| STATEMENT OF OEFICIENCIES | TATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA | | (X2) MI | I TIDLE CONSTRUCTION | | | |
|---|--|-----------------|---------------|--|-------------|------------------|--|
| ANO PLAN OF CORRECTION | IOENTIFICATION NL | JMBER: | | LTIPLE CONSTRUCTION | | E SURVEY | |
| | | | A. BUILL | DING | 001 | WLTE1EO | |
| NAME OF PROVIOER OR SUPPLIER | VA0218 | | B. WING | | 03 | /30/2018 | |
| EVERGREEN HEALTH AND RI | ELIAD | | | Y, STATE, ZIP COOE | | | |
| | CHAB | WINCHE | LWOOD AV | ENUE 22601 | | | |
| (X4) IO SUMMARY STA | ATEMENT OF OEFICIENCIE | <u></u> | 10 | | | | |
| AG REGULATORY OR L | Y MUST BE PRECEOEO BY SC IOENTIFYING INFORMA | FULL ATION) | PREFIX TAG | PROVIOER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY) | HOULOBE | (X COMP OA | |
| F 000 Initial Comments | | | F 000 | | | | |
| • | | | | | | : | |
| An unannounced bi | ionnial Ctat. 11 | | | · | | 1 | |
| Inspection was con | iennial State Licensu d∪cted 3/27/18 throu | re lab | | • | | | |
| 3/30/18. Correction | s are required for cou | mnliance | | | | · | |
| with the virginia Ru | les and Regulations t | for the | | | | i | |
| Code survey/report | g Facilities. The Life will follow | Safety | • | , | | | |
| | | | | | | | |
| 1.00 census in this 1 | 176 certified bed facil ne survey. The surve | ity was | ' | | | i | |
| consisted of 28 curi | rent resident reviews | | | | | i | |
| (Residents # 236, 2; | 35, 234, 132, 90, 133 | 89 97 | | | | i | |
| 74, 55, 83, 3, 61, 11. 38, 95, 384, 73, 66 | 4, 130, 99, 69, 17, 37 57, 47 and 98) and the | 7, 105, | | | | i I | |
| closed record review | vs (Residents # 334, | nree 135 and | | | | · - | |
| 134). | , | | | | | 4 | |
| F 001 Non Compliance | | | F 001 | | | î | |
| The facility was out of | of compliance with it | | | | | 1 | |
| Tollowing state licens | ure requirements: | e | | | | • | |
| This RULE: is not m 12VAC5-371- 370.A | et as evidenced by: cross references to F | 584 | | Please see corrective action u | ınder F584 | | |
| 12VAC5-371-220.D c | cross references to F | 677 | | | | | |
| 12VAC5-371-250.G c | cross references to F | 641 | | Please see corrective action ur | | : | |
| There is no state regulation of the PAS | ulation related to F 84 | 45 - | | Please see corrective action ur | | | |
| | | | | Please see corrective action un | ider F645 | ! | |
| 12 VAC 5 - 371 - 220 | | | | Please see corrective action un | der F684 | ; ; | |
| 12 VAC 5 - 371 - 300 | | | | Please see corrective action un | der F755 | : : | |
| 12 VAC 5 - 371 - 220 758 | A, B cross reference | s to F | • | Please see corrective action un | der F758 | | |
| 12 VAC 5 - 371 - 320 / | | | • | Please see corrective action un- | der F791 | | |
| ATORY OIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTAT | IVE'S SIGNA | TURE | / TITLE | | (YR) DATE | |
| ramora J. fu | narlack | | | Administrator | <u>,</u> | (XB) DATE/ | |

