the resident's needs or as requested by the resident,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(iiii)Reviewed and revised by the Interdisciplinary team after each assessment, Including both the comprehensive and quarterly review assessments.  This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan, for two of 32 residents in the survey sample, Resident #6 and Resident #25. The facility staff failed to review and revise Resident #5.25. The facility staff failed to review and revise Resident #5.26 and services and care of an indwelling catheter. The facility staff failed to review and revise the comprehensive care plan for Resident #25 to include the use of an indwelling catheter. The facility staff failed to review and revise the comprehensive care plan for Resident #25 to include the use of an incentive spirometer [1].  The findings include:  1. Resident # 6 was admitted to the facility on 07/02/19 with diagnoses that included but were not limited to: heart failure, stage 4-kidney disease and high cholesterol.  Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/22/19, coded Resident # 6 as scoring a 14 on the brief interview for mental status (8IMS) of a score of 0 - 15, 14 - being cognitively intact for making dally decisions.  The POS [physician's order sheet] dated and signed by the physician on 12/27/19, for Resident # 6 documented,		disciplines as determior as requested by the (iii)Reviewed and reviteam after each assessments.  This REQUIREMENT by:  Based on staff interviand clinical record revite facility staff failed comprehensive care in the survey sample, #25. The facility staff Resident #6's comprehospice care and servindwelling catheter. To review and revise the for Resident #25 to in incentive spirometer [  The findings include:  1. Resident # 6 was a 07/02/19 with diagnosmot limited to; heart fadisease and high cholonimited to; heart fadisease and reference Resident # 6 as scorir interview for mental staff. 15, 14 - being cognitions.  The POS [physician's signed by the physician's	ined by the resident's needs be resident, ised by the Interdisciplinary sament, including both the quarterly review  Is not met as evidenced  iew, facility document review view, it was determined that to review and revise the plan, for two of 32 residents. Resident #6 and Resident failed to review and revise chensive care plan to include vices and care of an the facility staff failed to comprehensive care plan clude the use of an 1].  Indmitted to the facility on ses that included but were affure, stage 4-kidney lesterol.  Recent MDS (minimum data assment with an ARD be date) of 10/22/19, coded and a 14 on the brief tatus (BIMS) of a score of 0 tively intact for making daily	F	657			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·			OMB NO. 0938-0391			
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		SURVEY PLETED	
						,	C	
14415.053		496389	B. WING		· · · · · · · · · · · · · · · · · · ·	01/	/09/2020	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
ENVOY O	F WINCHESTER, LLC				LAUCK DR			
<del></del>	T			WIN	CHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	i Vie	(X6) COMPLETION DATE	
F 657	Continued From page "Hospice services to Hospice and Telepho to be @ [at] facility 12	eval [evaluate]. [Name of ne Number], Hospice nurse	* ************************************	F657 1.	The care plan for resident #25	wac		
	12/27/2019." "Foley o	atheter for comfort		1				
	measures. Dated: 12				updated to include incentive s			
	massa see as an				on 1/8/2020. The care plan fo			
		6's clinical record revealed "[Name of Hospice] form."			#6 was updated to include hos			
	The form documented	in part, "Patient Name:			indwelling catheter care on 1/8			
	[Name of Resident # 6]. This is a patient of [Name of Hospice], INC. as of 12/28/19."			2.	Audit of care plans to ensure the	ney		
					include incentive spirometer, h	ospice		
	The comprehensive of	are plan for Resident #6			and indwelling catheter care w	•		
	dated of 01/06/2020 f	alled to evidence care and			completed by 1/10/2020. Follo			
	services for an indwelling catheter, and failed to				based on findings	w-ab		
	evidence documentation for hospice care and services			2	<del></del>			
	services. On 01/08/2020 at 3:2: conducted with LPN [5, traveling MDS coordescribe the purpose comprehensive care papedific to the resident done for the resident the process for updatiplan, LPN # 5 stated, the resident's status, care plan should be usaked to review the care plan for Resident # 6. When a care plan for Resident LPN # 5 stated she was care plan. When aske have been updated to provided, LPN # 5 stated the comprehensive care conductive care plan.	20 at 3:20 p.m., an interview was th LPN [licensed practical nurse] # iDS coordinator. When asked to curpose of the resident's we care plan, LPN # 5 stated, "It is resident and tells what should be resident." When asked to describe or updating the comprehensive care is stated, "When there is a change in status, condition or treatment the ruid be updated." LPN # 5 was sew the comprehensive care plan for When asked if the comprehensive Resident # 6 included hospice care, and she was unable to locate it on the hen asked if the care plan should redated to include hospice care being N # 5 stated, "Yes." When asked if		3. 4.	Nursing staff will be re-educated DCS/designee on including incest spirometer, hospice and indwe catheter care on the care plant 1/8/2020.  The DCS/designee to complete plan quality monitor for any reswith incentive spirometers, hospindwelling catheter care to ensure compliance is maintained week four weeks. Follow up based or findings and reported to the fact monthly QAPI meeting. Quality Monitoring schedule modified is findings.	entive Iling by the car sidents spice an ure bly for n cilities	re nd	
	included care and ser	vices for an indwelling		5.	Date of compliance 2/15/2020.			
	Cauleter, LPN # 5 stat	ed, "No, there Isn't a care	1	1				

1		MICDIOVID SEVAICES			·	OMR M	<i>).</i> 0938-0391
STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	SURVEY PLETED
		495389	B. WING			1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR		
	<del></del>	·········		V1	VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page plan for it."  On 01/09/2020 at app	9 45 proximately 8:10 a.m., ASM	E .	657			
	[administrative staff m nursing, provided this copy of Resident # 6's The care plan docume 6] has a terminal prog life hospice care. Dat "Focus: [Resident # 6	nember] # 2, director of surveyor with an updated s comprehensive care plan. ented, "Focus: [Resident # unosis r/t [related to] end of the Initiated: 01/08/2020" and ] has indwelling catheter r/t the Initiated: 01/08/2020."			·		
	The facility's policy "P in part, "Review, upda comprehensive care page goals, preferences an in response to current completion of each Of Reconciliation Act] MI assessment (except das needed. The intervensure the plan of car needs and that the platataining or maintaining."	lans of Care" documented ate and/or revise the plan based on changing d needs of the resident and at interventions after the BRA [ Omnibus Budget DS [minimum data set] lischarge assessment) and disciplinary team shall be addresses any resident					
And the second s	# 1, the executive dire of nursing, ASM # 3, r	roximately 5:50 p.m., ASM befor and ASM # 2, director egional director of clinical traveling MDS coordinator, he findings.				·	
	2. Resident # 25 was 11/20/2019 with diagn not limited to respirate	was provided prior to exit.  admitted to the facility on oses that included but were by failure, shortness of structive pulmonary disease		***************************************			

1		WEDICAID SERVICES				OMB N	<u>0, 0938-0391</u>
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILC		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	*	495389	B. WING			<b>I</b> .	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE	.t	
ENVOY O	F WINCHESTER, LLC			1	110 LAUCK DR		
			· · · · · · · · · · · · · · · · · · ·		WINCHESTER, VA 22803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X6) COMPLETION DATE
F 657	Continued From page	∍ 46	F	657	7		
	set), a quarterly asset (assessment reference Resident # 25 as soon assessment for mental of 0 - 15, 14- being or daily decisions. Resident get extensive as member for activities "Special Treatments, coded Resident # 25 properties as the properties of the properti	the date) of 11/29/19, coded ring a 14 on the staff al status (BIMS) of a score organitively intact for making dent # 25 was coded as selstance of one staff of daily living. Section O Procedures and Programs" for the use of oxygen.  The date of the use of oxygen.  The date of the use of oxygen.  The date of the use of oxygen.  The date of the use of oxygen.  The date of the use of t					
	The comprehensive c	are plan for Resident # 25					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					), 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	
		496389	B. WING		•	ì	C 09/2020
NAME OF P	ROVIDER OR SUPPLIER		I	87	TREET ADDRESS, CITY, STATE, ZIP CODE		VV/AUAU
ENVOY O	F WINCHESTER, LLC			1	10 LAUGK DR /INCHESTER, VA 22603		į
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	comprehensive care puthe care plan had bee incentive spirometer. Isn't a care plan for it.  On 01/08/2020 at app. 5 stated they had spo and stated, "The nurs [Resident # 25] doesn spirometer] so I will respirometer on 1/08/2020 at app. 4 1, the executive direction of nursing, ASM # 3, services and LPN # 5 were made aware of the No further information.  References: [1] A device used to healthy after surgery illness, such as pneurobtained from the well https://medlineplus.go.00451.htm.	f 12/03/2019 failed to ion for the use of an interview was \$ 5, traveling MDS riewing Resident # 25's plan, LPN # 5 was asked if an updated to include the LPN # 5 stated, "No, there " proximately 4:00 p.m., LPN # iken to the nurse practitioner feels she are practi	F	657			
	was obtained from the			***************************************			

		MEDIOAID OFKVICES	<del></del>				OMR M	<i>).</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		(X3) DATE SURVEY COMPLETED			
		495389	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER						01/	09/2020
100000	MOVIDER ON SOFFEER			S	TREET ADDE	RESS, CITY, STATE, ZIP CODE		
ENVOYO	F WINCHESTER, LLC			11	10 LAUCK E	OR .		
<u> </u>				W	VINCHEST	ER, VA 22603		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID			PROVIDER'S PLAN OF CORRECTION	<del></del>	(X5)
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!AG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	}	CR	ROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
<del></del>						DEFICIENCY)		
H								
F 684			F	684				
SS=D	OFR(s): 483,25							
	8 403 0E Ourille - f -							1
İ	§ 483.25 Quality of ca							
	conting to all transfer	ndamental principle that						
	facility regidents. Dec	nt and care provided to			F684			
1	geocemont of a rook	ed on the comprehensive dent, the facility must ensure		1				
<u> </u>	that residents receive	treatment and care in			1.	Nurses responsible for re	sident (	#3s care
	accordance with profe			İ		·		
	practice, the compreh	nensive person-centered		ļ		were re-educated on the		ior
	care plan, and the res	sidents' choices				documentation of insulin		
		is not met as evidenced				administration and site a	dminist	ered on
	by:	in hot mot do origonous				1/8/2020.		
	Based on clinical rec	ord review, staff interview			2	• •	la atan mar tan	
	and review of facility of	documentation it was			۷.,	Review of resident's rece	· <del>-</del>	
	determined the facility	y staff failed to provide				medical record was comp	leted o	n
	treatment and care in					1/31/2020 to ensure adm	iinistrat	tion is
	professional standard	ls of practice for one of 32				documented as well as sit	te. No c	other
	residents in the surve	y sample, Resident #3. The				findings were noted.		
	isculty starr tailed to a	dminister sliding scale			2			
	On 01/07/2020 at 7:20	ian orders to Resident # 3. 0 a.m., 11:30 a.m. and 4:30			3,	An in-service for nurses w		
	n.m. and 01/08/2020	at 7:30 a.m., 11:30 a.m.				on 1/10/2020 on docume	ntation	of
	there was no docume	ntation of the amount of	İ			insulin administration and	d site	
	insulin administered o	or the location of the				administered by the DCS/	design.	20
	injections.				4.		_	
			l		4.			
	The findings include:					insulin administration mo		
	,					a week for four weeks for	any re	sidents
	Resident # 3 was adn	nitted to the facility on				with physician orders for	insulin	to I
		dmission of 07/22/2019 with				ensure compliance is mai		
	ulagnoses that include	ed but were not limited to	- Carrier Carr					٠.
	yya ∠ alabetes melliti	us with complications [1].	***************************************			Follow up based on finding		
	Resident # 3's most ~	ecent MDS (minimum data				reported to the facilities r	nonthly	/ QAPI
	set), a quarterly asses					meeting. Quality Monitor	ring sch	edule
		e date) of 09/26/19, coded				modified based on finding	_	
	Resident # 3 as scorir	ng a 12 on the staff			r	•	-	
	assessment for menta	al status (BIMS) of a score			5.	Date of compliance 2/15,	ZUZU.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
	495389 B. WING			1	С		
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		5, 11110	STE	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	01	/0 <del>9</del> /2020 ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E	(X6) COMPLETION DATE
F 684	of 0 - 15, 12- being m cognition for making of 3 was coded as requione staff member for Section N "Medication receiving Insulin Inject days.  The POS [physiclan's 01/01/2020 through 0 documented, "Novolo [milliliter] Unit. Inject daily before meals peunits, 200-249: 6 unit 12 units, > [greater the call provider for diabe 09/03/2019."  The MAR [medication Resident # 3, dated ", the physiclan's order MAR revealed Reside 01/07/20 was 198 at 1 and 149 at 4:30 p.m. 3's blood sugars were at 11:30 a.m. Further evidence the amount the location of the injection on the dates.  The facility's nurse's rethrough 01/08/2020 for insulin administered injection on the dates.	coderately impaired of chaily decisions. Resident # ring extensive assistance of activities of daily living. ns" coded Resident # 3 as tions during the past seven to order sheet] dated (1/31/2020 for Resident # 3 ag [2] Flexpen 100/ML subcutaneously three times or sliding scale: 150-199: 3 ag, 250-299: 9 units, 300-349: an] 350 or < [lees than] 60 attes mellitus. Date the administration record] for January 2020" documented as above. Review of the pent # 3's blood sugar on 7:30 a.m., 206 at 11:30 a.m., On 01/08/20, Resident # 2 at 7:30 a.m. and 189 are review of the MAR falled to of insulin administered and pection on the dates and motes dated 01/07/2020 alled to evidence the amount d and the location of the	F	684			
		in the MAR (medication					

