STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/06/2021 through 4/08/2021. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 037 SS=B	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		5/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/29/2021

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

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E 037	Continued From page 1	E 037		

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

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E 037	Continued From page 2	E 037		

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

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E 037	Continued From page 3	E 037		

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency preparedness plan, the facility staff failed to ensure all new and existing staff were trained in their emergency preparedness policies and procedures. The findings include: During an interview with the Administrator, on 4/6/21 at approximately 11:30 a.m., she was not able to provide evidence of training in the facility's Emergency Preparedness Plan (EPP) for all new and existing staff to include agency staff and any other individuals that provide services and expected to assist in an emergency. One Annual inservice sign-in sheet dated 5/16/20 titled "Education regarding the Emergency	E 037	1. No resident experienced any adverse outcomes, in regards to emergency preparedness plan. All residents residing in the facility have the potential to be affected. 2. ED/Designee to review facilities Emergency Preparedness Plan and update as necessary. 3. ED/Designee will educate staff on the facilities Emergency Preparedness Plan. 4. ED/Designee will conduct quality monitoring rounds 3X a week for 1 month to ensure the practices are being maintained. Results will be brought to QAPI for 30 days for review and	

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	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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E 037	Continued From page 5 Preparedness Plan" indicated 19 employees were trained on the facility's Emergency Preparedness policies and procedures that included the following nursing staff: 4 Certified Nursing Assistants (CNA), 2 Licensed Practical Nurses (LPN), the Director of Nursing (DON), and staffing coordinator. The 11 remaining personnel consisted of 2 receptionists, Administrative assistant, Rehabilitation director, Business Office Manager (BOM) and Assistant BOM, medical records, 1 cook, 1 maintenance tech, 1 housekeeper and 1 unidentified employee. A second inservice sign-in sheet dated 6/30/20 titled "Disaster Drill Table Top" indicated 18 employees were trained specifically on this topic: 1 Medical Records person, 4 LPN's, 1 Care Liaison, Staffing Coordinator, Dietary Manager, Minimum Data Set (MDS) nurse, Registered Nurse Supervisor, 2 Admin personnel, 1 ABOM, Dementia Services Director, Director of Social Services, EVS Director, Activities Director and Central Supply. Four of these employees attended the 5/16/20 inservice on the EPP. The "Employee Master List with Exemptions" for the week ending 4/7/21 indicated 140 employees. The Administrator was unable to provide evidence that all 140 of these employees to include new and existing received the mandatory Annual Emergency Preparedness inservice education. In addition, the Administrator could not provide evidence that all staff were trained on the 6/30/20 table top after action findings to incorporate into the existing EPP.	E 037	recommendations. 5. May 4, 2021	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039		5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 6	E 039		

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).

*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or
(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.
(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by

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E 039	Continued From page 7 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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E 039	Continued From page 8	E 039		

a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 9 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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E 039	Continued From page 10	E 039		

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 11 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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E 039	Continued From page 12	E 039		

is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at
least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13	E 039		

Continued From page 13

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 14 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan (EPP), the facility staff failed to ensure staff were trained on the After Action Report/Improvement Plan (AAR/IP) findings that was facilitated by a Regional Health Care Coalition. The findings include: During an interview with the Administrator, on 4/6/21 at approximately 11:30 a.m., she stated	E 039	1. No resident experienced any adverse outcomes, in regards to emergency testing. All residents residing in the facility have the potential to be affected. 2. ED/Designee will schedule a time to participate in an emergency plan for disaster preparedness. 3. ED/Designee will educate staff on the plan for disaster preparedness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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E 039	Continued From page 15 only one staff person had knowledge of the analysis and conclusion from the Tabletop exercise that was conducted on 2/22/21. The AAR/IP dated 2/22/21 indicated the objective of the exercise was to inform staff, direct and non-direct, what to do in the event of a power outage in the facility, where certain equipment is located and to contact certain parties. Based on the conclusion used as a summary of all sections of the AAR/IP, it was determined the following results/findings would help further refine the facility's EPP, procedures and training in the event of a power outage: "Staff awareness of where flash lights and respective equipment is located behind/at nurse's station. Staff awareness of how to properly use extension cords, and their respective hazards and priorities. Staff awareness that the facility is powered by a back-up generator. Receptionist awareness of procedure of emergency call down list, as well as Executive Director informed on who to contact at (named local power company) to report outage." There was no evidence that the facility's EPP was revised, or that staff training and testing was conducted based on the aforementioned AAR/IP exercise analysis.	E 039	ED/Designee will conduct quality monitoring rounds 3X a week for 1 month to ensure the practices are being maintained. 4. Results will be brought to QAPI for 30 days for review and recommendations. 5. May 4, 2021	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/06/21 through 04/08/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 16 The census in this 174 certified bed facility was 110 at the time of the survey. The survey sample consisted of 40 resident reviews.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 584

Continued From page 17

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and facility document review, it was determined that facility staff failed to ensure a clean comfortable and homelike environment on 3 of 4 units, unit's 200, 300 and 400.

The findings include:

1. On 4/6/21 at 11:15 a.m. through 4/7/21 at 4:00 p.m., the following rooms represented the facility's failure to maintain a clean and comfortable homelike environment in the following rooms on the 300 and 400 unit:
-In Room #301 Heavy accumulations of dust, dirt, debris and unidentified food items were identified up against and behind the 5 chest, as well as under both beds. The base of the two over bed tables possessed spillage from liquids and food.

-In Room #306-A A urinal with yellow substance inside was wedged against the wall and the wheel of the resident's bed. A prominent urine odor permeated the room. The resident had a urinal on his over bed table that he said he was currently using. This urinal was observed removed on 4/8/21 after brought to the facility's attention on 4/7/21 at approximately 5:00 p.m.

F 584

1. The chest in room 301 was moved and cleaned behind as well as under both beds. The base of the two over the bed tables were cleaned. In room 306A the urinal was replaced, labeled and the room was cleaned. The chest in 306 B was moved and cleaned behind as well as under the bed. The chest in room 307B was moved and cleaned behind as well as under the bed. The Fruit-Loop cereal was picked up from the parenteral of his area as well as behind and under the chest. The chest in room 404 A was moved and cleaned behind as well as under the bed. The unidentified black substance between the A&B bed floors was cleaned. The chest in room 404B was moved and cleaned behind as well as under the bed. The window blinds were dusted and the cobwebs between the blinds were cleaned.