4W9K11

ITE FORM

APR 24 2018

DHIOLO

| | | T | | | | | | | |
|--------------------------|---|--|-------------------|---------------------|---|-------------------------------|--------------------------|--|--|
| STATEMEN AND PLAN (| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | ER/CLIA IMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | VA0218 | | B. WING | | 03/3 | 0/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY | , STATE, ZIP CODE | 00/0 | 0/2016 | | |
| EVERGE | REEN HEALTH AND RE | HAB | 380 MILL | WOOD AVE | INUE | | | | |
| (X4) ID PREFIX TAG | EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FIII | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETE DATE | | |
| F 001 | Continued From Pa | ige 1 | | F 001 | | | : | | |
| | 791 | | | : | · | | | | |
| | 12 VAC 5 - 371 - 36 | 0 B cross reference | s to F 842 | | Please see corrective action und | der F842 | | | |
| | 12 VAC 5 - 371 - 36 | 0 E cross reference | s to F 842 | | Please see corrective action under F842 | | | | |
| | 12VAC5-371-180. Infection Control. Cross reference to F880 12VAC5-371-220. Nursing Services. Cross reference to F622, F624, F625, F658, F695, and F756 | | | | Please see corrective action un | der F880 | | | |
| | | | | | Please see corrective action und F624, F625, F658, F695, F756 | der F622, | | | |
| | 12VAC5-371-240. Physician Services. Cross reference to F623 | | | | Please see corrective action un | der F623 | | | |
| | 12VAC5-371-250. R Planning. Cross reference to F | | and Care | | Please see corrective action un | der F641 | | | |
| : | 12VAC5-371-270. So Cross reference to F | ocial Services. | | | Please see corrective action un | der F645 aı | nd F745 | | |
| | 12VAC5-371-300. Pt Cross reference to F | | ces. | | Please see corrective action und | ler F756 | | | |
| | 12VAC5-371-340. Di Program. Cross reference to F | | rice | | Please see corrective action und | ler F812 | | | |
| : | 12VAC5-371-180. Inf cross reference to F8 | fection Control 380 | | | Please see corrective action unc | ler F880 | | | |
| | 12VAC-371-220. Nurs | 80 | | | Please see corrective action unc | ler F580 | | | |
| 1 | 12VAC-371-140. Poli references to F623, F 12VAC-371-250. Pos | ⁷ 689 | | | Please see corrective action under FF623, F689 | | | | |
| | 12VAC-371-250. Res Planning cross refere | nces to F657. | nd Care | | Please see corrective action und | er F657 | | | |

FORM APPROVED VDH STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ VA0218 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **EVERGREEN HEALTH AND REHAB** 380 MILLWOOD AVENUE WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY)

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|--|--|---------------------|--|--|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF | |
| EVERGR | REEN HEALTH AND RI | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE COMPLÉTION HE APPROPRIATE OATE |
| E 000 | Initial Comments | | E 0 | 00 | |
| | survey was conduct Corrections are req CFR Part 483.73, R Care Facilities. Establishment of the CFR(s): 483.73 The [facility, except comply with all applemergency prepare [facility] must estable comprehensive emergency and that meets section.* The emergency | imergency Preparedness ted 3/28/17 through 3/30/18. uired for compliance with 42 tequirement for Long-Term to Emergency Program (EP) for Transplant Center] must icable Federal, State and local dness requirements. The ish and maintain a tergency preparedness the requirements of this gency preparedness program of the limited to, the following | E 0 | E001 1. The facility has an emerger place. The plan will be revised elements so that it meets the representations. 2. Current facility residents has affected by the alleged deficients. 3. The emergency preparednes include missing elements so that that meets the requirements of | d to include any missing equirements of the ave the potential to be not practice. ss plan will be revised to lat it is a comprehensive plan |
| | *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. | | | Chairman will be educated on emergency preparedness plan revised requirements to the reg be educated on the updated em 4. The Administrator/designed updating the emergency plan a preparedness program will be a | updating and revising the to include any new and/or gulations. Facility staff will tergency plan. e will be responsible for s needed. The emergency |
| | with all applicable Fe emergency prepared CAH must develop a comprehensive emergency, utilizing and This REQUIREMEN by: Based on staff interreview it was determined to the staff of the s | .625:] The CAH must comply ederal, State, and local dness requirements. The and maintain a ergency preparedness all-hazards approach. IT is not met as evidenced view and facility document nined that the facility staff and maintain a complete | | Committee on a quarterly basis that need to be made. 5. Completion Date: May 11, | s for any changes/additions |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