	O TOTT MILDIOTAL O	MEDIONIO OLIVVICEO				OWR NO	<u> </u>
STATEMENT ( AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	SURVEY PLETED
		495389	B, WING			C 01/01	
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ENVOY O	F WINCHESTER, LLC			1	110 LAUCK DR		
<u> </u>				1	WINCHESTER, VA 22603		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
1.00	THE COUNTY OF T	LOO IDENTIFY THAT HAP ORIGINATION)	TAG	3	CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
<del></del>					DE(TOLENOT)		
F 004	<b>.</b>						
F 684	Continued From page		F	684	1		
	administration record	dated January 2020 and					
	nurse's notes dated 0						
	01/08/2020. When as	sked about the lack of					
	documentation show	ng how much insulin was					
	administered and loca	ation of the injection site,					
	LPN # 4 stated, "It do	esn't say if she got it					
	[insulin] or where," V	/hen asked if they could					
	evidence the sliding s	cale, insulin was					
	administered as order	red. LPN # stated.					
	"Absolutely not,"						
	, , , , , ,						
	On 01/09/20 at 11:14	a.m., an interview was					1
	conducted with ASM	administrative staff					{
	memberl # 2. director	of nursing. When asked to					
	describe the documer	ntation procedure for insulin			1		
	administration ASM #	# 2 stated, "Write down what					
		cording to the sliding scale,					
		was given and I'll ask the					
	resident where they w	ant the injection." When					[
	asked if they follow a	procedure to rotate the					
	injection site ASM # 2	stated, "Not all the time."					
	When asked about a	negative outcome of not					
	rotating the eite ASM	# 2 stated, "There wouldn't					
	he heralise were not	injecting in the exact same					
	spot." ASM # 2 agree	allocard in the exect settle					
	determined how if an	r insulin was administered					
	per the physician orde	r due to the lack of					
		a dde to the fack of				ļ	
	documentation.						
	The facility's policy "tr	Soulin Administration					
	documented in part, "	Pototo and document					
	Injection sites; Docum	notate and document					
	adoction sites, DOCAN	ioni medical record,"					
İ	"Insulin Injection Know	w How. Select a part of your					
	hady that you can acc	w now. Select a part of your o, reach, and access easily.				1	<b> </b>
	Rut he sure to use = =	r, readin, and access easily.					ŀ
	within that had need	number of different spots					
	infection offer this the	This is called "rotating"	1		1		
		ig into the same spot too	1				
	vitori cari causo skin i	problems and can Impair	1		Ī	į.	: <b>!</b>

PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 684  Continued From page 51 insulin absorption." This information was obtained from the website: https://www.diabeteseducator.org/docs/default-so urce/legacy-docs/_resources/pdf/general/Insulin_I njection_Pro_Tips_AADE.pdf  On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of			495389	B. WING			ſ	-
PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				110 LAUCK DR		110 LAUCK DR	01	/09/2020
insulin absorption." This information was obtained from the website: https://www.diabeteseducator.org/docs/default-so urce/legacy-docs/_resources/pdf/general/Insulin_I njection_Pro_Tips_AADE.pdf  On 01/08/2020 at approximately 5:50 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 3, regional director of clinical services and LPN # 5 traveling MDS coordinator, were made aware of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(XS) COMPLETION DATE
No further information was provided prior to exit.  References: [1] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. F 689 Free of Accident Hazards/Supervision/Devices GFR(s): 483.25(d)(1)(2)  \$483.25(d) Accidents. The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to	F 689	insulin absorption." Tobtained from the well https://www.diabeteseurce/legacy-docs/_resinjection_Pro_Tips_A/ On 01/08/2020 at app (administrative staff midirector and ASM # 2, 3, regional director of 5 traveling MDS coord the findings.  No further information References: [1] A chronic disease regulate the amount of information was obtain https://www.nlm.nih.go01214.htm. Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(1)(2)(2)(1)(2)(2)(2)(2)(3)(2)(3)(3)(3)(3)(3)(3)(4)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	This information was besite: educator.org/docs/default-so sources/pdf/general/Insulin_I ADE.pdf  proximately 5:50 p.m., ASM member) # 1, the executive director of nursing, ASM # clinical services and LPN # dinator, were made aware of a was provided prior to exit.  In which the body cannot of sugar in the blood. This ned from the website: ov/medlineplus/ency/article/ards/Supervision/Devices 2)  The that sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced in, staff interview, clinical cility document review, it					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

1		MEDICAID SERVICES			OMB NO. 0938-0391			
AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRU			SURVEY PLETED
		495389	B. WING				ł .	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADD	DRESS, CITY, STATE, ZIP CODE	1 017	U912U2U
ENVOVO	t MMOUTOTES			ı	LAUCK	•		
ENVOTO	F WINCHESTER, LLC	•		1		TER, VA 22603		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		Ц.,,		<del></del>	***************************************	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	of 32 residents in the #61. The facility staff interventions for Residual 12/29/19, fall mats an determined by the facinterventions. Neither	prevent accidents for one survey sample; Resident failed to implement fall dent #61 after a fall on d a scoop mattress were	F	689	F689			
	dementia with behavior disorder, restless leg, pressure and delirium MDS (Minimum Data: ARD (Assessment Recoded the resident as ability to make daily lift was coded as requirin hygiene, foileting, and assistance for ambula coded as incontinent of the code of	nclude but are not limited to ors, panic disorder, thyroid anxiety disorder, high blood. The admission / 5-day Set) assessment with an ference Date) of 12/29/19 being severely impaired in the decisions. The resident g total care for bathing, eating; extensive tion and transfers; and was of bowel and bladder.  1. Resident #61 was p. No fall mats were esident's bed and no scoop the bed.  1. M, LPN #3 (Licensed asked about the fall mats or Resident #61. She stated the resident was to have mattress. At this time, she #61 and verified that there			<ol> <li>2.</li> <li>3.</li> </ol>	The fall mats and scoop material materi	fall mat ducted s were conduct /2020 contions as in. plete the time a vertice to dents we complete to passed on the facility fied based	s and on noted. ted by on s e fall week with liance n
	When asked about im	zoop mattress in place. plementing these					1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		496389	B, WING				C 109/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	1 011	<del>V3</del> (2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	interventions, LPN #3 been implemented as needed them."  A review of the admis dated 12/23/19 docur History of Falls:	stated, "They should have a soon as it was decided she asoon as it was decided she asoon as it was decided she asoon as it was decided she asoon as it was decided she asoon as it was essent the state of the state of the second revealed a nurse's at 6:30 AM that documented, "help me!" Found on floor in W (moves all extremities and, neuro [neurological] (nurse practitioner), son, party) notified."  stigation dated 12/29/19 resident stated she had to ut did not ask for help.  eam (IDT) meeting note mented, "IDT met to unt's fall on 12/29/19. Found ide of bed in floor in sitting B+B (bowel and bladder), lew. No further	F	689			

		WEDIOAID GENVICES	1				<i>).</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		CONSTRUCTION		LETED
		495389	B, WING		MANAGEMENT OF THE PROPERTY OF	01/	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 Lauck dr Vinchester, va. 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 54 earn meeting note dated	F	689			
	1/6/20 documented, " fall on 1/3/20 (note: to 1/3/20. Note refers to Found laying (Sic.) or	IDT met to discuss/review here was no fall noted on o the IDT note dated 1/3/20), n floor beside bed. No					
	recommendations."	coop mattress. No further					
	12/30/19, documente an actual fall with no i balance, poor commu This care plan include	rehensive care plan dated d, "(Resident #61) has had injury r/t (related to) poor inication/comprehension." ed the intervention, dated is on both sides of bed."					
		include any intervention for					
	documented, "B, Fall Develop resident cent resident risk factors, care plan and the Nur interventionsC, Pos Re-evaluate fall risk us Evaluation; 4. Update Kardex with interventions	t Fall Strategies:4.					
	Staff Member - the Ex #2 (the Director of Nu	, ASM #1 (Administrative recutive Director and ASM rsing) were made aware of er Information was provided rey.					
F 695 SS≃E	Respiratory/Tracheos	tomy Care and Suctioning	F	695			:
	§ 483.25(I) Respirator	y care, including					

		MILDIOAID OLIVIOLO	<del></del>			<u>OMR MC</u>	<i>).</i> 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			· .		נרט נ	09/2020	
	F WINCHESTER, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	:		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
F 695	tracheostomy care are The facility must ensured respiratory care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sull This REQUIREMENT by:  Based on observation interview, clinical record document review, it was facility staff failed to practice, the compreheare plan for four of 3 sample; Residents #4 facility staff failed to ewas in place for Resident #4's nebulizes spirometer were store when not in use. The administer Resident #16 in a sanitary manner aphysician orders for the spirometer. The facility Resident #25's oxygenty sician's orders and 25's nebulizer mask a sanitary manner. The aphysician's order for incentive spirometer.	and tracheal suctioning.  The that a resident who  e, including tracheostomy  stioning, is provided such professional standards of pensive person-centered  ats' goals and preferences, poart.  I is not met as evidenced  The staff interview, resident and review, and facility are determined that the provide respiratory care and and preferenced  2 residents in the survey  1, #3, #163, and #25. The ansure a physician's order and failed to ensure  ter mask and incentive and in a sanitary manner facility staff failed to  3's oxygen at the flow rate and failed to obtain the use of the incentive by staff failed to  y staff failed to administer	F	695	1. An order for resident #41 for the incentive spiromet 1/8/2020. The incentive and nebulizer mask for rewas replaced with a new oplaced in a respiratory bag. The oxygen flow rate for rewas adjusted by the nurse ordered flow rate on 1/8/2000. The incentive spiromete 1/8/2020. The incentive spiromete 1/8/2020. The incentive spiromete on 1/8/2020. An order for was obtained for the incentive spirometer on 1/8/2020. Spirometer and nebulizer new one and nebulizer new spirometer spirometer and nebulizer new spirometer spir	ter on Spirome sident # one and g on 1/8 esident to phys 2020. An is obtain er on spirome aced with resident tive The ince	eter 41 8/2020, #3 sician ned tter tth a ry bag at #25	
	The findings include:						l	

STATEMENT	OF DEFICIENCIES		·			OMB NO	<u>0. 0938-0391</u>
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		SURVEY PLETED
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ENVQY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE I/O LAUGK DR WINCHESTER, VA 22603	1 01/	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	UMMARY STATEMENT OF DEFICIENCIES I DEFICIENCY MUST BE PRECEDED BY FULL. ATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
	1a. Resident #41 was 8/7/19; diagnoses inci hydrocephalus, psych cancer with removal of defibrillator, high blood diabetes, bipolar disordiabetes, bipolar disor	admitted to the facility on lude but are not limited to, otic disorder, right kidney of kidney, cardiac dipressure, atrial fibrillation, rider, spinal stenosis with alsy. The quarterly MDS issessment with an ARD on Date) of 12/21/19 coded cognitively intact in ability to ms. The resident was densive care for bathing, it transfers; supervision for and was coded as and bladder.  M, an observation was densive Spirometer was been table.  If, Resident #41 was dentive Spirometer beed table as previously  If, Resident #41 was dentive table. Resident #41 stated occasion.  Tecord failed to reveal any of sorder for the use of an whensive care plan failed to	F	695	resident #25 was replaced one and placed in a respirat 1/8/2020. The oxygen flow resident #25 was adjusted & to physician ordered flow ra 1/8/2020.  2. Audit of respiratory care to orders for incentive spirome given by the physician and i spirometers are stored in rebags, oxygen usage reflects orders and nebulizer masks in respiratory bags was comno issues of non-compliance noted on 1/31/2020.	rate for oy the nate on ensure eters we ncentive espirato physicies are sto	g on r nurse ere re ans ored
	reveal the use of the In	centive Spirometer as		1			ļ

STATEMENT OF AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			UCTION	(X3) DATE	SURVEY PLETED
		495389	1 01/09/					
	ROVIDER OR SUPPLIER F WINCHESTER, LLC	ATEMENT OF DEFICIENCIES		ST 110	LAUCH	STER, VA 22603		09/2020
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	SEFIX (EACH CORRECTIVE ACTION SHOULD BE				(X8) COMPLETION DATE
	(Registered Nurse), si be an order for the use Spirometer. RN #1 st "come in with them from the investment of the facility Spirometer" did not do obtaining a physician's On 1/8/20 at 5:50 PM, Staff Member - the Ex #2 (the Director of Nurthe findings. No furthe by the end of the survestment of the	In an interview with RN #1 the stated that there should e of the Incentive ated that the residents om the hospital."  policy, "Incentive ocument any criteria for s order prior to use.  ASM #1 (Administrative ecutive Director) and ASM rsing) were made aware of er information was provided ey.  illed to ensure Resident and Incentive Spirometer ary manner when not in use.  M, an observation was 's room. Resident #41 was centive Spirometer was oed table. It was not machine and mask was d next to the bed. The of covered.  I, Resident #41 was Incentive Spirometer and and uncovered as	F	695		Nursing staff were re-educe DCS/designee, including has for incentive spirometers, sincentive spirometers and masks in respiratory bags a administering oxygen by the order by 1/10/2020. The DCS/designee to comprespiratory quality monitor residents with incentive spiroxygen and nebulizers to excompliance is maintained of four weeks. Follow up base findings and reported to the monthly QAPI meeting. Que Monitoring schedule modifindings.  Date of compliance 2/15/20	aving or storing nebulized and lete the lete the for any iromete nsure veekly for ed on e faciliti iality ied base	ders er clans er, or