2. A quality review of all rooms will be completed by ED or Designee to ensure all chests are moved and cleaned behind, as well as under all beds. All bases of all of the over the bed tables were cleaned. The floors were cleaned in all rooms as well as the blinds and in-between the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18 -In Room #306-B Heavy accumulations of dust, dirt, debris and unidentified food items were identified up against and behind the chest, as well as under his bed. He stated no one ever addressed making an appointment with him to have him present in order to move his personal items and clean his room. He stated he would have no problem with that arrangement. -In Room #307-B Heavy accumulations of dust, dirt, debris and unidentified food items were identified up against and behind the 5 chest, as well as under his bed. Fruit-loops cereal was most identifiable food item under his bed, along the parenteral of his area, as well as behind and under his chest. He stated no one ever addressed making an appointment with him to have him present in order to move his personal items and clean his room. He stated he would have no problem with that arrangement. -In Room #404-A Heavy accumulations of dust, dirt, debris and unidentified food items were identified up against and behind the chest, as well as under the bed. Although this resident was in his wheelchair, an unidentified black substance was observed on the floor around the front wheels of another wheelchair that was positioned between the A and B bed. -In Room #404-B Heavy accumulations of dust, dirt, debris and unidentified food items were identified up against and behind the 5 chest, as well as under the bed. Heavy accumulations of dust were observed on his window blinds with cobwebs between the blinds and window. He stated no one ever addressed making an appointment with him to have him present in order to move his personal items and clean his	F 584	blinds and windows were cleaned. 3. The Housekeeping employees and Housekeeping Supervisor will be educated on cleaning procedures. Executive Director or Designee to complete weekly quality monitoring for 8 weeks to ensure all chests are moved and cleaned behind as well as under all beds. All bases of over the bed tables are cleaned, floors cleaned in all rooms, blinds cleaned and in-between the blinds and windows and blinds are cleaned. 4. The results of quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. May 4, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19	F 584		

room. He stated he would have no problem with that arrangement.

2. The facility's staff failed to maintain a clean, sanitary and homelike environment in Room 422.

During the initial tour on 4/6/21, at approximately 2:10 p.m., room number 422 was observed to have an extremely sticky substance in the middle of the floor and in the area where the resident was seated. The stickiness was so severe it adhered your shoes to the floor and resulted in much effort to lift ones feet. Further observation of room 422's floor revealed food particles, brown stains and other debris. There was also a permeating odor.

On 4/7/21, again in room 422, at approximately 10:10 a.m., the middle of the floor and in the area in which the resident sat in the wheel chair revealed a sticky substance, discoloration, crumbs, food and debris as well as a strong odor of uncleanliness.

An interview was conducted with Resident #94 on 4/7/21 at approximately 10:58 a.m. Resident #94 stated "no one does anything here for you". The resident wouldn't elaborate on the statement.

On 4/7/21 at approximately 11:08 a.m., the Environmental Services Manager was interviewed about the above conditions observed in room 422 over the two days. The Environmental Services Manager stated the specific room was considered a "hot" room; which indicated it required additional attention/services because of the untidy habits of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20	F 584		

On 4/8/21 at approximately 11:05 a.m., the middle of the floor of room 422 was less sticky but continued with stickiness, uncleaned spills and discoloration. No particles of food were present and the smell of uncleanliness was diminished but not eradicated.

Review of Resident Council grievances for 12/29/20, revealed the following concerns: "Housekeeping has not cleaned my room for three days, My room is not being cleaned on a regular basis, Resident would like a new trash bag and floor care, Housekeeping does not clean my room on the weekend, and Housekeeping has not come to my room to clean in a couple of days, Housekeeping is not coming in my room, scrubbing/mopping the floors. They are just getting the trash and leaving". The reply to the grievances was, "It has been addressed" or "done".

On 4/8/21 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and two Corporate Consultants. The Administrator stated she was aware of general environmental concerns and had reached out to the corporate office and the Environmental Services Manager regarding her concerns and methods to resolve the concerns.

3. The facility staff failed to provide housekeeping services to maintain a clean living environment for 2 Resident rooms (Room #206 and Room #209) on the 200 unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584		F 584		

Continued From page 21

On 4/6/21, during initial tour of the facility at approximately 11:30 AM, the following was observed:
* Room #206 in the window sill had crumbs of bacon and a yellow substance that appeared to be scrambled eggs.
* Room #209 had a copious amount of dust and debris under the bed, a used surgical mask in the floor and a q-tip under the bed. Dust and debris build-up was noted around the edges of all furniture and the room walls.

On 4/7/21 at 9:30 AM, observations were made of rooms #206 and #209. The observations revealed the following:
* Room #206 still had crumbs of bacon and a yellow substance throughout the window sill that appeared to be scrambled eggs. The Resident in room #206 stated, "they never come in here to clean, sweep or mop", when asked about the frequency of cleaning.
* Room #209 still had a copious amount of dust build-up throughout the room around furnishings, under the beds, and around the wall edges. A used surgical mask was noted to still be in the floor where observed on 4/6/21, and the q-tip still under the bed.

On 4/8/21 at 11:42 AM, Surveyor A went to room #206 and observed the yellow debris/substances still in the window sill.

On 04/07/21 at 09:51 AM, Employee C, a housekeeper was interviewed. When asked about the cleaning of Resident rooms, Employee C stated, "we clean all of the rooms every day. We wipe down the bathroom and walls, sweep, mop and sweep under the beds and take out the trash". Employee C was asked if he feels the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 22	F 584		

Resident rooms and facility are clean, he stated, "I feel like it is pretty clean". Surveyor A asked Employee C about the frequency of deep cleaning, he said "we remove everything twice a week, we take everything out including the dressers wheel chairs, etc. we put them in areas in the hall and clean the entire room".

On 04/07/21 at 11:44 AM, an interview was conducted with Employee D, the regional housekeeping supervisor. When asked how often Resident rooms are cleaned, Employee D stated, "every day". When asked what this includes, Employee D said, "the floors, bathroom, surfaces, and trash cans. Each room is deep cleaned [all items removed and cleaned from top to bottom], once every 30 days".

On 4/7/21, during an end of day meeting, the facility staff, to include the Administrator and Director of Nursing were made aware of the findings of the rooms on wing 2 to not be clean and sanitary.

On 4/8/21 at approximately 8:30 AM, the facility Administrator advised Surveyor A that "wing 2 will look different today, we did a lot of cleaning". When Surveyor A asked the Administrator of her findings of the cleanliness of wing 2, she stated, "it needed some work, but it is all taken care of".

On 4/8/21 at 10:23 AM, an interview was conducted with Employee I, the housekeeping supervisor. Employee I stated, Resident rooms are cleaned "everyday". When asked to describe what the daily cleaning in Resident rooms entails he stated, "high and low dusting, sweeping and mopping floors, cleaning the bathroom toilet, sinks, floors, basin of the commode, wipe down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 584	Continued From page 23	F 584		

stains on the walls and empty the trash". When asked how he monitors and ensures the Resident rooms are kept clean, Employee I stated, "we do QCI [quality control inspections]". When asked what the results of those inspections showed, Employee I stated, "last week some were good and some were bad".

Employee I was asked, if he found the conditions of Resident rooms to be acceptable, Employee I stated, "no". Surveyor A asked if he saw a build up of dust and debris, Employee I stated, "yes". Employee I was asked if it appeared the rooms had been cleaned daily, Employee I said, "yes, but the process was skipped". Surveyor A asked Employee I if he was comfortable with Residents living in the conditions he observed, Employee I stated, "no". Employee I stated that "windows are cleaned 3 times per week, we missed some areas, but what was found has been fixed".