(X6) DATE 4/23/2018

ny deficiency statement ending with an asterist (*) depose a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | 0 | | M APPROVED D. 0938-0391 |
|--------------------------|---|--|-------------------------|----|---|---|--|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | E CONSTRUCTION | (X3) DA | TE SURVEY |
| | | 495142 | B. WING_ | | | 03 | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | /30/2010 |
| EVERGI | REEN HEALTH AND RI | EHAB | | | 80 MILLWOOD AVENUE /INCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION OATE |
| E 001 | Continued From pa emergency prepare | = | E 00 | 01 | | | |
| | comprehensive eme | ed to establish and maintain a ergency preparedness the requirements of these | | | | | |
| | The findings include | : : | | | | | į |
| | preparedness plant (administrative staff administrator), ASM and OSM (other starmanager). Review of preparedness plant comprehensive plant | I #2 (the director of nursing) ff member) #1 (the dietary of the facility's emergency failed to evidence a that meets the requirements ASM #1, ASM #2 and ASM | | i | | | |
| E 004 SS=C | No further information Develop EP Plan, Ro CFR(s): 483.73(a) | on was presented prior to exit. eview and Update Annually | E 00 |)4 | E004 | | |
| | Federal, State and lo preparedness requir develop establish an | rements. The [facility] must and maintain a comprehensive | | | 1. The facility has an emergency prepared place. The plan will be revised to include a elements so that it meets the requirements or regulations. | any miss | |
| | | dness program that meets the | | | 2. Current facility residents have the poten affected by the alleged deficient practice. | tial to be | 3 |
| | with all applicable Fe emergency prepared [hospital or CAH] mu | 182.15 and CAHs at nospital or CAH] must comply ederal, State, and local dness requirements. The ust develop and maintain a progency preparedness | | : | 3. The facility emergency preparedness pla will be evaluated and updated on a quarterly basis, and reviewed for compliance at least Safety Chairman will be educated on updat the emergency preparedness plan to include revised requirements to the regulations. Fa | y, or as a annually ing and e any ne | needed y. The revising w and/or |

DRM CMS-2567(02-99) Previous Versions Obsolete

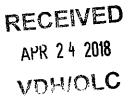
program that meets the requirements of this

Event ID: QP4M11

Facility ID: VA0218

be educated on the updated emergency plan.

If continuation sheet Page 2 of 328



| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | | FORM APPROVED MB NO. 0938-039 |
|--------------------------|---|--|----------------------|---|--|--------------------------------|
| STATEMENT | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | ن | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | <u></u> | 1 | | TREET ADDRESS, CITY, STATE, ZIP CODE | U3/3U/ZU10 |
| | REEN HEALTH AND RI | | | | 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | D BE COMPLÉTION |
| E 004 | Continued From page | = | Ε(| 004 | 4. The Administrator/designee will be re | esponsible for |
| | section, utilizing an | ı all-hazards approach. | | | updating the emergency plan as needed. preparedness program will be monitored | l by the QA |
| ı | The emergency pre include, but not be li elements:] | | · | Committee on a quarterly basis for any cl that need to be made. The QA Committe complete plan on an annual basis. | changes/additions | |
| : | 🛚 and maintain an em | n. The [facility] must develop nergency preparedness plan wed], and updated at least | | | 5. Completion Date: May 11, 2018 | |
| : | Plan. The ESRD factor maintain an emerge must be [evaluated], annually. | ies at §494.62(a):] Emergency icility must develop and ency preparedness plan that], and updated at least | | | | |
| | | NT is not met as evidenced | | | | |
| | Based on staff inter review it was determ failed to maintain a c | erview and facility document mined that the facility staff complete emergency | | | | |
| | preparedness plan. | | | | | ; |
| : | The facility staff faile complete emergenc | ed to develop and maintain a cy preparedness plan. | | | | |
| | The findings include | » : | | | | |
| | preparedness plan w (administrative staff in administrator), ASM and OSM (other staff manager). Review of preparedness plan fat plan that contained a | p.m., the facility's emergency was reviewed with ASM member) # 1 (the 1 #2 (the director of nursing) ff member) #1 (the dietary of the facility's emergency failed to evidence a complete all the required elements. | | | | |

No further information was obtained prior to exit.