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/31/2020 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495389	B. WING				C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	<b>V</b> 17	V312020
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X6) COMPLETION DATE
	spirometer was on the was observed to store. The nebulizer mask win a new bag and date he has used both item his recollection neithe.  On 1/8/20 at 1:07 PM (Registered Nurse), si mask should be cover incentive Spirometer si #1 stated, "I guess it si but I was never told the A review of the facility documented, "Place e maintained in the resident A review of the facility Spirometer" did not domaintaining the device between uses.  On 1/8/20 at 5:50 PM, Staff Member - Execution (the Director of Nursin findings. No further in the end of the survey.  2. Resident # 3 was a 05/09/2016 with a read diagnoses that include respiratory failure, sho chronic obstructive pul Resident # 3's most reset), a quarterly asses.	e table, uncovered. No bag the Incentive Spirometer. ras now, observed covered ed. The resident stated that as on occasion and that to r item, had been covered.  In an interview with RN #1 the stated that the nebulizer red. RN #1 stated the should be wiped clean. RN should be stored in a bag at."  policy, "Nebulizer" ntire unit in a bag to be dent's room."  policy, "Incentive roument any criteria for in a sanitary manner  ASM #1 (Administrative tive Director) and ASM #2 g) were made aware of the formation was provided by  dmitted to the facility on dmission of 07/22/2019 with d but were not limited to rtness of breath and fmonary disease [1].  cent MDS (minimum data sment with an ARD or date) of 09/26/19, coded	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A, BUILD		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER	OR SHPPHER	1	O. VAIRO		TOPPET ADDRESS SITE OF THE STAT	01/	09/2020
ENVOY OF WINCH	ESTER, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
assess of 0 - 1 cognitis 3 was a one star Section Progra oxyger On 01/Reside oxyger concer the oxy concer one-an On 01/Reside receivis an oxyger oxyger one-an The PC 01/01/2 physici documper mir The co with a refractal per mir The cous (SOB) Date in 12/31/2 documents of the point oxyger o	5, 12- being mon for making of coded as requially member for in O "Special Trims" coded Residual for 2020 at appoint # 3 was observed as a constrator that was a constrator revealed and a half liters proceeding oxygen by regen concentrator and a concentrator in d-a-half liters proceeding oxygen by regen concentrator and an on 1/7/2020 ented, "09/04/10 an on 1/7/2020 ented, "09/04/10 and 1/7/2020 ented in part," ented in part, "	al status (BIMS) of a score oderately impaired of daily decisions. Resident # ring extensive assistance of activities of daily living. eatments, Procedures and sident # 3 for the use of proximately 3:15 p.m., herved lying in bed receiving mula connected to an oxygen or running. Observation of ron the oxygen is a flow rate of per minute.  39 a.m., an observation of a they were lying in bed hasal cannula connected to for that was running. They were lying in bed hasal cannula connected to for that was running.	F.	695			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR		· · · · · · · · · · · · · · · · · · ·	<u> </u>	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X8) COMPLETION DATE
F 695	12/31/2018. Revision On 01/08/2020 at 1:00 conducted with LPN [4. When asked to dereading the oxygen, fi concentrator, LPN # 4 eye level with the met pass through the midd asked to read the flow oxygen concentrator, meter, LPN # 4 stated at one-and-a-half liter what the flow rate shot two-liter's per-minute, the flow rate to 2LPM oxygen concentrator. On 01/08/2020 at app (administrative staff m director and ASM # 2, 3, regional director of 5 traveling MDS coord the findings. No further information References: [1] Disease that make can lead to shortness was obtained from the https://www.nlm.nih.gd	on 04/16/2019,"  D. p.m., an interview was licensed practical nurse] # scribe the procedure for owrate meter on an oxygen a stated, "You should be at the and the liter line should be of the ball. LPN # 4 was a meter on Resident # 3's after looking at the flow I the oxygen flow rate was a per minute. When asked build be, LPN # 4 stated LPN # 4 then readjusted (liters per minute) on the proximately 5:50 p.m., ASM rember) # 1, the executive director of nursing, ASM # clinical services and LPN # Ilinator, were made aware of was provided prior to exit.  Is it difficult to breath that of breath. This information is website: ov/medlineplus/copd.html.	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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ENVOY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZI 110 LAUCK DR WINCHESTER, VA 22603	P CODE	1 01/	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI; TAG		CTION SHOULD B O THE APPROPRIA		(X6) COMPLETION DATE
F 695	Resident # 163 was n survey. The facility's sheet dated 01/03/20/documented in part, "Person," Under "Com "Usually Understood a "Respiratory", it documents and Proce and/or observation,"  On 01/07/20 at 1:49 p 4:05 p.m., observation over-the-bed table revisionmeter. Observat spirometer [1] failed to placed in a bag or cov On 01/08/20 at 8:25 a Resident # 163's over incentive spirometer. incentive spirometer followed in a bag or cov The POS [physician's 01/01/2020 through 0 physician on 01/04/20 to evidence document incentive spirometer.  The facility's baseline dated 01/03/2020 failed documentation for the spirometer.  On 01/08/20 at 8:30 a. conducted with Reside	S (minimum data set), for not due at the time of the "Admission Data Collection" 20 for Resident # 163 Cognition: Alert, Oriented to amunication" it documented, and Understands." Under mented, "Special adures: None per history  .m., at 2:43 p.m., and at as of Resident # 163's realed an incentive ion of the incentive of evidence that it was rered.  .m., an observation of the alled to evidence that it was ered.  order sheet] dated 1/31/2020 and signed by the 20 for Resident # 163 failed ation for the use of an care plan for Resident 163 d to evidence use of an incentive m., an interview was ent # 163. When asked if a spirometer, Resident #	F	695			

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	OOLOKO
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR		
LINVOIO	windrester, LLC			V	VINCHESTER, VA 22603		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	(DI	.l	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
	randam trotte offe	TOO INCIDENT FING HAT ON MAN TON!	TAG	•	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
				······································			·
F 695	Continued From page	e 62	E	695			
	<b>3</b>		•	000			
	On 01/08/2020 at 1:0	0 p.m., an Interview was					
	conducted with LPN [	licensed practical nurse]#					
	4. When asked if an	incentive spirometer was a					
,	piece of respiratory e	quipment, LPN # 4 stated	-				
	yes. When now the li	ncentive spirometer should					
	should be covered or	use, LPN # 4 stated it placed in a bag. LPN # 4					
	was shown Resident	# 163's incentive spirometer					
	on the over-the-bed to	able. LPN # 4 stated it					
	should be covered. V						
	incentive spirometer s	should be covered, LPN # 4					
	stated, "It could collect	ot germs and could cause an					
1	infection when used to	by the resident." When					
	#163's use of the loop	ian's order for Resident entive spirometer, LPN # 4					T-10-11-11-11-11-11-11-11-11-11-11-11-11-
	reviewed the physicia	in's orders and stated that					
	they could not locate						***************************************
	On 01/08/20 at 1:43 p	o.m., an interview was					
	conducted with LPN #	5, traveling MDS					
	coordinator. LPN # 5	stated there was no esident # 163's incentive					
	spirometer LPN#5	further stated that they had					
	spoken to Resident #	163's nurse practitioner and	-				
	that Resident # 163 w	ould benefit from the use of					
	the incentive spirome	fer. LPN # 5 stated they					
	would obtain a physic	ian's order for prn [as					
	needed] use of an inc	entive spirometer.					
	On 01/08/2020 at ann	proximately 2:00 p.m., LPN #		İ			
	5 provided this survey					ı	
		order dated 01/08/2020 for					
	Resident # 163. The	order documented.				ļ	
	"Encourage use of inc	centive spirometer PRN."					
	O. 04/00/0000						
	# 1 the executive dis-	proximately 5:50 p.m., ASM					
	of nursing. ASM # 2 +	ector and ASM # 2, director regional director of clinical					
	- Transmissi Licital II, O' )	APPARENT AND AND AND AND AND AND AND AND AND AND	1	- i		1	ı <b>.</b>

С	
495389 B. WING	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, LLC  WINCHESTER, VA 22603	)9/2020 
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695  Continued From page 83 services and LPN # 5 traveling MDS coordinator, were made aware of the findings.  No further information was provided prior to exit.  References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as preumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00451.htm.  [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/copd.html.  4a. Resident # 25 was admitted to the facility on 11/20/2019 with diagnoses that included but were not limited to respiratory fallure, shortness of breath and chronic obstructive pulmonary disease [1].  Resident # 25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/29/19, coded Resident # 25 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Resident # 25 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 25 for the use of oxygen.  The POS [physician's order sheet] dated of 1/10/12020 through 01/31/2020 and signed by the	

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AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495389	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER			- E	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	/09/2020
ENVOVO	F WINCHESTER, LLC			ļ	110 LAUCK DR		
ENVOIO	r winchester, LLC				VINCHESTER, VA 22603		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10			<b></b>	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE CO	
F 695	Continued From page	16A		005			
	physician on 1/7/2020			695			
	documented "12/17/1	19 Oxygen @ [at] 4L [four			The state of the s		
	liters per minute] via [	byl nasal cannula			TANK TO THE TANK T		
	continuous every shift	t to maintain SPO2 [oxygen					
	saturation] [2] greater	than 90%,"					
	The comprehens		ĺ				
	With a revision date of	are plan for Resident # 25 f 12/03/2019 documented,					
	"Focus: [Resident # 2	5] has Congestive Heart					
	Fallure. Revision Dat	e: 12/03/2019." Under					
	"Interventions" it docu	mented in part, "Oxygen					
	setting: O2 [oxygen] v	ia NC [nasal cannula] at 4L					
	(liter). Revision on 12	/03/2019."					
	On 01/07/20 at 1:25 n	.m., 2:45 p.m., and at 4:05					
	p.m., observations rev	realed Resident #25 in bed					.,
	receiving oxygen by n	asal cannula connected to					
	an oxygen concentrate	or that was running.					
	Observations of the flo	ow meter on the oxygen					
	three-and-a-half liters	an oxygen flow rate set at					
	anou-and-a-nan meis	per minute,				İ	
	On 01/08/20 at 8:30 a	.m., an observation					
	revealed Resident #25	in bed receiving oxygen by					
	nasal cannula connec	ted to an oxygen					
[	concentrator that was	running. Observation of					
	the flow meter on the	oxygen concentrator		ĺ			
	revealed an oxygen flo three-and-a-half liters	ow rate set at		.			
	unoc-and-a-nan nters	per minute.					
	On 01/08/2020 at appr	roximately 1:00 p.m., an					
	interview was conduct	ed with LPN [licensed					
	practical nurse] # 4, V	Vhen asked to describe the			•		
	procedure for reading	the oxygen, flowrate meter					
	on an oxygen concent	rator LPN # 4 stated, "You					
	line should noon there	with the meter and the liter					
	I PN # 4 was asked to	gh the middle of the ball. read the flow meter on					
	Resident # 25's oxyge	n concentrator. After	-			]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION				
		495389	B. WING				C /09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP 110 LAUCK DR WINCHESTER, VA 22603	CODE	1	V312V2V
(X4) ID PREFIX TAG			,	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 695	oxygen flow rate was minute. When asked be per the physician of four-liter's per-minute. the flow rate on the oxygen flow rate on the oxygen flow rate on the oxygen flow rate on the oxygen flow rate on the oxygen flow rate on the oxygen flow rate on the oxygen flow rate of the	at three-and-a-half liters per what the flow rate should order, LPN # 4 stated LPN # 4 stated LPN # 4 then readjusted expension concentrator to 4 LPM recipied for the flow from the flow for the flow for the flow flow flow flow flow flow flow flow	F	695			
A PORTION AND A	On 01/08/20 at 8:30 a Resident # 25's bedsident with the nebulizer and a nebuli						

VENTER	O I OIT MILDIONITE OF	AICHICAIN SEKAICES				OMB NO	D. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COME	SURVEY
		495389	B. WING			1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			l :	STREET ADDRESS, CITY, STATE, ZIP CODE	1 415	TOOILOLG
ENLOW O					110 LAUCK DR		
ENVOYO	F WINCHESTER, LLC			1	WINCHESTER, VA 22603		
WAND	SI BAMADY OT	ATTUCKE OF DESIGNATIONS		<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 695	Continued From page	• RR		005	_		
	, ,		Г	695	)		
	revealed it was upon	n of the nebulizer mask					
	of the hadelds table a	vector on incoming					
	shuomerer micovered						
	The "Physician's Tele	nhone Order" deted					
	12/27/2019 document	ed "Duo nehe O feverul 4					
	Ifour hours for SOB	shortness of breath!					
	Further review of the	clinical record failed to					
the table. Observation of the nebulizer mask revealed it was uncovered. Further observation of the bedside table revealed an incentive spirometer uncovered.  The "Physician's Telephone Order" dated 12/27/2019 documented, "Duo nebs Q [every] 4 [four] hours for SOB [shortness of breath]." Further review of the clinical record failed to evidence a physician's order for the use of an incentive spirometer.  The comprehensive care plan for Resident # 25 with a revision date of 12/03/2019 documented, "Focus: [Resident # 25] has COPD [chronic obstructive pulmonary disease]. Date Initiated: 12/03/2019." Under "Interventions" it documented, "Give nebulizer treatments and oxygen therapy as ordered. Date Initiated: 12/03/2019."  On 01/08/2020 at 1:00 p.m., an interview was							
							****
						İ	***
	The comprehensive c	are plan for Resident # 25					
	with a revision date of	f 12/03/2019 documented,					
	"Focus: [Resident # 2	5] has COPD [chronic				i	
	obstructive pulmonary	disease]. Date Initiated:					
	12/03/2019," Under "	Interventions" it					
	documented, "Give ne	bullzer treatments and					
	oxygen therapy as ord 12/03/2019,"	iered. Date Initiated:					
ļ							
	On U1/08/2020 at 1:00	p.m., an interview was				ļ	
	conducted with LPN [	icensed practical nurse] #					
	4. vvnen asked if an i	ncentive spirometer was a					
	piece of respiratory ed	uipment, LPN # 4 stated					
	he stored when not be	centive spirometer should					
	be stored when not in						
		placed in a bag. When r mask should be stored					
	When not in use 1 DM	# 4 stated it should be					
1	placed in a har When	n shown Resident # 25's					
}	nebulizer mask and in	centive spirometer on the			,	Ī	
]	bedside table LPN # 4	stated the incentive					
1	spirometer and nebuli	zer mask should be			i	1	
	covered. When asked	why the incentive					
	spirometer and nebuli	zer mask should be					
	covered, LPN # 4 state	ed, "It could collect germs				1	
	and could cause an in	fection when used by the					1
	resident."						