On 4/8/21 at 11:45 AM, Employee I, the housekeeping supervisor, accompanied Surveyor A to room #206. Surveyor A asked Employee I what he observed in the window, Employee I said "some type of debris, we didn't lift it [the window blinds] up".

On 4/8/21 at approximately 11:55 AM, Employee D, the regional housekeeping manager was interviewed by Surveyor A on the 200 unit. Employee D was asked about his observations of the Resident rooms on that unit and throughout the facility following the survey team expressing concerns on 4/7/21. Employee D stated, "the sticky floor couldn't be resolved with mopping, we had to scrub it with the machine". When asked about the build up of dust and debris throughout the rooms, Employee D acknowledged the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 24 staff had failed to follow the process. On 4/8/21, the facility Administrator provided the survey team with a document titled, "5-Step Daily Patient Room Cleaning". This document read, "Purpose: To show housekeeping employees the proper cleaning method to sanitize a patient's room or any area in a healthcare facility. 5-step patient room cleaning procedure: 1. Empty Trash.....2. Horizontal Surfaces.... as you enter the room, work clockwise around the room hitting all surfaces. Table tops, head boards, window sills, chairs- should all be done. 3. Spot clean walls.....4. Dust mop. The entire floor must be dust mopped- especially behind dressers and beds.....move all furniture to dust mop. All corners and along all baseboards must be dust mopped to prevent buildup"... On 4/8/21, during the end of day meeting the facility Administrator and Director of Nursing were made aware of the findings. No further information was received.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews	F 602	1. Resident #254 was discharged from	5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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

F 602 Continued From page 25

and review of facility documentation, the facility staff failed to ensure misappropriation of resident property to include the diversion of 2 of 40 resident's (#254 and #304) physician ordered controlled substances for staff use or personal gain.

The findings include:

1. Resident #254 was admitted to the nursing facility on 3/16/21 with a primary diagnosis of Human Immunodeficiency Virus (HIV) and secondary diagnoses that included generalized muscle weakness, pressure ulcers, seizures and pain. The resident was discharged to the local hospital on 3/22/21 and did not return to the admitting facility.

The Minimum Data Set (MDS) was an Admission dated 3/22/21 and coded Resident #254 on the Brief Interview for Mental Status (BIMS) with a 3 out of a total score of 15 which indicated the resident was severely impaired in the cognitive skills for daily decision making. The resident was assessed to require extensive assistance from two staff for bed mobility, transfer, locomotion on and off the unit, ambulation on and off the unit, dressing, toilet use and personal hygiene. Resident #254 was coded totally dependent on two staff for bathing. The wheelchair was coded as the primary mode of transportation. The resident was assessed frequently incontinent of bowel and bladder. The resident was coded to frequently experience pain in the last 5 days of the assessment period. The numeric pain rating scale from 00-10 (zero being no pain and ten as the worst pain) was left blank. One of the medications coded as received 5 of the last 7 days or since admission was an opioid.

F 602

the facility on March 22, 2021. Resident #304 was discharged from the facility on March 17, 2021. Neither resident was affected.

2. Director of Nursing or Designee will interview residents with prescribed pain medications to ensure that they are receiving their medications as ordered and are free from misappropriation of their medications. Follow ups will be done based on findings.

3. A) The Director of Clinical Services and Executive Director will be educated by the Regional Director of Clinical Services on the facility policy on abuse and neglect as well as the policy for maintaining narcotics. B) The licensed nursing staff will be educated by the DCS or designee on medication administration to include management of narcotic inventory. C) The facility staff will be educated on Resident Abuse by Executive Director or Designee. Executive Director or Designee to interview random residents weekly x 8 weeks and as needed to ensure residents are free from abuse.

4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.

5. May 4, 2021

F 602 Continued From page 26 F 602

Resident #254's care plan date 3/17/21 indicated the resident needed to be monitored for pain and discomfort, and to give analgesics as ordered. The care plan also indicated to document frequency, severity and location of pain.

Resident #254 had physician's orders for pain management with opioid medications dated 3/18/21 at 12:06 p.m. for *Tramadol HCL tablet 50 milligrams (mg), 1 tablet by mouth three times a day scheduled at 9:00 a.m., 1:00 p.m. and 5:00 p.m., and *Oxycodone HCL 5 mg, 1 tablet 30 minutes before wound care.

*Tramadol HCL is a DEA Schedule IV drug, defined as drugs with a low potential for abuse and low risk of dependence, used to relieve moderate to moderately severe pain. Tramadol is in a class of medications called opiate (narcotic) analgesics (Retrieved on 4/12/21 from reference https://pubchem.ncbi.nlm.nih.gov/compound/630 13).

*Oxycodone HCL is a DEA controlled drug opiate (narcotic) and a DEA Schedule II controlled substance. Substances in the DEA Schedule II have a high potential for abuse which may lead to severe psychological or physical dependence. It is widely used for acute or chronic management of moderate or moderately severe pain (Retrieved on 4/12/21 from reference https://pubchem.ncbi.nlm.nih.gov/compound/Oxy codone).

Resident #254's pain management program was reviewed during the course of a complaint investigation. On 4/7/21 at 2:50 p.m., the Director of Nursing (DON) presented a copy of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 27	F 602		

Controlled Medication Utilization Record (CMUR) for the Tramadol which reflected the pharmacist narcotic was administered 9 times with 21 as the amount remaining on the CMUR. The Medication Administration Record (MAR) indicated 9 Tramadol of the 30 tablets sent from the pharmacy were administered to Resident #254. When asked where she obtained the CMUR, she stated from the locked cabinet in her office and she maintains the keys. This surveyor (D) asked to see the actual remaining Tramadol that matched the CMUR, as well as the remaining Oxycodone HCL that matched its CMUR. According to the MAR, 4 Oxycodone HCL of the 7 tablets sent from the pharmacy were administered to the resident which would stand to reason, 3 would be the remaining amount. In the presence of Assistant Director of Nursing (ADON), Unit I and IV Licensed Practical Nurses (LPN) and the Corporate Registered Nurse (CRN), the DON proceeded to the locked cabinet. Twenty-One Tramadol tablets were visible through the blister card pack that matched the CMUR. After an exhaustive search of all 13 medications in the pad locked cabinet, neither the 3 remaining Oxycodone HCL or its matching CMUR were located for Resident #254.

During the above review, the DON stated, "I usually, on Friday's of every week, pick up all resident discharged/discontinued controlled medications from each cart's locked box on every unit and transfer them in a bag to the locked cabinet in my office. Those medications are destroyed once a month (usually last week of the month), depending on the amount of controlled drugs to be destroyed, with another nurse and the pharmacist via Zoom due to the Pandemic, but normally the pharmacist would be present

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 28	F 602		

otherwise. We have not destroyed any medications for the month of March." Resident #254 was discharged on 3/22/21 (Monday) which would make his discharged/discontinued controlled medications picked up by the DON and transferred to the locked cabinet in her office on Friday 3/26/21. Neither the DON or the Corporate Registered Nurse could explain the whereabouts of Resident #254's remaining Oxycodone HCL and its matching CMUR.