| | | I AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-039 |
|--|--|--|-------------------------|--|---|
| STATEMENT OF DE AND PLAN OF COR | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF PROVID | ER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | |
| EVERGREEN | HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG F | EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLÉTION |
| SS=C CFR [(a) I and that annu (1) E facili asse *[For on a comi all-ha (2) I even * [Fo strate ident mana failur that v care. This by: Base | (s): 483.73(a)(a)(a)(b): 483.73(a)(a)(b): Emergency Planalitation and enum type planality and type planality approach a type planality approach type planality app | Hazards Risk Assessment 1)-(2) In. The [facility] must develop hergency preparedness plan wed, and updated at least must do the following:] Id include a documented, community-based risk ag an all-hazards approach.* In §483.73(a)(1):] (1) Be based ocumented, facility-based and risk assessment, utilizing an och, including missing residents. In §483.475(a)(1):] (1) Be based on mented, facility-based and risk assessment, utilizing an och, including missing clients. In §483.475(a)(1):] (1) Be based on mented, facility-based and risk assessment, utilizing an och, including missing clients. In §418.113(a)(2):] (2) Include the risk assessment. In §418.113(a)(2):] (2) Include the risk assessment, including the econsequences of power asters, and other emergencies a hospice's ability to provide the risk not met as evidenced riview and facility document mined that the facility staff | E 04 | I. The facility has an emergency place. The plan will be revised to elements so that it meets the requiregulations. 2. Current facility residents have affected by the alleged deficient plants. 3. The emergency preparedness include a facility-based and commassessment that utilizes an all-haz Chairman will be educated on up emergency preparedness plan to irrevised requirements to the regulate be educated on the updated emergency plan as in preparedness program will be mo Committee on a quarterly basis for that need to be made. 5. Completion Date: May 11, 20 | o include any missing airements of the cathe potential to be practice. plan will be updated to munity-based risk cards approach. The Safety dating and revising the include any new and/or ations. Facility staff will gency plan. will be responsible for needed. The emergency printered by the QA or any changes/additions |

all-hazards approach.

failed to develop an emergency preparedness plan based on and including a facility-based and community-based risk assessment, utilizing an

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION **IOENTIFICATION NUMBER:** COMPLETEO A. BUILOING C 495142 B. WING 03/30/2018 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) IO SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION Ю (X5) COMPLETION (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULO BE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG TAG OEFICIENCY) E 006 Continued From page 4 E 006 The facility staff failed to complete a facility-based and community-based risk assessment. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence a facility-based and community-based risk assessment, utilizing an all-hazards approach. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit. E 007 EP Program Patient Population E 007 SS=C CFR(s): 483.73(a)(3) E007 [(a) Emergency Plan. The [facility] must develop 1. The facility has an emergency preparedness plan in and maintain an emergency preparedness plan place. The plan will be revised to include any missing that must be reviewed, and updated at least elements so that it meets the requirements of the annually. The plan must do the following:] regulations. 2. Current facility residents have the potential to be (3) Address patient/client population, including, affected by the alleged deficient practice. but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in 3. The emergency preparedness plan will be updated to an emergency; and continuity of operations, address our at-risk population by most to least vulnerable. including delegations of authority and succession

FQHC, or ESRD facilities.

*Note: ["Persons at risk" does not apply to: ASC,

This REQUIREMENT is not met as evidenced

hospice, PACE, HHA, CORF, CMCH, RHC.

plans.**

emergency plan.

Strategies for ensuring their safety and well-being will be

outlined in the plan. The Safety Chairman will be educated on updating and revising the emergency preparedness plan