		I				CIMB M	<i>J.</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION		SURVEY PLETED
		495389	B. WING			1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		T	STREET ADDRESS, CITY, STATE, ZIP CODE	J U1.	10312020
	<b></b>			1	110 LAUCK DR		
ENVOY O	F WINCHESTER, LLC				WINCHESTER, VA 22603		
(X4) ID	TO VARMMIS	ATEMENT OF DEFICIENCIES		<del>-</del>	<del></del>	***************************************	1
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 695	Continued From page	e 67	F	695			
	# 1, the executive dire of nursing, ASM # 3,	proximately 5:50 p.m., ASM ector and ASM # 2, director regional director of clinical traveling MDS coordinator, the findings.					
	No further information	was provided prior to exit.	***************************************				
	healthy after surgery illness, such as pneur obtained from the wel	elp you keep your lungs or when you have a lung monla. This information was osite: ov/ency/patientinstructions/0					
	Resident # 25's bedsi incentive spirometer u	25 p.m., an observation of de table revealed an incovered. When asked if e spirometer Resident # 25					
	4:05 p.m., observation	o.m., at 2:45 p.m., and at ns of Resident # 25's d an incentive spirometer.					
	On 01/08/20 at 8:30 a Resident # 25's bedsi incentive spirometer u	.m., an observation of de table revealed an incovered.					
	Review of Resident # evidence a physician's incentive spirometer.	25's clinical record failed to s order for the use of an					
	conducted with LPN [I	) p.m., an interview was icensed practical nurse] # a physician's order for the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING				C /09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		<b>!</b>	1.	TREET ADDRESS, CITY, STATE, ZIP CODE 16 LAUCK DR VINCHESTER, VA 22603	<u> </u>	U312U2U
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE	
F 695	Continued From page 68 use of the incentive spirometer for Resident # 25, LPN # 4 reviewed the physician's orders and stated that they could not locate one. On 01/08/20 at 1:43 p.m., an interview was		F	695		<b>\</b>	
	conducted with LPN # coordinator. LPN # 5 the nurse practitioner "The nurse practitioned doesn't need it [incent remove it. It was some belonging when she co	55, traveling MDS stated they had spoken to (NP) and the NP stated, or feels she [Resident # 25] ive spirometer] so I will ething she had in her ame here." LPN # 5 ore was no physiclan's order		The state of the s			
,	# 1, the executive dire of nursing, ASM # 3, r	reximately 5:50 p.m., ASM octor and ASM # 2, director egional director of clinical traveling MDS coordinator, he findings.					
F 757 SS=E		was provided prior to exit. from Unnecessary Drugs (6)	F	757		1	
		ary Drugs-General. egimen must be free from un unnecessary drug is any					
	§483.45(d)(1) In excest duplicate drug therapy						***************************************
	§483.45(d)(2) For exc	essive duration; or					
	§483,45(d)(3) Without	adequate monitoring; or					
	§483.45(d)(4) Without	adequate indications for its					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495389	B. WNG			(	-
NAME OF P	ROVIDER OR SUPPLIER	1 400000	1 0. 11.10		REET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020
ENVOY O	F WINCHESTER, LLC			110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X6) COMPLETION DATE
F 757	use; or  §483.45(d)(5) In the pronsequences which reduced or discontinu.  §483.45(d)(6) Any constated in paragraphs section.  This REQUIREMENT by:  Based on staff intervively, and clinical redetermined that the fitthe drug regimen must drugs for two of 32 resample, Resident # 3 failed to attempt non-interventions prior to needed) pain medical Acetaminophen (2) I dates in November at facility staff failed to a interventions prior to as needed) pain medical Acetaminophen (2) It dates during Novemb January 2020.  The findings include:  1. Resident # 3 was 05/09/2016 with a readiagnoses that includ lower back pain.  Resident # 3's most reset), a quarterly asset.	presence of adverse indicate the dose should be led; or mbinations of the reasons (d)(1) through (5) of this ls not met as evidenced lew, facility document ecord review, it was acility staff falled to ensure at be free from unnecessary sidents in the survey and # 25. The facility staff pharmacological the administration of prn (as tions [Oxycodone (1) and to Resident #3 on multiple and December 2019. The attempt non-pharmacological the administration of a prn dication [Hydrocodone-to Resident #25 on multiple ler, December 2019 and ladmitted to the facility on admission of 07/22/2019 with ed but were not limited to	F	757	F757  1. Nurses responsible for resides #25 care were re-educated policy for documentation of pharmacological intervention level scale prior to administ pain medication on 1/8/202  2. Audit of records of resident pain medication completed they include non-pharmaco	on the non- ns and pering pro 0. s on pro to ensu	pain n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A, BUILO	ING _				C
		495389	B, WING					09/2020
ENVOY O	PROVIDER OR SUPPLIER  F WINCHESTER, LLC  SUMMARY STA	ATEMENT OF DEFICIENCIES	l ID	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603 PROVIDER'S PLAN OF CORRE	CTION		(X6)
PREFIX TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	£	COMPLETION DATE
F 757	Resident # 3 as scoring assessment for mental of 0 - 15, 12- being months of 0 - 15, 12- being months of 0 - 15, 12- being months of 0 - 15, 12- being months of 12- b	ang a 12 on the staff al status (BIMS) of a score oderately impaired of daily decisions. Resident # ring extensive assistance of activities of daily living, aditions" coded Resident # 3 pain with a pain level of ero to ten with ten being the are plan with a revision date ident # 3 documented, I has chronic pain r/t abetic neuropathy, sease. Date initiated: interventions" it ster analgesia as per order, before treatments or care 018."  some order dated int # 3 documented, milligrams]. 1 [one] tab eight hours] prin for pain." administration record] for lovember 2019" cian orders as above, vealed Resident # 3 in the dates and times that and at 1:07 p.m., and at 9:00 p.m.,	F	757	interventions and pair to administration on 1 issues of non-complian.  3. Nursing staff were reconceptations on documentations on the level scale prior to admedications by 2/15/2.  4. The DCS/designee to compliance for 15 with prn pain medications of the compliance is maintain four weeks. Follow up findings and reported monthly QAPI meeting Monitoring schedule in findings.  5. Date of compliance 2/2.	/31/20 nce were ducate mentin /ention ninister 020. omplet randor ons to fed were based to the f , Qualinodified	D2O. Note the day not not and ring porte the more in ensure ekly for facility days and days a	lo red. the pain rn pain dents re or

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495389	B. WING			1	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		<b>I</b>	11	REET ADDRESS, CITY, STATE, ZIP CODE 0 Lauck dr Inchester, va. 22603	1 01	<u>/09/2020</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	11/30/19 at 10:00 a.m Further review of the documentation of nor interventions attempts of the pain medication documentation of Reabove dates and time.  The POS [physician's through 12/31/2019 fe "Acetaminophen 325! mouth every 4 [four] if 09/03/2019."  The MAR [medication Resident # 3, dated "I documented the same Review of the MAR received Acetaminophen 36 follows; 12/01/19 at 12:47 p.m., 12/07/19 at 12:47 p.m., 12/11/19 at 12:47 p.m., 12/15/19 at 12:47 p.m., and on 12/25/18 review of the MAR fail of non-pharmacologic prior to the administrated medication and failed of Resident # 3's pair and times.  The facility's nurse's retirough 12/28/2019 fedocumentation of Resided to document no interventions prior to the intervention prior to the i	MAR failed evidence I-pharmacological and prior to the administration in and failed to evidence sident # 3's pain level for the is.  order sheet] dated 12/01/19 or Resident # 3 documented, MG Tablet, Take 1 tab by nours as needed for pain.  administration record] for December 2019" is physician order as above. evealed Resident # 3 nen on the dates and times at 2:00 p.m., 12/02/19 at at 12:15 p.m., 12/10/19 at at 12:15 p.m., 12/10/19 at at 12:15 p.m., 12/10/19 at at 12:27 p.m., 12/10/19 at at 12:22 p.m. Further led evidence documentation al interventions attempted ation of the as needed pain at to evidence documentation in level for the above dates  notes dated 11/08/2019 alied to evidence sident # 3's pain level and in-pharmacological		757			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY LETED	
		495389	B. WING			I	C 09/2020	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUGK DR /INCHESTER, VA 22603	<u>, on</u>	U3/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE	
F 757	dates and times.  Review of Resident # November and Decer pain levels and non-p interventions for the a  On 01/07/2020 at app interview was conduct When asked if the state pain before administer Resident # 3 stated in  On 01/08/2020 at 4:0 conducted with LPN [ 4, regarding the proce [as needed] pain med "Start with non-pharm return in about a half- reassess, if it is not e- ordered, get the resid zero to ten, ten being meds [medication] and When asked about the documenting that nor interventions were att LPN # 4 stated, "It's of the MAR [medication nurse's notes." After nurse's notes for Res there was no docume non-pharmacological attempted or the pain the lack of document non-pharmacological levels, LPN # 4 stated say it's done."	as's pain flow sheets dated mber 2019 falled to evidence harmacological above dates and times.  broximately 4:00 p.m., an sted with Resident # 3, aff attempt to allevlate the bring pain medication o.  2 p.m., an interview was licensed practical nurse] # padure for administering profication. LPN # 4 stated, hacological interventions, shour to an hour and ffective check what is lent's pain level, based on the worse, and minister in directive the control of the pain levels, focumented on the back of administration record] or the reviewing the MAR and ident # 3, LPN # 4 stated entation of interventions being levels. When asked about	F	757				

STATEMENT ( AND PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY LETED
		495389	B. WING				C 09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUGK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	describe the procedur medication, ASM # 2 to ten, medicate them hour to see if was effer attempting non-pharm prior to administering ASM # 2 stated, "It deschronic pain such as attempt them. Somet for it and we won't argasked if they expected non-pharmacological was not experiencing stated it should docur or nurse's notes. ASI location and level of pon the pain assessment of nursing, ASM # 3, is services and LPN # 5 were made aware of the website: https://medlineplus.gottml.  [2] Used to relieve mil headaches, muscle acolds and sore throats	[administrative staff] of nursing. When asked to re for prn [as needed] pain stated, "Rate the pain zero n, and recheck in about an ective." When asked about nacological interventions as needed pain medication, epends on what the pain is, cancer pain we don't dimes the patient will just ask gue with them." When d to attempt Interventions if the resident chronic pain, ASM # 2 ment on the pain flow sheet wain should be documented ent sheet with the MAR.  Proximately 5:50 p.m., ASM ector and ASM # 2, director regional director of clinical traveling MDS coordinator,	F	757			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	D. 0936-0391 SURVEY PLETED
		495389	B. WING			į.	C /09/2020
ENVOY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22803	( 01)	109/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 757	reduce fever. Acetam medications called an antipyretics (fever red the way the body sense body. This information website: https://medlineplus.gotml.  2. Resident # 25 was 11/20/2019 with diagnot limited to chest particular to	inophen is in a class of algesics (pain relievers) and fucers). It works by changing ses pain and by cooling the in was obtained from the ov/druginfo/meds/a681004.h  admitted to the facility on closes that included but were sin.  recent MDS (minimum data assent with an ARD e.date) of 11/29/19, coded fing a 14 on the staff all status (BIMS) of a score gnitively intact for making lient # 25 was coded as sistance of one staff of daily living. Section O Procedures and Programs" for the use of oxygen.  order sheet] dated 01/01/20 or Resident # 25 odone-Acetaminophen ams] Tablet. Take 1 tab y 8 [eight] hours as needed a pain. 11/26/2019."  administration record] for November 2019" clan order as above, wealed Resident # 25 ochone. The control of the con	F	757			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE	SURVEY PLETED
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ENVOY O	F WINCHESTER, LLC		***************************************	STREET ADDRESS, CITY, STATE, ZIP COD 110 LAUCK DR WINCHESTER, VA 22603	E 		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		V SHOULD BE	TE	(X6) COMPLETION DATE
F 757	Further review of the documentation evider non-pharmacological dates and times were administration of as no The MAR [medication Resident # 25, dated documented the physical Review of the MAR resident # 25 and the market was not become the market was no	MAR failed evidence acing that interventions for the above attempted prior to the eeded pain medication.  administration record] for 'December 2019" ician order as above. vealed Resident # 25 e-Acetaminophen on the lows:	F	757			
	12/07/19 at 6:30 a.m. 12/13/19 at 5:05 p.m., 12/16/19 at 6:50 a.m., 12/17/19 at 7:18 p.m., 12/18/19 at 12:20 p.m., 12/21/19 at 5:56 p.m., 12/22/19 at 9:00 p.m., 12/23/19 at 8:00 p.m., p.m. Further review of the Mocumentation non-ph were attempted, prior of the Mocumentation non-ph were attempted, prior of the Mocumentation non-ph were attempted, prior of the Mocumentation non-ph were attempted, prior of the Mocumentation non-ph were attempted, prior of the MAR [medication attempted] in the MAR [medication has been determined by the physician order as MAR revealed Resider Hydrocodone-Acetami	and at 7:55 p.m., and at 8:00 p.m., and on 12/30/19 at 9:00  MAR failed evidence parmacological interventions to administration of as on. The MAR failed to on of Resident # 25's pain es and times.  administration record] for January 2020" documented above. Review of the ont # 25 received					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES				OMB N	O. 0938-0391
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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				L	WINCHESTER, VA 22603		
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F 757	Continued From page	<del>3</del> 76	F	75	7		
		a.m., 01/05/20 at 4;40 p.m.,	'	′ 🗸			
	01/06/20 at 4:45 p.m.	, and on 01/07 20 at 9:30					
	a.m. Further review of	of the MAR failed evidence					-
	interventions for the a	empted non-pharmacological above dates and times.					
	On 01/07/20 at 1:33 p	o.m., during an interview with					
	Resident # 25, when	asked if they received prn					
	[as needed] pain med	lication. Resident #25					
	When asked if the sta	ey have pain in their legs. If attempt to alleviate the					
	pain before administe	ring pain medication					
	Resident #25 stated r	10.					
	The facility's nurse's r	notes dated 11/2019 through					
	Resident # 25's pain le	evel and falled to evidence				-	
	non-pharmacological	interventions were					
	attempted prior to the	administration of	İ				
	for the above dates ar	inophen to Resident # 25 nd times.					A CONTRACTOR OF THE CONTRACTOR
***************************************	Review of Resident #	3's pain flow sheets dated					
	November and Decem	nber 2019 and January					
	2020 failed to evidence	e non-pharmacological					]
	interventions for the a	bove dates and times.					
	The comprehensive ca	are plan for Resident # 25					
	dated 12/03/2019 doc	umented, "Focus: [Resident					
	# 25] has chronic pain	r/t [related to] Neurology.					
.	Date Initiated: 12/03/2 "Interventions", it docu	ione," Under Imented in part, "Administer					
	analgesia as per order	rs. Date Initiated:				i	
	12/03/2019,"						
	On 01/08/2020 at 4:02	2 p.m., an interview was					
}	conducted with LPN [[i	icensed practical nurse]#					
	as needed) nain medi	dure for administering pm cation. LPN#4 stated.					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE C	ONSTRUCTION	(X3) DATI COM	O. 0938-0391 E SURVEY PLETED
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC			110	EET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	<u>, , , , , , , , , , , , , , , , , , , </u>	10012020
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F 757	"Start with non-pharm return in about a half-reassess, if it is not e ordered, get the resid zero to ten, ten being meds [medication] an When asked about th documenting that nor interventions were att LPN # 4 stated, "It's of the MAR [medication nurse's notes." After nurse's notes for Resithere was no docume non-pharmacological attempted or the pain the lack of documenta non-pharmacological	hacological interventions, hour to an hour and fective check what is ent's pain level, based on the worse, and minister d recheck in about an hour, e procedure staff follows for e-pharmacological empted and the pain levels, focumented on the back of administration record] or the reviewing the MAR and ident # 25, LPN # 4 stated interventions being levels. When asked about	F	757			
	conducted with ASM   member] # 2, director describe the procedur medication, ASM # 2 to ten, medicate them hour to see if was effeattempting non-pharm prior to administering ASM # 2 stated, "It dechronic pain such as attempt them. Somet for it and we won't argasked if they expected non-pharmacological was not experiencing stated it should document of the procedure of the proced	of nursing. When asked to be for prn [as needed] pain stated, "Rate the pain zero , and recheck in about an active." When asked about accological interventions as needed pain medication, pends on what the pain is, brancer pain we don't imes the patient will just ask at we with them." When it to attempt					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3		E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY
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F 759 SS=D	location and level of pon the pain assessme  On 01/08/2020 at app # 1, the executive dire of nursing, ASM # 3, r services and LPN # 5 were made aware of the No further information  References: [1] Hydrocodone is avother ingredients, and products are prescribe hydrocodone combinate relieve moderate-to-serelieves pain by change nervous system responsas obtained from the https://medlineplus.gov.tml.  Free of Medication ErrocFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensure \$483.45(f)(1) Medication percent or greater; This REQUIREMENT by: The facility staff falled residents in the Medica (Residents #41 and #3	ain should be documented int sheet with the MAR.  roximately 5:50 p.m., ASM actor and ASM # 2, director egional director of clinical traveling MDS coordinator, the findings.  was provided prior to exit.  allable in combination with different combination and for different uses. Some tion products are used to evere pain. Hydrocodone ling the way the brain and and to pain. This information website; widruginfo/meds/a601006.h		757	***************************************		
	five errors were observ	ed, resulting in a f 15.63%. The facility staff					