The Corporate Registered Nurse stated they checked the medical records department since the resident was discharged to determine if the CMUR was filed in Resident #254's closed record documents with no success. She stated they also checked the shred box on Unit II and in the DON's office for the prescription label of the Oxycodone HCL that is torn off when entire medication on the blister pack was used, again with no success.

The Corporate Registered Nurse began immediate inservicing on 4/7/21 at 3:15 p.m. with the ADON and Unit Managers on Controlled Drug Disposal and Storage and Diversion of Drugs. These nurses were tasked to inservice 100% of all nursing staff. Inservicing was continued by them on 4/7/21 at 5:00 p.m.

On 4/7/21 at approximately 5:50 p.m., a debriefing was conducted with the Administrator, DON and Vice President of Operations. The Administrator stated the missing narcotics, specifically Oxycodone was serious and said, "I am very upset and I contacted the police regarding the theft of these medications. We are drug testing all nursing staff." It was shared that although all nursing staff may test negative,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 29 Oxycodone was a popular street drug and could be sold at a high value amount. On 4/8/21 at 1:15 p.m., an interview was conducted with LPN (L). She stated and wrote the following statement: "I counted narcotics for (Resident #254's name) upon discharge (3/22/21). I placed narcotics, Tramadol and Oxycodone, and sheets together in narcotic box (on unit II) to the side. No discrepancies with count...At all times if there are discharge narcotics in the lock box, they are counted every shift with 2 nurses. If any discrepancies with count including discharge medications the DON is alerted." During the conversation, LPN (L) said when the discharge controlled drugs are picked up by the DON, they are counted with the DON, but there is no record of that count. She said, "They are taken to the DON's office and placed in a locked drawer until destroyed with two nurses and the pharmacist." Review of the Controlled Drug Count Sheet with the Corporate Registered Nurse evidenced on 3/19/21 Resident #254's controlled medications were delivered and the count correct at the begining and end of every shift as signed by two nurses through he entire month of March 2021. On 4/8/21, at the Corporate Registered Nurse forwarded a Facility Reported Incident (FRI) to the physicians, as well as the local, State agencies and law enforcement for misappropriation of resident property. The facility indicated Resident #254 had 7 Oxycodone 5 mg tablets delivered to the facility on 3/19/21. According to the Medication Administration Record (MAR) he was administered 4 tablets, one each day prior to wound care. He was	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602		F 602		

Continued From page 30

discharged on 3/22/21 and the administration records noted he should have had 3 tablets remaining. The FRI indicated that the nurse implicated in the missing narcotics was LPN (C), but according to the LPN's written statement, she went on vacation 3/19/21 and returned 3/24/21, after the resident was discharged from the nursing facility. In addition, LPN (L) in her aforementioned written statement and during interview stated, she discharged the resident on 3/22/21 and the count at that time revealed no discrepancies for both the Tramadol and the Oxycodone. The facility was unable to locate the Oxycodone or the controlled drug count record/CMUR.

On 4/8/21 at approximately 6:15 p.m., a final debriefing was conducted with the Administrator, the DON and the Vice President of Operations. It was shared that although a count takes place between a licensed nurse on that unit at the time of the removal of discharged controlled drugs from the various unit lock boxes, there was no record of that count between the DON or the second nurse. The Administrator stated that was something they needed to implement. No further information was provided prior to survey exit.

2. Resident #304 was admitted to the nursing facility on 3/17/21 with a primary diagnosis of aortic value disorders and physician orders for Intravenous (IV) antibiotic therapy related to infection of the heart valve. The resident signed out Against Medical Advice (AMA) on the same day he was admitted, 3/17/21 at 10:50 p.m.

The resident was not in the facility long enough

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 31	F 602		

for initiation of a Minimum Data Set (MDS) assessment or a 48 hour care plan. The nurse's notes dated 3/17/21 indicated the resident arrived to the facility at 5:15 p.m. alert and oriented time 4 (person, place, time and situation).

Based on concerns from a complaint investigation involving another resident, this surveyor (D) requested to filter by the drug Oxycodone 5 mg to determine if any other resident in the month of March 2021 had physician orders for the same narcotic. Resident #304 had admission physician orders dated 3/17/21 at 5:45 p.m. for *Oxycodone HCL 5 mg tablets, 1 tablet by mouth every 6 hours as needed (prn) for pain. According to pharmacy proof of delivery summary, 12 tablets of this medication was delivered to the nursing facility on 3/17/21 at 10:23 p.m., signed as received by Licensed Practical Nurse (LPN) (C). According to the Medication Administration Record (MAR) none of the Oxycodone 5 mg were administered prior to the resident leaving AMA.

On 4/7/21 at approximately 2:50 p.m., the DON stated, "I usually, on Friday's of every week, pick up all resident discharged/discontinued controlled medications from each cart's locked box on every unit and transfer them in a bag to the locked cabinet in my office and she maintains the keys. Those medications are destroyed once a month (usually last week of the month), depending on the amount of controlled drugs to be destroyed, with another nurse and the pharmacist via Zoom due to the Pandemic, but normally the pharmacist would be present otherwise. We have not destroyed any narcotics for the month of March." Resident #304's medications would have been secured in the controlled medication's lock box of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 32	F 602		

the medication cart on 3/17/21. This medication would be counted every shift with no reported decrepitates and picked up Friday 3/19/21 and placed in the DON's locked cabinet in her office. In the presence of Assistant Director of Nursing (ADON), Unit I and IV Licensed Practical Nurses (LPN) and the Corporate Registered Nurse (CRN), the DON proceeded to the locked cabinet. During a count of all medications in the DON's locked cabinet, neither Resident #304's Oxycodone HCL tablets blister card pack or its matching Controlled Medication Utilization Record (CMUR) were located, but a second medication *Gabapentin 45 tablets and its CMUR was accounted for in the locked cabinet. Neither the DON or the Corporate Registered Nurse could explain the whereabouts of Resident #304's full script of 12 un-administered Oxycodone HCL and its matching CMUR.

*Gabapentin is approved to treat neuralgia and epilepsy with partial-onset seizures and is a Scheduled V controlled substance and defined as drugs with lower potential for abuse (Retrieved on 4/12/21 from reference https://www.dea.gov/drug-scheduling and https://pubmed.ncbi.nlm.nih.gov/33674205/).

On 4/8/21, at the Corporate Registered Nurse forwarded a Facility Reported Incident (FRI) to the physicians, as well as the local, State agencies and law enforcement for misappropriation of resident property. The facility indicated Resident #304 had 12 Oxycodone 5 mg tablets delivered to the facility on 3/17/21. According to the Medication Administration Record (MAR) none of the 12 tablets of Oxycodone was administered to the resident. According to the nurse's notes, Resident #304

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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

F 602

Continued From page 33

signed out AMA the same day he was admitted 3/17/21 at 10:50 p.m.