regulations. Facility staff will be educated on the updated

to include any new and/or revised requirements to the

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|--|---|----------------------|--|---------------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | \$ | C 03/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • |
| EVERGR | REEN HEALTH AND RI | EHAB | , | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX (EACH CORRECTIVE ACTION SHOU | ILD BE COMPLÉTION |
| E 007 | review it was detern failed to have a compreparedness plan. The facility staff failed preparedness plan patient population the strategies that the father needs of at-risk. The findings included On 3/28/18 at 3:47 preparedness plan (administrative staff administrative staff administrator), ASM and OSM (other stampanager). Review preparedness plan the emergency prepare facility's patient popular address the needs of patients. ASM #1, A made aware of this | erview and facility document mined that the facility staff implete emergency. Ited to develop the emergency that included the facility's that would be at risk and facility put in place to address to r vulnerable patients. e: p.m., the facility's emergency was reviewed with ASM if member) # 1 (the M#2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency failed to evidence the edness plan included the oulation that would be at risk the facility put in place to of at-risk or vulnerable ASM #2 and ASM #3 were concern. | EC | 4. The Administrator/designee will be rupdating the emergency plan as needed, preparedness program will be monitored. Committee on a quarterly basis for any that need to be made. 5. Completion Date: May 11, 2018 | . The emergency d by the QA |
| | | ion was obtained prior to exit. Policies and Procedures | Ε(| 013 E0131. The facility has an emergency preparence | |
| : | develop and implem policies and procedu | ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk | | place. The plan will be revised to inclue elements so that it meets the requireme regulations. | ents of the |
| | assessment at para | agraph (a) (1) of this section, agraph (a)(1) of this section, at paragraph (c) of | | Current facility residents have the p affected by the alleged deficient practic | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED | | | |
|-------------------|---|--|-----------------------------|--|---|--|--|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | 495142 | B. WING | | C 03/30/2018 | | | |
| EVERGR (X4) ID | PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 013 Continued From page 6 | | 3 | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| TAG | REGULATORY OR LS | SC IDENTIFYING INFORMATION) | TAG E 0 13 | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) 3. The emergency preparedness plan of the control of the | vill be updated to | | | |
| | this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and | | | include written policies and procedures facility and community based risk asse communication plan that addresses the hazards. The Safety Chairman will be updating and revising the emergency p include any new and/or revised require regulations. Facility staff will be educated to the procedure of | essment and e areas of potential e educated on preparedness plan to ements to the | | | |
| | | | | 4. The Administrator/designee will be updating the emergency plan as needed preparedness program will be monitore. Committee on a quarterly basis for any that need to be made. 5. Completion Date: May 11, 2018 | . The emergency d by the QA | | | |
| : | procedures. The dia implement emergen procedures, based of forth in paragraph (a assessment at para and the communica this section. The pol reviewed and update emergencies include equipment or power emergencies, water | s at §494.62(b):] Policies and alysis facility must develop and cy preparedness policies and on the emergency plan set a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of icies and procedures must be ed at least annually. These e, but are not limited to, fire, failures, care-related supply interruption, and ely to occur in the facility's | ; | | · · · · · · · · · · · · · · · · · · · | | | |

geographic area.

by:

This REQUIREMENT is not met as evidenced

Based on staff interview and facility document

| | | AND HUMAN SERVICES | | | | | M APPROVED |
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| | | & MEDICAID SERVICES | | | | " " | 0. 0938-0391 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | | TE SURVEY MPLETED |
| | | 495142 | B. WING | | · · · · · · · · · · · · · · · · · · · | 03 | C 3/30/ 2018 |
| NAME OF F | PROVIDER OR SUPPLIER | <u> </u> | | | REET ADDRESS, CITY, STATE, ZIP COD | | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE INCHESTER, VA 22601 | | |
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| L 013 | • | mined that the facility staff | | 113. | | | |
| | preparedness plan | | | | | | ÷ |
| | the policies and pro based on the facilit | to provide documentation that ocedures were developed y-and-community based risk ommunication plan, utilizing an ch. | | | | | |
| | The findings includ | e: | | | | | |
| | preparedness plan (administrative star administrator), ASI and OSM (other st manager). Review preparedness plan documentation that were developed be community-based an all-hazards app | p.m., the facility's emergency was reviewed with ASM ff member) # 1 (the M #2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency failed to evidence the policies and procedures used on a facility-based and risk assessment and utilizing roach ASM #1, ASM #2 and e aware of this concern. | | | | | |
| | | tion was obtained prior to exit. s for Staff and Patients (1) | E | 015 | | | |
| | develop and imple policies and procedular set forth in parassessment at parand the communicathis section. The previewed and updates | rocedures. [Facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ated at least annually.] At a cies and procedures must | | | The facility has an emergency pplace. The plan will be revised to it elements so that it meets the require regulations. Current facility residents have that affected by the alleged deficient principle. | nclude any mi ements of the he potential to | ssing |

