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	495327	A. BUILDING _____ B. WING _____	C 10/28/2022

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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	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 10/27/2022 through 10/28/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. (VA0005668, which was substantiated with deficient practice). The census in this 174 certified bed facility was 126 at the time of the survey. The survey sample consisted of three (3) resident reviews.	F 000	F000 The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations a nd other information cited in support of the alleged deficiencies. The facility sets forth following plan of correction to remain in compliance with all federal state and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
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;	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Units 200, 300, and 400 halls, the facility provided adequate amount of linen, including wash cloths, towels, and bed linens to care for residents. 2. Current residents in the center have the potential to be affected. 3. The Administrator will educate the Director Housekeeping on ordering linen, washcloth, towels, and bedlinen and to inform Administrator if ordered supplies require additional orders to provide resident care. The Director of Housekeeping or designee will educate all housekeeping staff on ensuring an adequate amount of linen, including wash cloths, towels, and bed linens to care for residents are stocked on each unit linen carts. Housekeeping staff will inform the Director of Housekeeping for concerns if adequate supplies are not available to stock the linen carts.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ron Tealakh | Regional Director of Operations | 12/13/22

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

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F 584	Continued From page 1 §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; §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 observation, staff interviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide adequate linen to for Resident care on 3 of 4 nursing units, the 200, 300, and 400 halls. The findings included: On the 200, 300, and 400 halls, the facility failed to provide enough linen, including wash cloths, towels, and bed linens to care for residents. On 10/27/22 at approximately 5:50 PM, observations were made on all Resident care units. The linen carts on three of the units/halls contained a scarce amount of linen. On the 200 hall, the linen cart contained only 4 wash cloths, 1 towel and only 3 sheets. The linen cart on the 300 hall contained only 2 bath towels and no wash cloths. The linen cart on the 400 hall had 3 pillow cases and 1 hospital gown, and contained	F 584	4. The Housekeeping Manager or designee will complete weekly audits x 4 weeks then monthly x 2 to validate adequate supplies of linens, washcloths, towels, and bedlinen are stocked and available on the linen carts on the units.Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist, the review will be conducted on a random basis. 5. Date of compliance12/13/2022	

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no towels, wash cloths or bed linen.

Surveyors B and D went to the laundry department, accompanied by a facility staff member, Employee E. The laundry department was not occupied/staffed at the time. A few washcloths were observed to be clean and available. No clean towels or bed linen was observed.

On 10/28/22, an observation was made on the 200 hall, revealing a scarce amount of linen available. The linen cart on the 300 unit had 2 towels, and enough bed linen to change 2 beds. The linen cart on the 400 hall had no towels or wash cloths.

Staff interviews with CNAs (certified nursing assistants) B, C, D and E all revealed that frequently they do not have enough linen. When asked what they do if a Resident has an accident, each of the CNAs reported they have to go to other units to see if they can find linen. One of the CNAs, who asked to remain anonymous, said that she has to bring her own body wash and such, because the facility just doesn't have adequate supplies to provide for Resident care needs. That CNA also said that she had been told to use paper towels to clean Residents, "it is like this all the time, the washer is always broken."

On 10/28/22, during an interview with the Ombudsman, she stated, "That's always been an issue here." She shared that this has been an ongoing issue of concern for facility staff and Residents.

On 10/28/22, the above findings were shared with

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F 584	Continued From page 3 the facility Administrator and Regional Director of Clinical Services. Following the end of day meeting, the facility Administration provided the survey team with evidence of linen being ordered on a monthly basis. They were made aware that despite the orders, there is no evidence that there is sufficient linen to provide for Resident care needs. No further information was provided.	F 584		
F 600 SS=D	Complaint related deficiency. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, observation, and clinical record review, facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure Residents were free from neglect for one Residents (#1) in a survey sample	F 600	F 600 Free from Abuse and Neglect 1. Resident #1 no action was taken due to the time frame having already passed. 2. Current residents in the center have the potential to be affected. 3. The DON or designee will educate license nurses on the process for change in condition with nausea and vomiting. The physician and RP will be notified. New orders for antiemetics will be administered as per physician as soon as available when resident is symptomatic. Confirm if in Omnicell for availability and administer. 4. The DON or designee will complete weekly audits x 4 weeks then monthly x 2 to verify residents change in condition with nausea and vomiting have physician and RP notification for new orders for antiemetics were administered. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist, the review will be conducted on a random basis. 5. Date of compliance12/13/2022	

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of 3 Residents.

The findings include:

For Resident #1, the facility staff neglected to provide medication to alleviate symptoms of nausea and vomiting following observations of such, and after contacting the doctor for treatment options/orders.

On 10/28/22, Resident #1 was visited in her room; she was non-verbal.