The FRI indicated that the nurse implicated in the missing narcotics was LPN (C), because she had received the medication from the courier, but failed to have two nurses sign the medications into the building per the facility's policy. LPN (C) written statement indicated she had completed the admission for Resident #304 on 3/17/21. She wrote that the resident had a hard script for Oxycodone 5 mg and she called the pharmacy to attempt to cancel all medications due to the resident telling her he may sign himself out AMA, but the medications were processed to come to the nursing facility. The statement indicated she received the medications and per policy signed in his medications and reconciliation sheet, but accepted the controlled medications without a second signature. She documented the count was completed at the end of her shift for Oxycodone and Gabapentin without any discrepancies. She left for vacation on 3/19 and returned to work on 3/24/21. The facility was not able to explain why the 45 Gabapentin tablets and its matching CMUR was in the DON's locked cabinet drawer, but not the 12 Oxycodone or the matching controlled drug count record/CMUR.

On 4/8/21 at approximately 6:15 p.m., a final debriefing was conducted with the Administrator, the DON and the Vice President of Operations. It was shared that although a count takes place between a licensed nurse on that unit at the time of the removal of discharged controlled drugs from the various unit lock boxes, there was no record of that count between the DON or the second nurse. The Administrator stated that was something they needed to implement. No further

F 602

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 34 information was provided prior to survey exit.	F 602		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to implement their abuse policy with regard to employee screening for 9 Employees (CNA C, CNA D, CNA E, CNA F, CNA G, LPN D, LPN E, LPN F, LPN G) in a survey sample of 25 employee records. The findings included: The facility staff failed to implement their abuse policy to screen employees prior to hire. On 4/8/21, a review was conducted of a sample of 25 employee records. This review was conducted with Employee J, the human resources coordinator. The review revealed the following: 1. The facility staff failed to check references prior	F 607	1. A) CNA C, CNA E, CNA F, CNA G, LPN D, LPN E, LPN F, and LPN G no longer work in the facility, B) CNA D has an active license that has been verified as of April 23, 2021. CNA F, CNA G, and LPN E no longer work in the facility. C) CNA D has a current background check as of April 23, 2021. CNA C, CNA E, CNA F, CNA G, LPN E, LPN F, LPN G no longer work in the facility. 2. Human Resource Manager or designee will review new hires in last 30 days to include agency staff to ensure all new hire screenings were received prior to starting work to include reference checks, license verification, and background checks. Follow ups will be done based on findings.	5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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

F 607

Continued From page 35

to employment for 8 employees CNA C, CNA E, CNA F, CNA G, LPN D, LPN E, LPN F, LPN G.

2. The facility staff failed to verify employee license prior to hire for 4 employees CNA F, CNA G, LPN D, LPN E.

3. The facility staff failed to obtain a Criminal Background check with the within 30 days of hire for 8 employees CNA C, CNA D, CNA E, CNA F, CNA G, LPN E, LPN F, LPN G.

On 4/8/21 at 8:55 AM, Surveyor A sat with Employee J, the Human Resources Coordinator. The employee file findings for the above noted employees was confirmed by Employee J. Employee J made note of the missing documents and agreed that if she found any of the missing items she would provide them to Surveyor A. No additional information was received prior to the survey team exit at 6:15 PM.

On 4/8/21 at 12:07 PM, Surveyor A met with the Facility Administrator to review the findings. Surveyor A let the Administrator know that if any additional items were found they could be provided to Surveyor A. No additional information was received prior to the survey team exit at 6:15 PM.

On 4/8/21, review of the facility policy titled, "Abuse, Neglect, Exploitation & Misappropriation" was conducted. Page 5 read, "1. Screening. Persons applying for employment within the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes but is not limited to: * employment history, *criminal background

F 607

3. Human Resources Manager will be educated on the new hire screening process to prevent abuse and neglect as it relates to obtaining background checks, references checks and license verification prior to employment by Executive Director or Designee. The Executive Director or designee will review new hire files weekly x 8 weeks to validate compliance with new hire screening.

4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.

5. May 4, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 36 check, * abuse check with appropriate licensing board and registries, prior to hire, * licensure or registration verification prior to hire, * documentation of status of any disciplinary actions from licensing or registration boards and other registries, * information from former employers. The center will ensure that all prospective consultants, contractors, volunteers, caregivers, and students are pre-screened as required by law". The Administrator and Director of Nursing (DON) were made aware of the findings again on 4/8/21 during the end of day meeting. No further information was received.	F 607		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility documentation, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week.	F 727	1. No residents were affected. The facility has 8hrs of RN staffing daily as required.	5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 37 The findings included: A review of the facility as-worked staffing documentation during a 30-day look back indicated the following: 1.) On 03/14/21, Registered Nurse (RN-A) worked a total of 7.68 hours out of a scheduled 8 hour shift. 2.) On 04/03/21, (RN-B) worked a total of 7.31 hours out of a scheduled 8 hours shift. A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Corporate Nurse on 04/07/21 at 6:30 p.m. During that time, the Administration team were made aware that the facility did not have 8 hours of RN coverage on 03/14/21 and 04/03/21. A phone interview was conducted with the (DON) on 04/08/2021 at approximately 8:27 a.m. When asked about the facility not having 8 hours of RN coverage on 03/14/21 and 04/03/21, the DON replied, "My first time hearing about the nurses not working a full 8 hour shift was yesterday, 04/07/21". The DON stated, "I expect for the RN providing coverage to work their full 8 hour shift". A pre-exit conference was conducted with the Administration team on 04/08/21 at approximately 5:30 p.m. No further information was provided prior to exit.	F 727	2. The Director of Clinical Services or designee will review the last 30 days of as worked schedules to ensure compliance with required 8hr RN staffing. Follow up based on findings. 3. The Workforce Manager and the Director of clinical services will be educated on the requirements for daily registered nurse coverage by the Regional Director of Clinical Services. The clinical team will review staffing coverage daily for 8 weeks to ensure requirements are meet. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. May 4, 2021	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 755	Continued From page 38 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an accurate record of controlled medications and provide safekeeping of hard scripts for controlled drugs, for 3 Residents (Resident #28, #32, and #102) in a survey sample of 40 Residents.	F 755	1. Resident #28, #32 narcotic count sheets were corrected during survey and the residents are receiving their medications as ordered. The hard script for resident #102 was removed from the record during the survey and sent to the pharmacy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 39 1. For Resident #28, the facility staff failed to maintain an accurate inventory of controlled medications. 2. For Resident #32, the facility staff failed to maintain an accurate inventory of controlled medications. 3. For Resident #102, the facility staff failed to provide safekeeping of hard scripts for controlled drugs, to prevent drug diversion. The findings included: 1. For Resident #28, the facility staff failed to maintain an accurate inventory of controlled medications. On 4/7/21 at 1:35 PM, a review of the medication storage of the unit 2 back hall medication cart was performed by Surveyor A, who was accompanied by LPN A, the unit manager. This review revealed the following: The "controlled drug count sheet" was compared to the actual medication count and there were a total of 2 discrepancies found as follows: Resident #28, Tramadol, count per record=15, actual count=14 LPN A confirmed the count was inaccurate according to the Controlled Drug Count Sheet. LPN A stated, "it wasn't signed out at 9 AM". 2. For Resident #32, the facility staff failed to maintain an accurate inventory of controlled	F 755	2. A quality review of resident narcotic count records will be completed by the Director of clinical services or designee to ensure administered medications are signed out. 3. The Director of Clinical Services or designee will educate the licensed nursing staff on medication administration to include narcotic count accuracy as well the process for returning hard scripts to the pharmacy to prevent drug diversion. The DCS or designee will complete random medication administration observations to ensure compliance weekly for 8 weeks. The DCS or designee will complete random chart reviews weekly to ensure no hard scripts are identified weekly for 8 weeks. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. May 4, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 755	Continued From page 40	F 755		