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F 759	failed to ensure that F medication errors. Re administered a medic for him and staff failed medications. The facili Resident #37 was free Resident #37 was adrithe blood pressure me the full dose that was The findings include:  1. Resident #41 was 8/7/19; diagnoses incl hydrocephalus, psych cancer with removal o defibrillator, high blood diabetes, bipolar disor fusion, and cerebral psychological make daily life decision coded as requiring ext toileting, dressing, and eating and hyglene; an and bladder.  On 1/08/20 at 8:52 Alv Nurse) was observed administering the follow Resident #41:  Clonidine (1) 0.1 mg (r Metoprolol (2) 100 mg, Metformin (3) 500 mg,	desident #41 was free of desident #41 was attent #41 was attent #41 was attent #41 was not ordered at to administer ordered at the of medication errors, ministered a partial dose of edication, Atenolol, and not ordered.  admitted to the facility on uded but are not limited to otic disorder, right kidney fixing, cardiac dispressure, atrial fibrillation, der, spinal stenosis with alsy. The quarterly MDS seesment with an ARD conditively intact in ability to ans. The resident was ensive care for bathing, it transfers; supervision for and was incontinent of bowel wing medications to milligrams), 1 tablet 1 tablet 1 tablet 1 tablet	F	759	<ol> <li>Nurses responsible for resider #37 care were re-educated policy on medication admir 1/8/2020.</li> <li>Observation of medication administration was comple nursing staff to ensure the medication is followed by 1 No findings were noted.</li> <li>Nursing staff will be re-edumedication administration DCS/designee by 2/15/2020.</li> <li>The DCS/designee to complemedication administration 2 random med passes per vieweeks. Follow up based on reported to the facilities meeting. Quality Monitorin modified based on findings.</li> <li>Date of compliance 2/15/20</li> </ol>	on the nistration ted for policy of ated on the control of the control of the control of the control of the control of schedus of the control	n on 20. for four s and
	Metformin (3) 500 mg,	1 tablet nded release) 500 mg, 1		Hammer of the state of the stat			

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F 759	Continued From page	80		700			
	Accupril (5) 20 mg, 1		"	759			
		tablet, observation revealed					
	another recidente no	me was documented on the	İ				
	pharmacy label of the	medication cord	į				
	Azithromycin (7) 250	ma 1 fahlat					
	Prednisone (8) 20 mg	1 1 tablet					
	Mucinex (9) 600 mg,	1 tablet (as needed)					
	(-7 7.19)	· maint (dis risodod)					
	Upon record review o	f the physician's orders, it					
	was verified that Resi	dent #41 was not ordered to					
	receive the Folic Acid	that was observed being					
	administered to the re	sident as documented					
	above from another re	esident's medication card.					
	In addition upon ross	and anythere de le College					
	medications were not	rd review, the following ed as being ordered but		[			
	were not prepared an	d administered:			• •		
	Holo not propared an	u adılıılıstaled,					
	Multivitamin (10) 1 tat	olet every morning (listed on		ı			-
	orders but was not giv	/en.)					
		(micrograms) (1000 units)					
	every morning (listed	on orders but was not		- 1			ļ
	given.)						
	Glimepiride (12) 4 mg	tablet daily (listed on		1			
	orders but was not ob	served administered.)				l	
	These medications us	ere not administered and					
	Were all listed on the	are not administered and same page of the MAR				١	
	(Medication Administr	ation Record), evidencing					
	an entire page of med	lications was missed during					
	the Medication Admini	istration observation.					
						į	
	The multivitamin, Vitar	min D, Glimepiride, and				ļ	
		dication errors for Resident				İ	' I
	#41.					ļ	
	On 1/08/20 of 4:07 Da	i in an internal country to					
	#1, when asked how F	/i, in an interview with RN		- 1			
ł		Nesiderik #41 Was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		STRUCTION	(X3) DATE COMP	SURVEY LETED
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MAIATATA	70,40,50,00,00	495389	B. WING			01/	09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			110 LA	ET ADDRESS, CITY, STATE, ZIP CODE AUCK DR HESTER, VA 22603		
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F 759	Resident #41's MAR, name documented or the MAR (Medication the medication card. know how that happe On 1/8/19 at 3:27 PM with RN#1, when ask medication administration person, right dose,	tion that was not listed on that had another resident's a it, if she was comparing Administration Record) to RN#1 stated she did not ned.  I, in a follow up interview ed about the five rights of atlon, RN #1 stated, "Right ght med, right time, right  IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	¥	759			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		_1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10312020
	F WINCHESTER, LLC				110 LAUCK DR		
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F 759	Continued From page References;  1. Clonidine - is used pressure. Information obtained in https://medlineplus.go tml  2. Metoproloi - is user pressure. Information obtained in https://medlineplus.go tml  3. Metformin - is used information obtained in https://medlineplus.go tml  4. Depakote ER - is used to information obtained in https://medlineplus.go tml  5. Accupril - is used to information obtained in https://medlineplus.go tml	to treat high blood from v/druginfo/meds/a682243.h  d to treat high blood from v/druginfo/meds/a682864.h  I to treat diabetes from v/druginfo/meds/a696005.h  ised to treat bipolar disorder from v/druginfo/meds/a682412.h  to treat high blood pressure.		759	DEFICIENCY)	NE .	UALE
	tml  6. Folic Acid - helps the cells. Information obtained find the cells. Information obtained find the cells. Information obtained find the cells are cells.		77.00				
	7. Azithromycin - is ar Information obtained fi https://mediineplus.go tml	n antlbiotic. rom v/druginfo/meds/a697037.h					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PREEX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 769  Continued From page 83 8. Prednisone - reduces swelling and redness by changing the way the immune system works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.ht ml  9. Mucinex - is used to relieve chest congestion. Information obtained from https://medlineplus.gov/druginfo/meds/a682494.h tml  10. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multivitamin-oral/multivitamins-includes-prenata l-vitamins-oral/details  11. Vitamin D - Vitamins are substances that your body needs to grow and develop normally, Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamin.html  12. Glimlperide - is used to treat diabetes. Information obtained from https://medlineplus.gov/vitamin.html	ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR		
8. Prednisone - reduces swelling and redness by changing the way the immune system works. Information obtained from https://medlineplus.gov/druginfo/meds/a601102.ht mf  9. Mucinex - Is used to relieve chest congestion. Information obtained from https://medlineplus.gov/druginfo/meds/a682494.h tml  10. Multivitamin - used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health, Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multivitamin-oral/multivitamins-includes-prenata I-vitamins - O- Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html  12. Glimiperide - is used to treat diabetes. Information obtained from	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD IN CROSS-REFERENCED TO THE APPROPRIES	Æ	COMPLETION
https://medlineplus.gov/druginfo/meds/a696016.h tml		8. Prednisone - redu changing the way the Information obtained https://medlineplus.gr ml  9. Mucinex - is used Information obtained https://medlineplus.gr tml  10. Multivitamin - used deficiency due to poor during pregnancy. Vit blocks of the body an health, Information obtained https://www.webmd.cs/multivitamin-oral/mult-vitamins-oral/details  11. Vitamin D - Vitami your body needs to gr Vitamin D helps your Calcium is one of the bone. A lack of vitami diseases such as osted D also has a role in your immune systems. Information obtained if https://medlineplus.go	ces swelling and redness by immune system works, from by/druginfo/meds/a601102.ht to relieve chest congestion. from by/druginfo/meds/a682494.h bed to treat or prevent vitamin or diet, certain illnesses, or samins are important building d help keep you in good from om/drugs/2/drug-18820-903 ultivitamins-includes-prenata hins are substances that row and develop normally, body absorb calcium, main building blocks of in D can lead to bone exporosis or rickets. Vitamin our nerve, muscle, and from by/vitamind.html	F	759			

i .	OT ON WEDIORIL O	MEDICAID SEKAICES				OMB N	D. 0938-0391
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F 759	2. The facility staff fa #37 was free of media was administered a p and not the full dose to the full dose t	cation errors. Resident #37 cartial dose of a medication, hat was ordered, mitted to the facility on included but are not limited eart disease, dysphagia, abdominal aortic pressure, cardiac ground. The admission / Data Set) assessment with Reference Date) of insident as significantly in ability to make daily life ent was coded as requiring and tolleting; extensive ris, dressing, and hygiene; setting; and was coded as and bladder.  M. RN #1 (Registered preparing and wing medications for insident), ablet tablets for 75 mg (RN #1 or tablet), ablet	F	759			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC		I	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUGK DR WINCHESTER, VA 22603	<u> </u>	/09/2020 
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 759	was to get three (3) 2: Atenolol. RN #1 only tablet during the obse medication error for R On 1/09/20 at 9:54 AN with RN #1 after the n reviewed, when asked Atenolol, RN #1 states know him that well." I know the resident rea check the MAR (Medi Record) against the p medication card, and amount of medication stated, "Well, yes, one A review of the facility Administration of" doc MAR or EMAR (Medic or Electronic Medicati with the Physician's O clarification as indicate medication unit/dose i EMAR prior to returnin or card to the medicate empty container; and resident to accept and medication" On 1/8/20 at 5:50 PM, Staff Member - the Ex #2 (the Director of Nur	record revealed, the cumented that the resident 5 mg tablets (75 mg) of the administered one 25 mg rvation. This resulted in a resident #37.  A, in a follow up interview medication orders were diabout the dose of the di, "I don't know. I don't when asked if one has to ally well in order to carefully cation Administration harmacy label on the to ensure that the correct is prepared per orders, she adoes."  policy, "Medication - Oral numented, "Review the cation Administration Record on Administration Record on Administration Record on Administration Record on Administration Record on Administration container in cart or disposing of the prior to supporting the I ingesting the  ASM #1 (Administrative recutive Director) and ASM resing) were made aware of ar information was provided	F	759			
		•			* The second sec		

<u> </u>	OT OIL MILDIOANE &	INCOLONIO SELATOES				OWR M	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	COM	E SURVEY PLETED
		495389	B. WING			1	C /09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 759	Continued From page	∍86	F	759			
	References:						
	Allopurinol is used Information obtained https://medlineplus.go tml						
	information obtained	o treat high blood pressure. from ov/druginfo/meds/a684031.h					The second property of the second property of
	clots in people with a Information obtained						
	deficiency due to poo during pregnancy. Vit blocks of the body an health. Information obtained https://www.webmd.co	om/drugs/2/drug-18820-903 ultivitamins-includes-prenata					
	body needs to grow a Vitamin D helps your Calcium is one of the bone. A lack of vitami diseases such as oste	body absorb calcium. main building blocks of in D can lead to bone eoporosis or rickets. Vitamin our nerve, muscle, and from					

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		495389	B. WING	•		l	C	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	1 01.	/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760 SS=D	CFR(s): 483.45(f)(2)  The facility must ensu §483.45(f)(2) Resider medication errors.  This REQUIREMENT by: Based on observation record review, and fact was determined that the ensure that one of 32 sample, Resident #37 medication errors. Resident #37 medication errors. Resident #37 was adr 12/10/19; diagnoses into encephalopathy, he diabetes, atrial flutter, aneurysm, high blood pacemaker, and pneusoday MDS (Minimum an ARD (Assessment 12/17/19 coded the recognitively impaired in decisions. The reside total care for bathing a assistance for transfer was independent for eincontinent of bowel at A review of the clinical revealed that on 1/8/2 1/7/20 to 7a.m., on 1/8/2 1/7/20 to 7a.m.	its are free of any significant  Is not met as evidenced  In, staff interview, clinical cility document review, it the facility staff failed to residents in the survey  Was free significant esident #37 was not ect dose of the blood Atenolol (2).  mitted to the facility on included but are not limited eart disease, dysphagia, abdominal aortic pressure, cardiac imonia. The admission / Data Set) assessment with Reference Date) of esident as significantly in ability to make daily life ent was coded as requiring and tolleting; extensive ins, dressing, and hygiene; eating; and was coded as	F	760	,			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILC		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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ENVOY O	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1.	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		Udikuku
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETION DATE
F 760	was obtained. On 1/08/20 at 9:08 Al Nurse) was observed administering the folio Resident #37: Allopurinol (1) 100 mg Atenolol (2) 25 mg, 3 #1 only prepared 1 ta Eliquis (3) 2.5 mg, 1 the Multivitamin (4), 1 tab Vitamin D3 (5), 1000 units. On 1/8/19 at 3:27 PM with RN#1, when ask medication administration person, right dose, righ	M, RN #1 (Registered preparing and owing medications for a (milligrams), 1 tablet tablets for 75 mg (Note: RN blet), ablet let units, 2 tablets for 2000  in an interview conducted ed about the five rights of ation, RN #1 stated, "Right let med, right time, right record revealed the cumented that the resident 3) 25 mg tablets (75 mg) of only administered one 25 mg rivation.  M, in a follow up interview led about the dose of the d, "I don't know. I don't When asked if one has to lly well in order to carefully cation Administration harmacy label on the to ensure that the correct is prepared per orders, she	F	760 F	<ol> <li>Nurses responsible for residence were re-educated on the medication administration</li> <li>Observation of medication administration will be comparing staff to ensure block medication is administered physician order by 1/31/20 findings were noted.</li> <li>Nursing staff will be re-edumedication administration DCS/designee by 2/15/2020</li> <li>The DCS/designee to compare medication administration 2 random med passes per varied four weeks to ensure comparing blood pressure medication administration. Follow up the findings and reported to the monthly QAPI meeting. Que Monitoring schedule modifications.</li> <li>Date of compliance 2/15/20</li> </ol>	he policy on 1/8/2 pleted for od pressu per 20. No cated on by 0. ete the monitor veek for liance w pased on e facilitie ality led base	y on 2020. or ure for ith