On 10/27/22 and 10/28/22, a clinical record review of Resident #1's electronic health record was conducted. This review revealed the following details:

a. On 10/13/22, the nurse noted a change in condition and completed a "Change in Condition" assessment. This form noted, "Resident vomited x 1 light brown emesis, increased agitation. Residual 165ml, Alert to self w/o [without] respiratory distress or SOB [shortness of breath]. No noted changes to mentation." The doctor was notified of the change.

b. The doctor gave the following orders: "Hold feeding if residual is over 160 ml, administer Zofran 4mg prn [as needed] for Nausea and Vomiting."

c. The order for Zofran was entered into the physician orders. According to the MAR (medication administration record), it was not given.

On 10/28/22, a review of the Omnicell (system/supply of medications maintained in the

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facility for administration to residents) contents revealed the generic medication of Zofran (Ondansetron) was available.

On 10/28/22, LPN (licensed practical nurse) C was interviewed. When asked what she would do if a Resident had a feeding tube, and has vomiting, she stated, "I would do an assessment, get vital signs, call the Doctor, do a change in condition form/assessment and follow orders the doctor gives."

On 10/28/22 at 11 AM, an interview was conducted with LPN D. LPN D said if a Resident has a feeding tube vomits, she would "Make sure the head of the bed is elected, notify the doctor, assess the Resident and get vital signs." When asked what she would do if the doctor gave an order for Zofran, LPN D said, "I would see if the Resident had the medication and give it. If they don't have it, then I would check the emergency supply and get it from there to give and if not, I would call the doctor back and let them know I don't have it available."

On 10/28/22 at 12:28 PM, an interview was conducted with the Nurse Practitioner (NP)/Employee F. The NP was made aware of the events on 10/13/22, when the nurse assessed Resident #1, identified 165 ml of residual, and that the Resident had vomited brown emesis and presented in increased agitation. The NP said she gave an order for Zofran, "I believe they keep that on-hand in the medication system [Omnicell]." When asked, when she expected the medication to be administered, the NP said, "Immediately and then every 4-6 hours as needed thereafter."

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F 600	Continued From page 6 A review of the facility policy, "Abuse, Neglect, Exploitation & Misappropriation" revealed, in part: "Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to: a. Failure to provide adequate nutrition and fluids. b. Failure to take precautionary measures to protect the health and safety of the resident. c. Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed. d. Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program. e. Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize." On 10/28/22, during an end of day meeting, the facility Administration were made aware of the above findings. No further information was provided. Complaint related deficiency.	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		

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F 658	Continued From page 7 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to follow professional standards of practice for one of three residents in the survey sample, Resident #3. The findings include: For Resident #3 the facility staff neglected to evidence the medication administration and feeding tube care on 10/22/22. The findings include: On 10/27/22 a review of the clinical record revealed that Resident # 3 had multiple issues with digestion to include Ogilvie syndrome (a type of pseudo obstruction in the bowels), a history of gastrointestinal bleed, and several instances where Resident #3 had to be sent to the hospital for severe vomiting. He received tube feedings as his only source of nutrition. The Resident had a history of 9 strokes and was unable to communicate verbally. English was not his primary language, and his BIMS (Brief Interview of Mental Status) score was 0/15 indicating he had severe cognitive impairment. On 10/27/22, a review of the clinical record revealed a skilled progress note written on the evening shift of 10/22/22. This note stated that the Resident was at his baseline, there were no problems with his peg tube or tube feeding, and	F 658	F 658 Services Provided Meet Professional Standards 1. Resident #3 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. 3. The DON or designee will educate licensed nurses on the process for documenting on the E-MAR/E-TAR after administration of medications or treatments provided for peg tube orders per physician to validate peg tube care, water flushes, checking function and placement, residual and elevating head of bed. 4. The Unit Manager or designee will complete weekly audits x 4 weeks the monthly x 2 to verify medications and peg tube orders have been administered and provided per physician orders with documentation on the E-MAR/E-TAR. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem to no longer exist, the review will be conducted on a random basis 5. Date of compliance12/13/2022	

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that he received his medications without issue.

A review of the MAR (Medication Administration Record) revealed inconsistent documentation of flushing the G-Tube and checking for residual. There was no separate flow sheet for tube feeding it was all included on the MAR.

A review of the MAR revealed that on 10/22/22 LPN (licensed practical nurse) B, who was working with Resident #3, did not sign off on peg tube care, on checking for placement of the peg tube every shift, on elevating head of bed due to the tube feeding running, on the evening g tube flush, on giving the 10:00 PM dose of Reglan (an anti-nausea drug), and on the administration of Prostat for wound healing,

On 10/27/22 at approximately 8:00 pm, an interview was conducted with LPN B, who stated that she worked a double shift on the night Resident #3 passed away. She stated that she worked 3-11 and 11-7. When asked about the health of Resident #3 and the reason for the g tube, she stated that Resident #3 had recurrent pneumonia, and came to the facility with the tube. She stated at times he would pull at the tube, and he had dementia. She stated he had some issues with the tube, including tolerating the tube feeding. When asked to elaborate, she stated that he always had loose stools. When asked about the orders for his tube feeding, she stated that he was on Jevity 1.5 at 35 ml (milliliters) an hour continuous feed. When asked why there were empty spaces on the MAR where medications and treatments and tube feeding should have been signed off for the 10/22/22 evening shift, she stated she forgot to sign off. She insisted she gave the meds and did all of the

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peg tube care.