medications.

On 4/7/21 at 1:35 PM, a review of the medication storage of the unit 2 back hall medication cart was performed by Surveyor A, who was accompanied by LPN A, the unit manager. This review revealed the following:

The "controlled drug count sheet" was compared to the actual medication count and there were a total of 2 discrepancies found as follows:
Resident #32, Tramadol, count per record=9, actual count=8

LPN A confirmed the count was inaccurate according to the Controlled Drug Count Sheet. LPN A stated, "it wasn't signed out at 9 AM".

On 4/7/21 at 1:43 PM, an interview was conducted with LPN H, the nurse assigned to the unit 2 back hall medication cart. LPN H stated, "I didn't sign it out this morning when I gave it". When LPN H was asked when she should have signed the Controlled Drug Count Sheet she stated, "I should have signed it after they took it, I got distracted and forgot to come back and do it, I am sorry".

On 4/8/21 at 2:09 PM, an interview was conducted with Employee B, the facility Director of Nursing (DON). The DON was asked by Surveyor A, when she expects medications to be signed out, the DON stated, "when the meds are given".

Review of the facility pharmacy policy titled "General Dose Preparation and Medication Administration" read, "5.5 document the administration of controlled substances in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 755	Continued From page 41	F 755		

accordance with applicable law. 6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 document necessary medication administration information (e.g., when medications are opened, when medications are given....) on appropriate forms".

The Facility Administrator (Employee A) was informed of the findings and no further information was provided.

3. For Resident #102, the facility staff failed to provide safekeeping of hard scripts for controlled drugs, to prevent drug diversion.

On 4/7/21, during review of Resident #102's clinical chart an original hard script for Percocet 5 mg-325 mg tablets was noted.

04/07/21 at 09:44 AM, an interview was conducted with LPN A, the unit manager. When LPN A was asked what is the process when admissions come in and have hard scripts for narcotics, LPN A stated, "when someone comes back from the hospital we call the doctor immediately, tell them about the resident, give the medication list before we put in anything, once they approve, we take the hard script and fax to the pharmacy and the pharmacy will either send it. We have a baggie that is for prescriptions that get sent to the pharmacy". Surveyor A asked if hard scripts for narcotics are to be in the clinical chart, LPN A stated, "no". When asked what is the associated risk of having them in chart "usually the pharmacy needs them to verify, they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 755	Continued From page 42 need the hard script". Surveyor A asked what would prevent someone from taking the prescription down to a local pharmacy and having it filled, LPN A stated "that is true, nothing really. Hopefully they have better morals than that". LPN A was shown the script for Percocet 5-325 in Resident #102's chart and was asked, should it be in the chart "no ma'am" whenever we fax it, we have a bag where we put the hard script and send it back with them". On 4/8/21 at 2:09 PM, an interview was conducted with the facility Director of Nursing (DON). The DON stated, "hard scripts should be faxed to the pharmacy, draw a line through it and put it in the bag for the pharmacy. I already know about it". When asked if someone could take the prescription to a retail pharmacy and have it filled if it is left in the chart, the DON stated, "yup, we got tagged for that a few years back". On 4/8/21, during an end of day meeting the Facility Administrator and DON were made aware of the findings. No further information was provided.	F 755		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g)	F 791		5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 791	Continued From page 43 of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to obtain routine dental services for 1 of 40 residents (Resident #52), in the survey sample.	F 791	1. Resident #52 was seen at the dentist on April 19, 2021 and had tooth extractions. He is continuing to be provided care as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 791	Continued From page 44 The findings included: Resident #52 was originally admitted to the facility 4/20/20 and had never been discharged from the facility. The current diagnoses included; high blood pressure, atrial-fibrillation and a seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/1/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #52's cognitive abilities for daily decision making were intact. In section "L" (Dental) the resident was coded as having obvious or likely cavities or broken natural teeth. On 4/7/21 an interview was conducted with Resident #52. The resident stated he had been seen by the dentist last August and the plan was to have thirteen teeth extracted for they were not repairable and would eventually cause additional pain if not extracted. Resident #52 further stated he was experiencing minor discomfort, not pain but it was his preference to have the dental concerns taken care of before complications like the abscess occurred again. The resident then stated at the time of this conversation the facility's staff had not arranged his follow-up dental appointment. Review of the clinical record revealed on 8/18/20, Resident #52 was started on an antibiotic for dental caries and an oral abscess.	F 791	2. A quality review of residents in the facility will be completed by the licensed nursing staff to ensure no emergent dental needs are required. Follow up based on findings. 3. The licensed nursing staff and director of resident and family services will be educated by the Director of Clinical services on assisting residents with routine and emergency dental care. Residents will reviewed for emergent dental needs weekly by a licensed nurse for 8 weeks. Any resident without a routine dental visit in the last 12 months will be scheduled by the social worker until all residents have been seen or schedule. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. May 4, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 791	Continued From page 45	F 791		

The dental progress note dated 8/31/20 revealed the resident was seen by the dentist because of pain of the bottom teeth and the treatment would require a dental cleaning procedure, restoration with a resin composite of tooth # 29, 1, 2, 4, 17 and 10, extractions of #18, 19, 20, 21, 22, 26, 27, 23, 24, 25, 2, 7 and 13.

Resident #52 returned to the facility on 8/31/20, after the dental consultation, with a letter of financial approval for the planned services and a document for medical clearance prior to beginning the restoration, use of a local anesthetic and extractions of the unrestorable teeth.

On 9/1/20, the Nurse Practitioner signed the resident was cleared to proceed with the dental treatment plan but the services were not scheduled with the dental office.

On 4/8/21 at approximately 10:30 a.m., an interview was conducted with the Business Development Coordinator for the facility. This team member assisted residents to coordinate outside dental services. The Business Development Coordinator stated because of the pandemic and the procedure was not considered essential by policy, the appointment had not been scheduled. The Business Development Coordinator further stated on 4/8/21 the dental services for Resident #52 had been scheduled for 4/19/21.