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING			SURVEY PLETED
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	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, 2 110 LAUCK DR WINCHESTER, VA 22803	ZIP CODE	01	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 760	Administration of door MAR or EMAR (Medior Electronic Medicat with the Physician's Clarification as indicat medication unit/dose EMAR prior to returni or card to the medica empty container; and resident to accept an medication"  On 1/8/20 at 5:50 PM Staff Member - the Ac (the Director of Nursir findings. No further in the end of the survey.  References:  1. Allopurinol is used Information obtained in https://medlineplus.gottml  2. Atenolol is used to Information obtained in https://medlineplus.gottml  3. Eliquis is used to polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the polots in people with at Information obtained in the properties of	y polloy, "Medication - Oral cumented, "Review the cation Administration Record ion Administration Record ion Administration Record ion Administration Record ion Administration Record ion Administration Record ion Administration Record ion Compare the label against the MAR or ng the medication container tion cart or disposing of the prior to supporting the dingesting the  1. ASM #1 (Administrative dministrator) and ASM #2 ng) were made aware of the information was provided by  1. ASM #1 (Administrative dministrator) and ASM #2 ng) were made aware of the information was provided by  1. As #1 (Administrative dministrator) and ASM #2 ng) were made aware of the information was provided by  1. As #1 (Administrative dministrator) and ASM #2 ng) were made aware of the information was provided by	F	760			
	4. Multivitamin - used	d to treat or prevent vitamin					

NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  STREET ADDRESS, DITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603  FOR WINCHESTER, V		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATE	2. 0936-0391 SURVEY
NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC  COUD BOUNDARY STATEMENT OF DEPOCECIES (EACH CORRECTION PRETAY TAO BY INCHESTER, VA. 22803  COUD BOUNDARY STATEMENT OF DEPOCECIES (EACH CORRECTION PRETAY REGULATORY OR LSC IDEMTIFYING INFORMATION)  FROM CONTINUED FROM LSC IDEMTIFYING INFORMATION PROPRIATE DEPOCECIES (EACH CORRECTIVE ACTION SHOULD BE ORDERED FROM COMPANY OR LSC IDEMTIFYING INFORMATION)  F 760  Continued From page 90 deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health.  Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multivitamin-oral/multivitamins-includes-prenate I-vitamins-oral/multivitamins-includes-prenate I-vitamins-includes-prenate	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING.			•
ENVOY OF WINCHESTER, LLC  SUMMARY STATEMENT OF DESCRIPCIES PREFIX TAG  SUMMARY STATEMENT OF DESCRIPCIES (EACH DESCRIPTIVE MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 760  Continued From page 90 deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multifytamins-oral/details  5. Vitamin D Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://mediineplus.gov/vitamind.html F 812 SS=E CFR(s): 483.60(I)(1)(2)  §483.60(I) F Procure food from sources approved or considered satisfactory by federal, state or local authorities. (I) This may include food items obtained directly from local protucers, subject to applicable State			495389	B, WING				
ONJ DE SUMMARY STATEMENT OF DEFICIENCIES PREFEX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 760  Continued From page 90 deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/mutitivitamins-oral/details  5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D needs to grow and develop normally. Vitamin D needs to grow and develop normally. Vitamin D needs to grow and develop normally. F 812  F 812  F 812  F 812  F 812  F 812  S=E  CFR(s): 483.60(i)(1)(2)  \$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	NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	V3/2020
PREFIX TAG    Continued From page 90   Geficiency dues to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multivitamin-oral/details    S. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html    F 812	ENVOY O	· ·			1			
deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health.  Information obtained from https://www.webmd.com/drugs/2/drug-18820-903 8/multivitamin-oral/multivitamins-includes-prenata I-vitamins-oral/details  5. Vitamin D - Vitamins are substances that your body needs to grow and develop normally. Vitamin D helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as osteoporosis or rickets. Vitamin D also has a role in your nerve, muscle, and immune systems. Information obtained from https://medlineplus.gov/vitamind.html F812 F812 F812 SS=E S483.60(i) (1)(2) §483.60(i) (1)(2) §483.60(i)(1)(2) §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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
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.	F 812	deficiency due to pooduring pregnancy. Vit blocks of the body an health. Information obtained https://www.webmd.c8/multivitamin-oral/mult-vitamins-oral/details  5. Vitamin D - Vitamin body needs to grow a Vitamin D helps your Calcium is one of the bone. A lack of vitamin diseases such as osted D also has a role in your immune systems. Information obtained https://medlineplus.go Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considered state or local authoriti (i) This may include form local producers, and local laws or regulii) This provision does facilities from using progradens, subject to consider safe growing and food (iii) This provision does facilities from using progradens, subject to consider safe growing and food (iii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiii) This provision does (iiiii) This provision does (iiiiiiii) This provision does (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	r diet, certain illnesses, or amins are important building d help keep you in good from om/drugs/2/drug-18820-903 ultivitamins-includes-prenata ins are substances that your and develop normally, body absorb calcium, main building blocks of n D can lead to bone ecoporosis or rickets. Vitamin our nerve, muscle, and from ov/vitamind.html ore/Prepare/Serve-Sanitary 2) by requirements.  The food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State ulations. In some prohibit or prevent roduce grown in facility ompliance with applicable chandling practices. In some preclude residents					

STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	Survey Leted
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NAME OF P	ROVIDER OR SUPPLIER	490389	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X6) COMPLETION DATE
F 812	§483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio of facility documents is staff falled to store an accordance with profeservice safety.  The findings include:  On 01/072020 at 12:2 the facility's kitchen we lother staff member] # Observation of the reacility's kitchen reveal One 46-ounce carton with approximately had One 46-ounce carton with approximately the remaining. Further One 46-ounce carton with approximately the remaining. Further one quart of honey the contents remaining. One quart of honey the contents remaining further observation or evidence any open dately from the refrigerator.	prepare, distribute and ince with professional rvice safety.  Is not met as evidenced in staff interview and review it was determined the facility in distributed prepare food in essional standards for food in essional	F	812	<ol> <li>The containers of thickend orange juice, cranberry juwater were discarded on Items found to be wet near removed and re-washed completed open items and unlabeled open items were noted on 1/9/3. Dietary staff will be re-edited food storage policies and items by Administrator/de 2/15/2020.</li> <li>The Dietary Manager/desicomplete the Food storage of storage items are compliance with formaintained. Follow up be findings and reported to the monthly QAPI meeting. Of Monitoring schedule modifindings.</li> <li>Date of compliance 2/15/3</li> </ol>	ice and 1/7/2025 ting we in 1/7/2 ere cheems and 2020. Ucated of drying we ignee to be monit weeks to od store sed on he facility iffed ba	lemon 20. 20

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DAT	<u>U. U936-U39 T</u> E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		12		STREET ADDRESS, CITY, STATE, ZIP CODE	01	/09/2020
	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 812	Observation of the dry kitchen revealed three deep, wet nesting on drying rack. Further chalf pans, six inches comiddle shelf of the dry immediately removed drying rack and sent to OSM # 2 stated the powet.  The facility policy "Rec" All food items will be	ving rack in the facility's e quarter pans, four inches the middle shelf of the observation revealed two deep wet nesting on the ving rack. OSM # 2 the above item from the hem to the dishwasher. ans should not be stacked ceiving" documented in part, appropriately labeled and nanufacturer packaging or lanual Warewashing" 3. All serviceware and	F	812			
F 842 SS=D	(administrative staff m director and ASM # 2, 3, regional director of (licensed practical nur coordinator, were mad No further information Resident Records - Ide CFR(s): 483.20(f)(5), 4 §483.20(f)(5) Resident (i) A facility may not re resident-identifiable to (ii) The facility may religious facility facility may religious facility may religious facility may religious facility may religious facility may religious facility facility may religious facility	te aware of the findings.  Was provided prior to exit.  entifiable Information 483.70(i)(1)-(5)  t-identifiable information. lease Information that is the public. ease Information that is an agent only in tract under which the agent	F{	342			

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ENVOY OF WINCHESTER, LLC 110 LAUGK DR WINCHESTER, VA 22603	NVOY OF WINCHESTER, LLC
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	REFIX (EACH DEFICIE
F 842  Continued From page 93  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; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.508; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement 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-	except to the extent to do so.  §483.70(i) Medical §483.70(i)(1) In acc professional standar must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically §483.70(i)(2) The fall information contregardless of the forecords, except who (i) To the individual representative whe (ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domestificativities, judicial are law enforcement pupurposes, research medical examiners, a serious threat to by and in compliance §483.70(i)(3) The farecord information a unauthorized use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	495389	B, WING		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020
ENVOY O	WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	(i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The medical age under State §483.70(i)(5) The medical age under State (ii) A record of the resident information. (iii) The comprehensing provided; (iv) The results of any and resident review edeterminations conductly (v) Physician's, nurse professional's progressiona	required by State law; or e date of discharge when int in State law; or ars after a resident reaches a law.  dical record must containon to identify the resident; sident's assessments; we plan of care and services or preadmission screening evaluations and acted by the State; or and other licensed is notes; and ones; and ones; and ones; and ones; and other diagnostic equired under §483.50.  The facility staff interview, and it was determined that the maintain a complete and ord for one of 32 residents in esident #43. The facility staff	F	842			
		noses that included but were					

STATEMENT ( AND PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	73300	B, Valled			01	/09/2020
ENVOY O	F WINCHESTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
	not limited to osteomy Resident #43's most r set), an admission ass (assessment reference coded Resident #43 a interview for mental st - 15, 15 - being cognit decisions.  On 1/7/20 at approxim interview was conduct Resident #43 was obs bed watching television dressing on her foot R was staying at the fact antibiotics for an infect #43 stated that she had doctor's office having a When asked if the stat treatment to the foot, I staff change the dress wound vac on it when Resident #43 stated th the antibiotics in her IV to treat the infection. If the physician had chai foot at the office that in with a compression ba staff provide the order daily, Resident #43 sta  The physicians order s dated "01/01/20 throug "12/11/19: Nystop (ger 100000 Unit/1G (gram	relitis (1) and dlabetes (2).  recent MDS (minimum data sessment with an ARD redate) of 12/17/2019, is scoring a 15 on the brief ratus (BIMS) of a score of 0 reduced in the distribution of the distribution	F	842			
	pre-programmed settin	ig every shift- change					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
						(	<b>o</b>
		495389	B, WING			01/	09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	as needed,"  The TAR (treatment a "01/01/20-01/31/20" f documented the treat Review of the TAR re evidence documental performed for the following dates and ti 1. "Nystatin Apply to twice daily."  -1/1/20 on "3-11" shift.  -1/2/20 on "7-3" and "3-11" shift.  -1/3/20 on "7-3" and "3-11" shift.  -1/8/20 on "3-11"  -1/6/20 on "3-11"  -1/8/20 on "7-3" and "3-12" shift.  -1/8/20 on "7-3" and "3-12" shift.  -1/8/20 on "1-3" and "3-12" shift.  -1/8/20 on "1-3" and "3-12" shift.  -1/8/20 on "7-3" and "	Administration record) dated for Resident #43 ament orders listed above, vealed that it falled to the tion of treatments being owing treatments on the mes:  affected areas topically  (3:00 p.m. to 11:00 p.m.)  (7:00 a.m. to 3:00 p.m.) shift  shift and "3-11" shift.  shift.  shift.  shift.  p-programmed setting every g on  -Friday & as needed."  mately 5:10 p.m., an otted with RN (registered at the they are stated that they are the they are the they are the they are the they are the they are th	II.	842			
	dressing on the dates	and changing the wound vac s listed above. RN #2 stated that the nurse did not sign					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WNG		· · · · · · · · · · · · · · · · · · ·	!	C
	ROVIDER OR SUPPLIER	144400	1 se vino	s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	09/2020
ENVOTO	F WINCHESTER, LLC			٧	WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	RN #2 stated that the been in a different are charting, the nurse m TAR, or that the treat done. When asked if treatment was admini documentation on the could not be determined treatment should have record to document it.  On 01/09/20 at approrequest was made by (administrative staff in director for the facility accurate and complet.  On 01/09/20 at approthe regional director of that the facility did no maintaining an accurate.  On 01/20/20 at appro (administrative staff in nursing confirmed that policies, Lippincott, at standard of practice.  According to "Fundamincredibly Easy Lippin Philadelphia PA page is a highly significant is a fundamental feature cords are legally valued and comprehensive stamminicated effectiunless the content of	the treatment was done, treatment book might have a when the nurse was ay have forgotten to sign the ment may have not been it could be determined if the stered according to the TAR, RN #2 stated that it led. RN #2 stated that it led. RN #2 stated that the been signed off on the as being completed.  Eximately 12:30 p.m., a written list to ASM nember) #1, the executive policy on maintalning an le medical record.  Eximately 1:00 p.m., ASM #3, of clinical services stated that have a policy for late medical record,  Eximately 1:30 p.m., ASM member) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:30 p.m., ASM nember) #2, the director of late medical record,  Eximately 1:00 p.m., ASM #3, of clinical services stated that the late has been services that the late has	F	842			