| | | | | | | FORM APPROVE |
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| STATEMENT | IT OF DEFICIENCIES | MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION A BUILDING 495142 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 MENT OF DEFICIENCIES IN IDENTIFYING INFORMATION) B. WING FREFIX TAG TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE INCLUDENTIFYING INFORMATION) B. WINCHESTER, VA 22601 PREFIX TAG TAG TAG TAG TAG TO PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 3. The emergency preparedness plan will be up include written policies and procedures for the peregrency resources to include food, water, sev waste disposal. The Safety Chairman will be e inplating and revising the emergency prepared include any new and/or revised requirements to regulations. Facility staff will be educated on the emergency plan. 4. The Administrator/designee will be response inplating the emergency plan as needed. The er preparedness program will be monitored by the Committee on a quarterly basis for any changes that need to be made. 5. Completion Date: May 11, 2018 STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY) 3. The emergency preparedness plan will be up include written policies and procedures for the peregrency prepared include any new and/or revised requirements to regulations. Facility staff will be educated on the emergency plan as needed. The en preparedness program will be monitored by the Committee on a quarterly basis for any changes that need to be made. 5. Completion Date: May 11, 2018 5. Completion Date: May 11, 2018 | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | | | |
| | | 495142 | | | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | 00,00,2010 |
| EVERGE | REEN HEALTH AND R | EHAB | | 38 | 80 MILLWOOD AVENUE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | PREF | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | DBE COMPLÉTION |
| E 015 | EAR OF CORRECTION A95142 E OF PROVIDER OR SUPPLIER ERGREEN HEALTH AND REHAB DESCRIPTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage | EC |)15 | include written policies and procedures for emergency resources to include food, wat waste disposal. The Safety Chairman will updating and revising the emergency prep- include any new and/or revised requirement regulations. Facility staff will be educated | or the provision of ter, sewage, and ill be educated on paredness plan to ents to the | |
| | (ii) Alternate source following: (A) Temperatures safety and for the saprovisions. (B) Emergency light | s to protect patient health and cafe and sanitary storage of ghting. | maintain the 4. The Administrator/designee will updating the emergency plan as nee ient health and preparedness program will be monit y storage of Committee on a quarterly basis for a that need to be made. | | inpdating the emergency plan as needed. preparedness program will be monitored to Committee on a quarterly basis for any chat need to be made. | The emergency by the QA |
| : | systems. (D) Sewage and v | waste disposal. | | | • | |
| | Policies and procedu (6) The following are hospice-operated in The policies and pro- following: | dures. The additional requirements for apparent care facilities only. The occurred must address the | | | | |
| | (iii) The provision of hospice employees evacuate or shelter limited to the followin (A) Food, water, r | and patients, whether they in place, include, but are not ing: | | | | : : |
| : : : | (B) Alternate sour following: (1) Temperature | res to protect patient health | | | | |
| | (2) Emergency | on, extinguishing, and alarm | | | | |

| | | AND HUMAN SERVICES | | | 0 | | APP R OVED . 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DAT COM | E SURVEY IPLETED |
| | | 495142 | B. WING | | | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 180 MILLWOOD AVENUE | | |
| EVERGR | EEN HEALTH AND R | EHAB | | ٧ | VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| E 015 | by: Based on staff intereview it was determated to have a compreparedness plan. The facility staff fail procedures for the needs including but sewage and waste. The findings include On 3/28/18 at 3:47 preparedness plan (administrative staff administrative), ASM and OSM (other stamanager). Review preparedness plan documentation of provision of subsist limited to food, water | NT is not met as evidenced erview and facility document mined that the facility staff inplete emergency ed to develop policies and provision of subsistence to not limited to food, water, disposal. e: p.m., the facility's emergency was reviewed with ASM if member) # 1 (the M#2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency | E (| 015 | | | |
| | made aware of this No further informat Procedures for Trac CFR(s): 483.73(b)([(b) Policies and procedure policies policies and procedure policies and procedure policies and procedure policies and procedure policies policies and procedure policies an | concern. ion was obtained prior to exit. cking of Staff and Patients | | 018 | E018 1. The facility has an emergency prepare place. The plan will be revised to includ elements so that it meets the requirement regulations. 2. Current facility residents have the pot affected by the alleged deficient practice | le any mists of the | ssing |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) E 018 Continued From page 10 E 018 3. The emergency preparedness plan will be updated to reviewed and updated at least annually.] At a include written policies and procedures of how staff and minimum, the policies and procedures must residents will be tracked as to location should evacuation address the following:] due to an emergency be necessary. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised (2) A system to track the location of on-duty staff requirements to the regulations. Facility staff will be and sheltered patients in the [facility's] care during educated on the updated emergency plan. an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the 4. The Administrator/designee will be responsible for [facility] must document the specific name and updating the emergency plan as needed. The emergency location of the receiving facility or other location. preparedness program will be monitored by the OA Committee on a quarterly basis for any changes/additions *[For PRTFs at §441.184(b), LTC at §483.73(b), that need to be made. ICF/IIDs at §483.475(b), PACE at §460.84(b):1 Policies and procedures. (2) A system to track the 5. Completion Date: May 11, 2018 location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of

assistance.

communication with external sources of

the receiving facility or other location.