On 4/8/21 at approximately 5:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. The facility's staff presented no additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		5/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation, the facility staff failed to maintain infection control practices in accordance with the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommendations to prevent the spread of COVID-19 for 2 Residents (Resident #555 and #102) and 2 of 5 areas of the facility. 1. The facility staff failed to implement	F 880	1. Resident #102 was placed on transmission based precautions on April 8, 2021. Resident #555 was placed on transmission based precautions on April 8, 2021. The facility is screening visitors and vendors prior to admission to the facility. Dietary personnel are wearing personal protective equipment properly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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

F 880

Continued From page 48

transmission based precautions (TBP) for Resident #555, who was a new admission to the facility.

2. The facility staff failed to implement transmission based precautions (TBP) for Resident #102, who was a new admission to the facility.

3. The facility staff failed to provide proper screening for visitor/vendor entry into the facility.

4. The facility staff failed to ensure personal protective equipment was properly worn.

The findings included:

1. The facility staff failed to implement transmission based precautions (TBP) for Resident #555, who was a new admission to the facility.

Resident #555 was admitted to the facility on 3/30/21. Diagnoses for Resident #555 included, but were not limited to: acute metabolic encephalopathy, seizure disorder, hypertension, hypokalemia, hepatocellular carcinoma and hepatitis-C cirrhosis.

For Resident #555 the facility had not had time to complete a minimum data set (MDS) (an assessment tool). However, nursing staff recorded in the clinical record that Resident #555 required staff assistance with activities of daily living, to include bathing, dressing, toileting and ambulation.

F 880

2. Residents residing in the facility have the potential to be affected.
New/readmissions who are not fully vaccinated are being placed on transmission based precautions per CDC guidance to prevent the spread of Covid 19. A quality review of visitors and vendors entering the facility will be completed by the Executive Director to ensure compliance. Observation of the meal prep line will be completed by the Executive Director to ensure compliance. Follow up based on findings.

3.A) Facility staff will be educated on infection control practices that include the centers process for screening visitors and vendors prior to entry, housing of new admission and readmission residents who have not been fully vaccinated and donning and doffing personal protective equipment by the Director of Clinical services or designee.
B) New admissions will be reviewed prior to admittance to the facility to determine their need for transmission based precautions. Those needing TBP will be housed on unit 2 during their quarantine period the clinical team will validate compliance during the daily clinical review.
C) The Executive Director or designee will complete weekly reviews of visitor and vendor screenings to ensure continued compliance for 8 weeks.
The Executive Director or designee will complete weekly observations during meal prep and delivery to ensure appropriate usage and wearing of PPE for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 On 4/6/21, upon the survey team entry to the facility, the facility Administrator identified "unit 2 is our observational unit" for COVID-19. On 4/6/21 at approximately 11:30 AM, upon Surveyor A's initial tour of unit 2 Resident #555 was observed in her room, in bed. There was no sign on the room door to indicate Resident #555 was on TBP. There was no personal protective equipment (PPE) noted outside of the room of Resident #555. On 4/6/21 and 4/7/21, facility staff to include nursing staff and housekeeping staff were observed to enter the room of Resident #555, only wearing a surgical mask. None of the staff put on any additional PPE prior to entering the room. 2. The facility staff failed to implement transmission based precautions (TBP) for Resident #102, who was a new admission to the facility. Resident #102 was admitted to the facility on 3/27/21. Diagnoses for Resident #102 included, but were not limited to: type 2 diabetes, metastatic prostate cancer and chronic deconditioning. Resident #102's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/27/21, was coded as an admission assessment. Resident #102 was coded on this assessment as having had a BIMS (brief interview for mental status) score of 8, of a possible 15. This indicated	F 880	8weeks. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. May 4, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50	F 880		

Resident #102 was moderately impaired in cognition. Resident #102 was also coded on this assessment as having required the assistance of at least one staff member for transfers, dressing, personal hygiene and bathing. This same assessment was coded in section O, to indicate Resident #102 had not been on any type of isolation for infectious disease(s).

On 4/6/21, upon the survey team entry to the facility, the facility Administrator identified "unit 2 is our observational unit" for COVID-19.

On 4/6/21 at approximately 11:45 AM, upon Surveyor A's initial tour of unit 2 Resident #102 was observed sitting in his wheelchair in the hallways outside of his room. There was no sign on Resident #102's room door, to indicate Resident #102 was on TBP. There was no personal protective equipment (PPE) noted outside of the room of Resident #102.

On 4/6/21 and 4/7/21, facility staff to include nursing staff and housekeeping staff were observed to enter the room of Resident #102, only wearing a surgical mask. No additional PPE was donned [put on], prior to entering the room, by any staff. No PPE was available outside of the room for staff.

On 4/7/21, during an end of day meeting the facility Administrator was asked to clarify what the purpose of the observational unit was, because nothing indicated unit 2 was any different from other units within the facility. Surveyor A explained that staff are not wearing any different PPE on unit 2. The Administrator said she would need to check and get back to the survey team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 880	Continued From page 51	F 880		

On 4/8/21 at approximately 8:30 AM, upon Surveyor A's entry to the facility, the Administrator called Surveyor A into her office. The Administrator stated, she and the Director of Nursing were on a conference call a few weeks ago and were confused and had mistaken that admissions needed to be on precautions. The Administrator showed Surveyor A the CDC guidance that she had printed and said, "we see we were wrong. The new admissions are now on precautions and staff are wearing PPE, unit 2 will look different today".

On 4/8/21, Employee P, the regional nurse consultant informed Surveyor A that the facility policy is that "if a new admissions comes in staff are to wear a surgical mask, gown and gloves. If they [the Resident] is fully vaccinated they can go into a regular room and not on an observation unit. Only one of the new admits has received a COVID vaccine and she only received one, so she would have to be on precautions".

On 4/8/21, during observations on the 200 unit signs were noted outside of the room door for Resident #555 and Resident #102 which stated, "STOP. CONTACT PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person". This document had the CDC logo at the bottom. There were PPE bins outside the rooms with isolation gowns and gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 52	F 880		

Review of the facility policy titled, "COVID-19 Pandemic Plan", with a revision date of 3/30/21, read, "...17. the center will designate an area and cohort new admissions/re-admissions.....Initiate transmission based precautions based on CDC guidance (standard, contact and droplet and eye protection). Including PPE. Respirator, (or facemask if respirators are not available) faceshield or eye protection, gown and gloves. The resident will remain in their room during this time. After 14 days the resident will be moved to a different room/area of the center".

The Centers for Disease Control and Prevention (CDC) guidance for nursing homes dated March 29, 2021, read, "New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions..... In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions

The facility Administrator and Director of Nursing were made aware of the findings during an end of day meeting held on 4/7/21 and again on 4/8/21.