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	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		TIPLE CC	COM	SURVEY PLETED	
		495389	B. WING		the Control of the Co	1	C /09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1101	EET ADDRESS, CITY, STATE, ZIP CODE .AUCK DR CHESTER, VA 22603		
(X4) IĐ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	quality of care may no do not realize that wh record can produce a care that is provided in health care team."	e 98  of the possible. Many nurses  nat they document or fail to  n enormous effect on the  by other members of the  on is found in Potter and	F	842			
	Perry's Fundamentals (2005, p. 477): "Doct written or printed that proof for authorized pwithin a client medica nursing practice. Nur accurate, comprehen retrieve critical data, track client outcomes standards of nursing client record provides	s of Nursing 6th edition Limentation is anything Its relied on as record or Persons. Documentation If record is a vital aspect of rsing documentation must be sive, and flexible enough to maintain continuity of care,					
·	(administrative staff n director, ASM #2, the the regional director of	eximately 1:00 p.m., ASM nember) #1, the executive director of nursing, ASM #3, of clinical services and LPN rse) #5 were made aware of					
	No further information References:	n was provided prior to exit.					
	bacterial infection. It of the arms and legs, bone. This informatio website:	nedical term for ne. It's usually caused by a often affects the long bones but can happen in any n was obtained from the /en/parents/osteomyelitis.ht					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
÷		496389	B. WING				C 09/2020
	ROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603	<u> </u>	<i>83/2020</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	κ .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page ml	99	F &	342			
F 880 SS=E	regulate the amount of information was obtain https://www.nlm.nih.go01214.htm. Infection Prevention 8		F	380			
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and aent and to help prevent the asmission of communicable		***************************************			
	program. The facility must esta	orevention and control  blish an Infection prevention (IPCP) that must include, at ving elements:	A Address and the state of the	A CONTRACTOR OF THE CONTRACTOR			
	reporting, investigatir and communicable di staff, volunteers, visit providing services un arrangement based u	ipon the facility assessment to §483.70(e) and following					
	procedures for the pr but are not limited to:	n standards, policies, and ogram, which must include, Ilance designed to Identify					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495389	B. WNG				C 09/2020	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	communicable disease reported; (iii) Standard and trar to be followed to prev. (iv)When and how isc resident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed iscase or infected sic contact with residents contact will transmit the (vi)The hand hygiene by staff involved In discassed in the factoric actions taken \$483.80(a)(4) A system in the factoric actions taken \$483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual retained in the facility will conduit the facility will conduit the facility will conduit the This REQUIREMENT by:	can spread to other can spread to other can spread to other can spread to other can spread to other can spread to other spread of infections; clation should be used for a trot limited to: ation of the isolation, infectious agent or organism at the isolation should be the clation of the resident under the clation should be the clation of the resident under the clations from direct can or their food, if direct the disease; and procedures to be followed rect resident contact.	F	880	1. Residents #41, #163 and Spirometer replaced with and placed in a respirator 1/8/2020. Nebulizer mas #41, #47, and #25 replace one and placed in a respirator 1/8/2020. The nurse proversident #37 was reeduce handling medications with on 1/8/2020.  2. Audit to ensure incentive and nebulizer masks are serespiratory bags was complished in a medication administration completed for nursing star medications are not touch hands by 1/31/2020. Folloon findings.	a neway bag ook for received with a ratory be received in spirom stored in spirom of on of a will be aff to en hed by i	one n sidents a new ag on are for not ands eters and no oted sure oare	

		(X3) DATE SURVEY COMPLETED
495389 B. WING		С
NAME OF DECIMEND OF COMMISSION	PET ADDEDO ANY STATE TO SO THE	01/09/2020
ENVOY OF WINCHESTER, LLC	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 880  Continued From page 101 interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices for four of 32 residents in the survey sample; Residents #41, #37, #47, #163, and #25. The facility staff failed to store Resident #41's nebulizer and Incentive spirometer in a manner to prevent infections. Resident #41's nebulizer mask and Incentive spirometer were observed uncovered on the residents over the bed table. The facility staff failed to prepare and administer medications to Resident #37, in a manner to prevent the spread of infection. RN (registered nurse) #1 was observed touching medications in a plastic medication cup with her ungloved finger. The facility staff failed to maintain infection control practices in the storage of a nebulizer for Resident #47, the storage of Resident #163's incentive spirometer and Resident #25's nebulizer and incentive spirometer to prevent infection.  The findings include:  1. Resident #41 was admitted to the facility on 8/7/19; diagnoses included but are not limited to hydrocephalus, psychotic disorder, right kidney cancer with removal of kidney, cardiac defibrillator, high blood pressure, atrial fibrillation, dlabetes, bipolar disorder, spiral stenosis with fusion, and cerebral palsy. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/21/19 coded the resident as being cognitively intact in ability to make dailly life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; supervision for eating and hyglene; and was incontinent of bowel and	<ol> <li>Nursing staff will be re-ed infection control and med handling, including storing spirometers and nebulizer respiratory bags and not the medications with bare has DCS/designee by 2/15/20/4. The DCS/designee to comprespiratory quality monitor residents with incentive spinebulizers to ensure compressional medication administration 2 random med passes per weeks to ensure medication administration 2 random med passes per weeks to ensure medication based on findings and representation findings.</li> <li>Date of compliance 2/15/3</li> </ol>	ication g incentive masks in outhing nds by 20, plete the or for any pirometer and pliance is ar weeks. The e the monitor for week for four ons are not Follow up orted to the eeting. ule modified

STATEMENT	OF DEFICIENCIES	Local Sports of the Control of the C				OWR M	<i>J.</i> 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILD			(X3) DATE SURVEY COMPLETED	
		495389	B, WING		· .		C /09/2020
NAMEOFP	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 01	IUVIEVEV
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22803		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	Continued From page bladder.	e 102	F	880			
-	A review of the facility documented, "Place of maintained in the res	entire unit in a bag to be					
	A review of the facility Spirometer" did not d maintaining the devic between uses.	y policy, "Incentive ocument any criteria for e in a sanitary manner					
	made of Resident #4 not in the room. An I observed on the over covered. A nebulizer	PM, an observation was 1's room. Resident #41 was ncentive Spirometer was bed table. It was not machine and mask was nd next to the bed. The d.			;		
	On 1/08/20 at 8:52 Al observed in bed. The nebulizer mask remain previously observed.	Incentive Spirometer and					
	bed table was across spirometer was on the was no bag present to incentive spirometer. nebulizer mask reveatinew bag and dated, has used both items of spirometers.	rview conducted. The over the resident. The Incentive e table, uncovered. There o cover and store the					
	(Registered Nurse), s mask should be cove	i, in an interview with RN #1 the stated that the nebulizer red. She stated the should be wiped clean. RN					

STATEMENT	OF DEFICIENCIES	NAI PROMPTROUGH	1 .	······································	OMB NO. 0938	<u>-0391</u>
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	r
ļ		495389	B. WING		C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/09/202	0
	F WINCHESTER, LLC			110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPL	ETION
F 880	#1 stated, "I guess it s but I was never told the On 1/8/20 at 5:50 PM Staff Member - the Ex #2 (the Director of Nu the findings. No further by the end of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the findings of the survent the	should be stored in a bag nat."  ASM #1 (Administrative cutive Director) and ASM rsing) were made aware of er information was provided ey.  led to prepare and s to Resident #37, in a spread of infection. RN was observed touching ic medication cup with her	F 884			
	12/10/19; dlagnoses in encephalopathy, heard dlabetes, atrial flutter, aneurysm, high blood pacemaker, and pneur 5-day MDS (Minimum (Assessment Reference the resident as signific ability to make dally life was coded as requiring toileting; extensive assidessing, and hygienes eating; and incontinent On 1/08/20 at 9:08 AM Nurse) was observed to administering the follow Resident #37:	nclude but not limited to, a disease, dysphagia, abdominal aortic pressure, cardiac monia. The admission / Data Set) with an ARD ce Date) of 12/17/19 coded cantly cognitively impaired in e decisions. The resident g total care for bathing and elistance for transfers, was independent for to fowel and bladder.				

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		0. 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495389	B. WING			l	C	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/	09/2020	
ENVOY O	F WINCHESTER, LLC			1	10 LAUGK DR VINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X6) COMPLETION DATE	
.F 880	" Atenolol (2) 25 mg " Eliquis (3) 2.5 mg " Multivitamin (4), " Vitamin D3 (5), 1 units.  The Eliquis was missi RN #1 closed up the a medication cup that c medications to the me missing Eliquis from t observed with her fing cup that contained the pills while she was ca the cart with the medi the medications and a	ng, 3 tablets for 75 mg g, 1 tablet 1 tablet 000 units, 2 tablets for 2000  ing from the medication cart. cart and carried the ontained the other edication room to obtain the the stat box. RN #1was ger down in the medication a medications, touching the urrying it. RN #1 returned to cations, and then crushed	F	880				
	with RN #1, she state the medication with yo didn't realize I was do to do that. I know that touch the pills."  A review of the facility Administration of doc	M, in an interview conducted d that you shouldn't touch our fingers. RN #1 stated, "I ring that. I know better than t you are not supposed to policy, "Medication - Oral cumented, "Refrain from						
	On 1/8/20 at 5:50 PM Staff Member - the Ex #2 (the Director of Nu	psules, or pills with hands."  , ASM #1 (Administrative recutive Director) and ASM rsing) were made aware of er information was provided rey.						
	References:							
	1. Allopurinol is used	to treat gout.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
		495389	B. WING				C /09/2020
ENVOY 0	ROVIDER OR SUPPLIER F WINCHESTER, LLC			1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	<u></u>	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Information obtained thitps://medlineplus.go tml  2. Atenolol is used to Information obtained thitps://medlineplus.go tml  3. Eliquis is used to polots in people with at Information obtained thitps://medlineplus.go tml  4. Multivitamin - used deficiency due to pool during pregnancy. Vit blocks of the body an health. Information obtained thitps://www.webmd.co.8/multivitamin-oral/mult-vitamins-oral/details  5. Vitamin D - Vitamin body needs to grow a Vitamin D helps your Calcium is one of the bone. A lack of vitamin diseases such as osted D also has a role in your immune systems. Information obtained thitps://medlineplus.go	from by/druginfo/meds/a682673.h  of treat high blood pressure, from by/druginfo/meds/a684031.h  orevent strokes and blood trial fibrillation. from by/druginfo/meds/a613032.h  of to treat or prevent vitamin r diet, certain illnesses, or amins are important building d help keep you in good from om/drugs/2/drug-18820-903 ultivitamins-includes-prenata one are substances that your and develop normally, body absorb calcium. main building blocks of n D can lead to bone exporosis or rickets. Vitamin our nerve, muscle, and from by/vitamind.html		880	, , , , , , , , , , , , , , , , , , , ,		
	<ol> <li>The facility staff fall control practices in the for Resident #47.</li> </ol>	lled to maintain infection e storage of a nebulizer (1)					

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STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING			1	C /09/2020
NAME OF P	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
				1	110 LAUCK DR		
ENVOY O	f winchester, llc				•		
				<u> </u>	WINCHESTER, VA 22603		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	NEGOLATORI OR L	LSC IDENTIFYING INFORMATION)	TAG	3	CROSS-REFERENCED TO THE APPROPE	IATE	DATE
					DEF(CIENCY)		
		*	1				
F 880	Continued From page	∍ 106	F	880	o ·		
			1 '		<b>*</b>		
	Resident #47 was add	mitted to the facility					
		noses, that included but	l				
		ngestive heart failure (2),	Ì				
	pneumonia (3) and cr	hronic obstructive pulmonary	ŀ		****		
	disease (4),						
		recent MDS (minimum data					
		sessment with an ARD			Sample State of th		
	(assessment reference	ce date) of 12/19/19, coded					
	Resident #47 as scori	ing a 15 on the staff					l
	assessment for menta	al status (BIMS) of a score					
	of 0 - 15, 15- being co	ognitively intact for making					
	daily decisions.	agriculty intoot of maining					
	dany decisions,						:
	On 1/7/19 at approxin	motaly 2:20 n m an					
		cted with Resident #47.					
	Observation of Reside	ent #47's room revealed a					
	nebulizer delivery dev	nce on the top of a			3.00 m		
	nightstand, which was	s located to the right side of					]
		er device was observed					
	uncovered with the m	outhpiece touching the					
		id top. When asked about					
	the nebulizer Residen	nt #47 stated that she used it					
	as needed. Resident	#47 stated that she had					
		neumonia and had required					
		sion and had not used it					
		peen feeling better. When			***		
		was ever placed in a bag or					
	Action in the Hebblice	was ever placed in a pag or					
	covered between use	s, Resident #47 stated that					
	sne did not remembel	r it being covered. Further					
		ent #47's room revealed an					
	oxygen concentrator I	located on the right side of			***************************************		
	the bed with a nasal o	cannula (oxygen delivery					
	device) in a plastic ba	g and a prefilled humidifier			-		<b>[</b>
	bottle of sterile water	dated 12/23/19. When					1
	asked about the oxvo	en Resident #47 stated that					1
	she had not used it re	ecently. Resident #47 stated					
		gen when she first came					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•		495389	B. WING			С	
	ROVIDER OR SUPPLIER WINCHESTER, LLC	450003	D. VIIIVO	110	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	<u>  01/</u>	D9/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Ε	(X5) COMPLETION DATE
F 880	not used it recently be felt that she needed it felt that she needed it The order summary in through 01/31/20 doc Albuterol (5) inhale 1 of) nebulizer every 6 "12/14/19 Oxygen @ minute) via (by way omaintain sats (oxygen than) 92%."  The "Physician's Inter "12/15/19" document via inhalation q6 (ever days pring (as needed)  The MAR (medication dated "December 20 documented the physical MAR documented Resident puoneb nebulizer tree 12/17/19, no time of a documented Residen nebulizer treatment of 12:00 p.m., and 12:00 f.00 a.m., 12:00 p.m.  The MAR (medication dated "December 20 Resident #47 failed to oxygen for Resident sident in the sident	middle of December but had ut it was there in case she t.  eport dated 01/01/20 cumented, "12/22/19 Duoneb (one) unit dose via (by way (six) hours as needed," and (at) 2 (two) LPM (liters per of) N/C (nasal cannula) to a saturations) > (greater fill) (greater fill) (for the condition of the con	F	880			
	"01/01/20-01/31/20" (						