A review of the clinical record revealed that Resident #3's tube feeding orders read:

"Start date 10/20/22 - Jevity 1.5 via [sic] @ 30 ml /hr. [milliliters per hour] to go up at 7 AM and to stop at 11 PM to run a total of 16 hours per day."

On 10/27/22 at 9:12 PM an interview was conducted with the Employee C and the Administrator. Employee C is the Director of Clinical Services (Corporate Employee) who was covering for the DON (director of nursing), who was on vacation. Employee C was shown the inconsistent documentation (blank spaces on the MAR where no one signed off). When asked what the blank spaces mean, she stated we cannot prove or disprove the actions were taken. She stated in this case, it was unclear because the flushes and checking for residual, as well as starting and stopping tube feeding, was not signed as being done, and was not signed off as being refused or held. When asked about the expectation of the nurses filling out this document, she stated that all nurses on all shifts are to sign off on all meds and treatments, including tube feeding.

"10/6/2022 12:08 PM -Note Text Resident has had multiple of vomiting, abd (abdomen) distended, loose stool incoherence with multiple ABT therapy, NP made aware of episodes resident is own RP, NP has N.O for a KUB and AP lateral r/o aspiration r/t vomiting. Tube feeding on hold until results come back."

On 10/28/22 a Review of the MAR revealed Resident #3 had an order for Routine

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Metoclopramide (Trade Name Reglan anti-nausea given routinely 3 times per day). The Resident also had a PRN (as needed) order for ZOFRAN, also an anti-nausea medication, to be given every 6 hours as needed. The medication was not administered in the month of October.

On 10/28/22 at 12:28 PM, an interview was conducted with the Nurse Practitioner (NP)/Employee F. The NP was familiar with Resident #3 and his nausea and profuse vomiting episodes. The NP said she gave an orders for Zofran back in September, and it was to be used PRN. When asked, when she expected the medication to be administered, the NP said, "Immediately and then every 4-6 hours as needed thereafter."

On 10/28/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

According to Fundamentals of Nursing, Sixth edition, 2007; by Perry and Potter, page 843 reads "After the nurse administers the medication, the medication administration record (MAR) is completed per agency policy to verify that the medications was given as ordered."

According to "Fundamentals of Nursing- Lippincott Williams and Wilkins 2007 page 165: After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patient's medication record ...any omission or withholding of a drug for any reason. If a drug is refused, withheld, or omitted for any reason, the prescriber must be notified..."

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F 921 SS=E	Continued From page 11 F 921 Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and in the course of a complaint investigation, the facility staff failed to maintain a clean and sanitary environment for 2 Residents (Resident #1 and #2) in a survey sample of 3 Residents. The findings included: On 10/27/22 at approximately 5:50 PM, observations were made on all of the Resident care units. The Resident rooms were observed to have a copious amount of debris in the floor which was visible from the hallway. The secure memory care unit was noted to have a strong odor of urine. On 10/27/22 at approximately 6:34 PM, an interview was conducted with Resident #2's family. They reported that almost every time they visit, they have to ask facility staff to provide care to the roommate, (Resident #1) because there is a strong odor of feces throughout the room. On 10/28/22 at approximately 10:30 AM, the room of Residents #1 and #2 was visited by Surveyor B. There was a strong odor of feces that permeated the entire room and was significantly worse around Resident #1. Also observed was a large stain of tan colored substance by the bed, which appeared to be dried	F 921 F 921	F 921 Safe/Functional/Sanitary/Comfortable Environ 1. Resident #1 and #2 rooms were cleaned and sanitized by a housekeeping staff member. 2. Current residents in the center have the potential to be affected. 3. The Director Housekeeping will educate the housekeeping n the process for cleaning and sanitizing the resident rooms to reduce odors. 4. The Director of Housekeeping or designee will complete weekly audits x 4 then monthly x 2 to validate resident's rooms are cleaned with sanitation and odors are controlled. Results of the review will be presented to the QAPI committee for review and recommendation. 5. Date of compliance12/13/2022	

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 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 12	F 921		

tube feeding. On the wall across from the bed, there was a significant amount of feces smeared on the wall above the trashcan.

Several additional observations were made on 10/28/22, with the last one being at 1:30 PM, and the same findings as noted above.

On 10/28/22 at 1:35 PM, during an end of day meeting, the facility Administrator and Regional Director of Clinical Services were made aware of the above findings.

On 10/28/22 at approximately 3 PM, the facility Administration reported they had given Resident #1 a bath, had cleaned the room and were having to dissolve the tan colored substance on the floor with chemicals in an effort to be able to scrape it up. The facility Administration indicated they expect rooms to be cleaned daily and as needed to maintain a sanitary environment.

On 10/28/22 at 3:30 PM, during an interview/meeting with the Ombudsman she verbalized that frequently when she visits, she brings the concern of cleanliness and sanitation to the management's attention. She said Residents often complain to her.

No further information was provided.

Complaint related deficiency.