No further documentation was provided.

3. The facility staff failed to provide proper screening for visitor/vendor entry into the facility.

On 4/6/21 at approximately 11:15 AM, Surveyors A, D, F, I, and J arrived at the front door of the facility which was locked. Surveyor A pushed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880		F 880		

Continued From page 53

button located on the outside of the facility near the front door, heard a buzzer that unlocked the door, and entered the facility into the front lobby along with the other 4 Surveyors. The Survey Team was immediately greeted by the Receptionist (Employee M) who was sitting at a desk in the front lobby. Surveyor A identified the members of the Survey Team, stated the purpose for the visit, and asked to meet with the Facility Administrator.

The Survey Team waited approximately 5 minutes in the front lobby without receiving any COVID screening by Employee M. The Facility Administrator and Director of Nursing arrived at the front lobby and escorted the Survey Team to a conference room located on the first floor at the end of the hall on Nursing Unit 1.

On 4/7/21 at 4:27 PM, Surveyor A conducted an interview with Employee L, Administrative Assistant/Receptionist. Employee L stated the facility has been allowing visitors for about 2 weeks and described the process stating, "they [visitors] fill out the visitor screening form, I take their [the visitor's] temperature, make sure they have their mask on and sanitize their hands". When asked if this process is the same for anyone that enters, Employee L stated, "yes". Surveyor A asked if there was any reason the survey team would not be screened upon entry and Employee L stated, "no, I screened everyone [the survey team members] today, I wasn't here when y'all [the survey team] arrived yesterday". Employee L stated that Employee M was working the reception desk at the time the survey team arrived the previous day.

On 4/7/21 at approximately 4:40 PM, Surveyor A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 880	Continued From page 54	F 880		

conducted an interview with Employee M. Employee M stated she has worked at the facility since May 2020. When asked why the survey team was not screened upon entry on 4/6/21, Employee M stated, "This is the first time I've ever worked here when y'all [survey team] come in, I know I was supposed to screen y'all, they had said we didn't have to get your COVID results and I got confused and just froze, I'm sorry".

On 4/7/21 at approximately 5:30 PM, Surveyor A informed the Facility Administrator of the absence of COVID screening when the Survey Team arrived on 4/6/21. The Facility Administrator stated, "the Survey Team should have been screened upon entrance into the facility". Facility documents with regard to the visitor/vendor screening process were requested and received.

Review of the facility's policy titled, "COVID-19 Pandemic Plan", revised 3/30/2021, "Policy", item 4 stated, "Receptionist/designee will provide visitor/vendor self-report questionnaire to complete".

The Centers for Disease Control and Prevention (CDC) provided guidance in the document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated February 23, 2021, subheading "Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19", item 3 read, "Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880		F 880		

Continued From page 55
practicing source control [facemasks, hand hygiene]". This information was accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-contol-recommendations.html on 4/12/21.

The Facility Administrator and DON were made aware of the findings during the end of day meeting held on 4/7/21. No further information was provided.

4. The facility staff failed to ensure personal protective equipment was properly worn.

On 04/08/2021 at approximately 12:00 PM, the Cook and Dietary Manager were observed standing in the kitchen by the steam table. The Cook was observed with her face mask under her nose, exposing her nose. The Dietary Manager was asked if staff were supposed to wear their face mask under their nose and the Dietary Manager replied, "No, they are not". The Dietary Manager asked the Cook to step away from the steam table and correct the fit of her face mask. The Cook walked out of the kitchen and when she returned her face mask was covering her nose and mouth.

On 04/08/2021 at 1:40 PM, an interview was conducted with the Cook. When asked how should you wear your face mask, the Cook stated, "over my nose and mouth". When asked were you wearing the face mask over your nose when checking the temperature of the food, the Cook stated, "No". When asked the reason for wearing a face mask over your nose and mouth, the Cook stated, "Because of the COVID and in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 880	Continued From page 56 case I should sneeze or something".	F 880		

An interview was conducted with the Dietary Manager on 04/08/2021 at approximately 1:43 PM, when asked what are your expectations of staff when wearing their face mask, Dietary Manager stated, "Make sure to cover the nose and mouth and if they need to readjust, they should walk outside and readjust, then wash their hands".

Review of facility document entitled, "COVID-19 Pandemic Plan", dated "3/2/2020, Revised 03/30/2021", read, "Policy: COVID-19 is a respiratory illness thought to be spread mainly from person to person, between people who come in close contact to one another (about 6 feet). The virus is spread through droplets produced when an infected person coughs or sneezes. Symptoms include fever, cough, shortness of breath, sore throat, vomiting, diarrhea, muscle pain, headache, new loss of taste or smell, chills and repeated shaking with chills" and "2. Staff will be re-trained in Hand Hygiene and proper use of PPE (Personal Protective Equipment) including competency"

The Administrator, Director of Nursing and Corporate Staff were informed of the finding on 04/08/2021 at approximately 6:45 PM. The facility did not present any further information.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		5/4/21

§483.90(i) Other Environmental Conditions
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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

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F 921	Continued From page 57	F 921		

This REQUIREMENT is not met as evidenced by:

Based on observations, staff interviews and facility document review, it was determined that facility staff failed to provide a safe environment in 1 bathroom on 1 of the facility's 4 units.

The findings included:

On 4/6/21 at 11:15 a.m., during the orientation tour through 4/8/21 at 3:15 p.m., the ceiling panels in the bathroom of Room #301 were observed loose, bowed and unstable.

The aforementioned finding was brought to the attention of the Administrator during an end of day debriefing on 4/7/21 at approximately 5:50 p.m. She stated she would have the maintenance inspect all bathrooms and ensure all necessary repairs were made.

On 4/8/21 at approximately 3:15 p.m., Surveyor (D) took the Maintenance Director to Room #301. He stated he repaired a ceiling track of a bathroom on the 200 Unit and was never made aware by the Administrator or the maintenance team of the needed repairs in the 301 bathroom. He stated, the housekeeping staff push broom handles up into the ceiling tiles when they are mopping and dislodge them. He made the necessary adjustment and stated he will discuss the matter with the Housekeeping Director.

On 4/8/21 at approximately 6:15 p.m., the Administrator stated she had toured the rooms and saw the bowed ceiling and it was repaired on 4/7/21. It was brought to her attention that the ceiling in Room 301's bathroom was not fixed until 4/8/21 at approximately 3:30 p.m.

Provider's Plan of Correction (F 921):

1. The ceiling panels in the bathroom of Room 301 were secured back on the ceiling tile track.

2. The Maintenance Director or Designee will review all bathroom ceiling tile tracks to ensure all panels are on track. Follow up based on findings.

3. The Maintenance Director will be educated by the Executive Director on ensuring ceiling tile panels are on the tracks. The Executive Director or Designee to complete quality monitoring of resident bathrooms weekly for 8 weeks to ensure all ceiling tile panels are on the tracks.

4. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.

5. May 4, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING ______ B. WING ______	C 04/08/2021

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