OLIVILIV	STON WEDICARE &	MEDICAID SERVICES	****			OMB NO	) <u>. 0938-0391                                    </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A, BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	8. WING			C 01/09/2020	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				i	110 LAUCK DR		
ENVOY OF	f winchester, llc			Ι.			
					WINCHESTER, VA 22603		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID DDEC		PROVIDER'S PLAN OF CORRECTION	-	(X5)
TAG		SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
		· ·		_	DEFICIENCY)		
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F 880	Continued From page	108	=	880		ſ	
	· · · · · · · · · · · · · · · · · ·	. 100	1	000			
	The comprehensive of	eare plan for Resident #47					
	failed to evidence day	cumentation for nebulizer			. •		
	treatments or oxygen						
	TORUMENTS OF OXYGEN	administration.	1		,		
	On 1/08/20 at 1:00 p.	m an interview was					
	conducted with LPN (	licensed practical nurse) #4,					
	regarding the process	s staff follows for handling					
		rices. LPN #4 stated that					
		r each use, and then stored					
	in a bag. LPN #4 sta	ted that the hads are					
		undays. When asked why					
	staff clean and store t						
		ed that if they, (nebulizer)					
		ey could be exposed to			·		
		ise infection when used by					
		sked how often sterile water					
		the oxygen concentrators					
	are changed, LPN #4						
		undays or before if needed.					
		y are changed weekly, LPN					
i		Infection control practice.					
		ygen is used as needed					·
		ence in how often the water					
	bottle is changed, LP	N #4 stated that it should still					
	be changed weekly.	An observation was					
	conducted with LPN #	#4 of the uncovered					
	nebulizer device with	the mouthpiece touching the					
		d top. LPN #4 stated that it					
		in a bag. An observation					
	was made with LPN #				1		
	humidifier bottle date	d "12/23/19" located in					
	Resident #47's room.	LPN #4 stated that it					
*	(sterile water humidif						
		ould have been changed					
		reed that the oxygen and					
		allable for use for Resident				,	
	#47.					-	
l i	l		1				I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		496389	B. WING			1	C
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		<b>L</b>	110	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	( 07/	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X6) COMPLETION DATE
F 880	On 01/09/20 at approrequest was made by (administrative staff in director for the facility oxygen.  On 01/20/20 at appro (administrative staff in nursing stated that the Lipplicott, and Potter practice.  The facility policy "Neinebulizer", Effective ID Date: 03/20/2018" do Disassemble device and nebulizer cup with the entire unit in a barresident's room."  The facility policy "Ox Date: 11/30/2014; Redocumented in part, "procedures, as approhumidifier with date a lin "Fundamentals of I Patricia A. Potter and Inc; Page 648. "Box of Health Care-Assoc Respiratory Tract Ox therapy equipment."  "The humidification sybacteria. Pseudomorthe organism involved equipment such as called the called th	eximately 12:30 p.m., a written list to ASM member) #1, the executive policy on nebulizers and eximately 1:30 p.m., ASM member) #2, the director of the facility uses their policies, and Perry as their standard of eximately 1:30/2014; Revision eximated in part, "example and rinse the mouthpiece of the water and air dry. Place of the maintained in the existence of the maintained in the existence of the mouthpiece of the maintained in the existence of the mouthpiece of the maintained in the existence of the mouthpiece of the maintained in the existence of the mouthpiece of the mouthpi	F	880			

		I DIONID SERVICES				OWR	VO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
		495389	B. WNG			n	C 1/09/2020
NAME OF P	ROVIDER OR SUPPLIER		<del></del>		STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	
ENVOY O	F WINCHESTER, LLC	•			110 LAUCK DR WINCHESTER, VA 22603		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE.	(X6) COMPLETION DATE
F 880	(p.492) Philadelphia, Saunders Company.) On 01/08/20 at appro (administrative staff in director, ASM #2, the the regional director of (licensed practical number findings.  On 1/9/20 at approxim (administrative staff in director of clinical series "Physician's Interim/T Resident #47 which of (discontinue) O2 (oxy medication) & (and) Is dated "1/8/20, 1610 (element)." No further information Reference:  1. Nebulizer - "a device used to ae delivery to patients." Dictionary of Medicine-Seventh Edition, Mille 2. Congestive heart for A condition in which the	ative Care, 4th edition. Pennsylvania: W. B.  ximately 5:50 p.m., ASM nember) #1, the executive director of nursing, ASM #3, of clinical services and LPN rse) #5 were made aware of mately 8:00 a.m., ASM nember) #3, the regional vices provided a copy of elephone Orders" for ocumented, "DC gen), Duonebs (nebulizer S (incentive spirometer)" 4:10 p.m.)."  a was provided prior to exit.  prosolize medications for Taken from Encyclopedia & e., Nursing & Allied Health er-Keane, page 1182.  allure ne heart can't pump enough by's needs. This information is website:	F	880			
	lungs. This informatio	nfection in one or both of the n was obtained from the neplus.gov/pneumonia.html					

STATEMENT ( AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	470303	B. WING		TREET ADDRESS SITY DATE TO SOSE	01	/09/2020
ENVOY O	F WINCHESTER, LLC			1	STREET AODRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 880	Continued From page	111	T	880			
	lead to shortness of bobtained from the well https://www.nlm.nih.g  5. Duoneb Albuterol The combination of al used to prevent whee chest tightness, and ochronic obstructive purchased to prevent whee chest tightness, and ochronic obstructive purchased surges) such as chrothe air passages that emphysema (damage lungs). Albuterol and used by people whose controlled by a single Albuterol and ipratrop medications called broipratropium combination opening the air passabreathing easier. This from the website: https://medlineplus.gottml  4. Resident # 163 was 01/03/2020 with diagr not limited to high bloobstructive pulmonary.  Resident # 163's mos data set), was not due The facility's "Admissidated 01/03/2020 for in part, "Cognition: Ale	t difficult to breath that can breath. This information was bosite: ov/medlineplus/copd.html.  Ibuterol and ipratropium is being, difficulty breathing, coughing in people with almonary disease (COPD; a staffect the lungs and book on the air sacs in the lipratropium combination is elead to the lungs) and to the air sacs in the lipratropium combination is elead to the lungs. Inhaled medication, itum are in a class of conchodilators. Albuterol and on works by relaxing and ges to the lungs to make information was obtained ov/druginfo/meds/a601063.h					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER;			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING			С	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC			11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUGK DR VINCHESTER, VA 22603	01	/0 <del>9</del> /2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 880	Understood and Unde "Respiratory", it docu Treatments and Procand/or observation."  On 01/07/20 at 1:49 processed in the Pos Incentive spirometer incentive spirometer. The Pos Interviolence documenticentive spirometer.  The facility's baseline dated 01/03/2020 faility's baseline dated 01	erstands." Under mented, "Special edures: None per history  o.m., an observation of r-the-bed table revealed an Observation of the failed to evidence that it was wered.  o.m., an observation of r-the-bed table revealed an Observation of the failed to evidence that it was wered.  o.m., an observation of r-the-bed table revealed an Observation of the failed to evidence that it was wered.  o.m., an observation of r-the-bed table revealed an Observation of the failed to evidence that it was wered.  o.m., an observation of r-the-bed table revealed an Observation of the failed to evidence that it was wered.  order sheet] dated of the failed to evidence that it was wered.  order sheet] dated of the failed of the failed to evidence that it was wered.	F	880			
	The facility's baseline	ed to evidence					

STATEMENT OF AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WNG			C 01/09/2020	
	ROVIDER OR SUPPLIER F WINCHESTER, LLC		· <b>L</b>	T	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	<u>  U1/</u>	09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page On 01/08/20 at 8:30 at conducted with Resid they used the incentive 163 stated sometimes. On 01/08/2020 at 1:00 conducted with LPN [4. When asked if an ipiece of respiratory en yes. When how the inbestored when not inshould be covered or was shown Resident on the over-the-bed to should be covered. Vincentive spirometer's stated, "It could collection when used be Con 01/08/2020 at app #1, the executive direction when used be Con 01/08/2020 at app #1, the executive direction when used be Con 01/08/2020 at app #1, the executive direction when used be Con 01/08/2020 at app #1, the executive direction when used be Con 01/08/2020 at app #1, the executive direction when used be Con 01/08/2020 at app #1, the executive direction when used be considered and LPN #5 were made aware of the latting after surgery of liness, such as pneur spirometer teaches you breaths. Deep breath inflated and healthy were used to healthy after surgery to be provided and healthy were used to healthy after surgery to be provided and healthy were used to healthy after surgery to breaths. Deep breath inflated and healthy were used to healthy were used to healthy after surgery to breaths. Deep breath inflated and healthy were used to healthy were used to healthy after surgery to breaths. Deep breath inflated and healthy were used to healthy were used to healthy after surgery to breaths. Deep breath inflated and healthy were used to healthy were used to healthy after surgery to breaths.	ent # 163. When asked if re spirometer, Resident # 5.  D. p.m., an interview was licensed practical nurse] # incentive spirometer was a quipment, LPN # 4 stated incentive spirometer should use, LPN # 4 stated it placed in a bag. LPN # 4 # 163's incentive spirometer able. LPN # 4 stated it vhen asked why the should be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the stould be covered, LPN # 4 stated it vhen asked why the should be covered, LPN # 4 stated it vhen asked why the s		880	DEFICIENCY)	MC	
	https://medlineplus.go 00451.htm.	v/ency/patientinstructions/0					

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STATEMENT ( AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495389	B. WING		**************************************	C 01/09/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·····	
ENVOY O	F WINCHESTER, LLC			1	10 LAUCK DR VINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 880	Continued From page	<del>2</del> 114	F	880			
	can lead to shortness was obtained from the https://www.nlm.nih.g	es it difficult to breath that of breath. This information e website: ov/medlineplus/copd.html. lled to store nebulizer mask	1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944 - 1944				
	and an incentive spire manner.	ometer [1] in a sanitary					
	11/20/2019 with diagr not limited to respirate	imitted to the facility on noses that included but were ory failure, shortness of ostructive pulmonary disease					
	set), a quarterly asset (assessment reference Resident # 25 as scot assessment for mental of 0 - 15, 14- being or daily decisions. Resident requiring extensive as member for activities	the date) of 11/29/19, coded fring a 14 on the staff all status (BIMS) of a score organitively intact for making dent # 25 was coded as a saltance of one staff of daily living. Section O Procedures and Programs"					
	Resident # 25's bedsl nebulizer and a nebul the table. Observation revealed it was uncovereceive nebulizer treat stated yes. Further of table revealed an income	ilzer mask sitting on top of n of the nebulizer mask vered. When asked if they itments, Resident #25 bservation of the bedside entive spirometer ked if they use the incentive		:	·		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	······································	495389	B. WNG			01/	09/2020
	ROVIDER OR SUPPLIER F WINCHESTER, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	On 01/07/20 at 2:45 p Resident # 25's bedsi nebulizer and a nebul the table. Observatio revealed it was uncov of the bedside table in spirometer uncovered On 01/07/20 at 4:05 p Resident # 25's bedsi nebulizer and a nebul the table. Observatio revealed it was uncov of the bedside table in spirometer uncovered On 01/08/20 at 8:30 at Resident # 25's bedsi nebulizer and a nebul the table. Observatio revealed it was uncov of the bedside table in spirometer uncovered The "Physician's Tele 12/27/2019 documen [four] hours for SOB [ Further review of the evidence a physician' incentive spirometer.  The comprehensive of with a revision date of "Focus: [Resident # 2 obstructive pulmonar 12/03/2019." Under ' documented, "Give in oxygen therapy as or	o.m., an observation of de table revealed a lizer mask sitting on top of in of the nebulizer mask vered. Further observation evealed an incentive d.  o.m., an observation of ide table revealed a lizer mask sitting on top of in of the nebulizer mask vered. Further observation evealed an incentive d.  a.m., an observation of ide table revealed a lizer mask sitting on top of ide table revealed a lizer mask sitting on top of ide table revealed a lizer mask sitting on top of in of the nebulizer mask vered. Further observation evealed an incentive d.  a.m. an observation of ide table revealed a lizer mask sitting on top of in of the nebulizer mask vered. Further observation evealed an incentive d.  a.m. an observation of ide table revealed a lizer mask sitting on top of in of the nebulizer mask vered. Further observation evealed an incentive d.  a.m. an observation of ide table revealed a lizer mask sitting on top of ide table revealed a lizer mask vered. Further observation evealed an incentive d.  a.m. an observation of ide table revealed a lizer mask sitting on top of ide table revealed a lizer mask vered. Further observation evealed an incentive d.  a.m. an observation of ide table revealed a lizer mask sitting on top of ide table revealed a lizer mask vered. Further observation evealed an incentive d.	F	880			
	[four] hours for SOB [Further review of the evidence a physician incentive spirometer.  The comprehensive of with a revision date of "Focus: [Resident # 2 obstructive pulmonar 12/03/2019." Under documented, "Give n	shortness of breath]." clinical record failed to 's order for the use of an care plan for Resident # 25 f 12/03/2019 documented, 25] has COPD [chronic y disease]. Date Initiated: 'Interventions' it ebullzer treatments and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING			C 01/09/2020		
	NAME OF PROVIDER OR SUPPLIER  ENVOY OF WINCHESTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE	
F 880	On 01/08/2020 at 1:00 conducted with LPN [4. When asked if an piece of respiratory eryes. When how the in be stored when not in should be covered or asked how a nebulizer when not in use, LPN placed in a bag. When ebulizer mask and in bedside table LPN #4 spirometer and nebuli covered.  On 01/08/2020 at app #1, the executive dire of nursing, ASM #3, services and LPN #5 were made aware of No further information.  References: [1] A device used to healthy after surgery illness, such as pneu spirometer teaches y breaths. Deep breath well-inflated and heal prevent lung problem information was obtain	O p.m., an interview was [licensed practical nurse] # incentive spirometer was a quipment, LPN # 4 stated neentive spirometer should nuse, LPN # 4 stated it placed in a bag. When ar mask should be stored if # 4 stated it should be en shown Resident # 25's neentive spirometer on the 4 stated the incentive lizer mask should be proximately 5:50 p.m., ASM ector and ASM # 2, director regional director of clinical 5 traveling MDS coordinator,	F	880				