(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of

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| TATEMEN | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILC | | STRUCTION | 0 | (X3) DATE: COMPI | |
| | | 495142 | B. WING | | | | 03/30 | 0/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | FHAR | | | ADDRESS, CITY, STATE LWOOD AVENUE | E, ZIP CODE | | |
| LVERGI | | LIIAD | | WINCH | IESTER, VA 22601 | | | |
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| E 018 | Continued From pa | ge 11 | ΕŒ | 018 | | | | |
| | which includes constreatment needs of responsibilities; trarevacuation location means of communiassistance. *[For OPOs at § 48 procedures. (2) A stance downward and actual secures and maintal secures and staff included and secures and staff intereview it was determined to have a compreparedness plan. The facility staff fails procedures to include patients and staff. The findings include On 3/28/18 at 3:47 | asportation; identification of (s); and primary and alternate cation with external sources of 6.360(b):] Policies and ystem of medical preserves potential and actual protects confidentiality of donor information, and ains the availability of records. 4.62(b):] Policies and e evacuation from the dialysis les staff responsibilities, and ts. NT is not met as evidenced rview and facility document mined that the facility staff aplete emergency | | | | | | |

administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495142

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

(X3) DATE SURVEY COMPLETED

B. WING

C 03/30/2018

NAME OF PROVIDER OR SUPPLIER

EVERGREEN HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

1D **PREFIX** TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION

E 018 | Continued From page 12

manager). Review of the facility's emergency preparedness plan failed to evidence policies and procedures to include a tracking system for patients and staff. ASM #1, ASM #2 and ASM #3 were made aware of this concern.

No further information was obtained prior to exit. E 022 Policies/Procedures for Sheltering in Place SS=C CFR(s): 483.73(b)(4)

- [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]
- (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility], [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].
- *[For Inpatient Hospices at §418.113(b):] Policies and procedures.
- (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
- (i) A means to shelter in place for patients. hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document

E 018

E 022 E022

- 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations.
- 2. Current facility residents have the potential to be affected by the alleged deficient practice.
- 3. The emergency preparedness plan will be updated to include policies and procedures that address the facility's ability to shelter in place for patients, staff and volunteers should the need arise. Sheltering in place will be dependent on the facility risk assessment and the hazard encountered. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.
- 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made.
- 5. Completion Date: May 11, 2018

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 13 of 328

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| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
| | | 495142 | B. WING_ | | | 1 | 30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | EVERGREEN HEALTH AND REHAB | | | | 0 MILLWOOD AVENUE INCHESTER, VA 22601 | | |
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| E 022 | Continued From pa review it was detern failed to have a con preparedness plan. | nined that the facility staff nplete emergency | E 0: | i 22: | | | |
| | procedures of how means to shelter in volunteers who rem | ed to develop policies and the facility will provide a place for patients, staff and nain in the facility and how procedures are aligned with a nent. | | : | | | |
| | The findings include | e: | | | | | • |
| | preparedness plan (administrative staff administrator), ASM and OSM (other stamanager). Review preparedness plan documentation of pathe facility will provide for patients, staff and the facility and how are aligned with a facility and the staff and the s | #2 (the director of nursing) iff member) #1 (the dietary of the facility's emergency | | | | | |
| E 023 SS=C | | ion was obtained prior to exit. s for Medical Documentation 5) | E 0 | 23 | E023 | | · |
| | develop and impler policies and proced plan set forth in parassessment at para | ocedures. The [facilities] must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of | • | | The facility has an emergency prepared place. The plan will be revised to include elements so that it meets the requirements regulations. Current facility residents have the potentificated by the alleged deficient practice. | any missi of the | ing |

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| | | 495142 | B. WING | | 03 | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | |
| EVERGE | REEN HEALTH AND RI | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | reviewed and update minimum, the policic address the following (5) A system of median preserves patient in confidentiality of pate and maintains avails (3),(4),(6)] A system that preserves patient confidentiality of pate and maintains avails *[For RNHCls at §40 procedures. (5) A system that does the following (ii) Preserves patient (iii) Protects confider (iii) Secures and maintains avails *[For OPOs at §486 procedures. (2) A system that it is a secure and maintain that it is a secure and m | dicies and procedures must be seed at least annually. At a see and procedures must age;] dical documentation that formation, protects tient information, and secures ability of records. [(5) or of medical documentation and information, protects tient information, protects tient information, and secures ability of records. 03.748(b):] Policies and vetem of care documentation and ing: tinformation. Initiality of patient information. Initiality of patient information. Initiality of period and vetem of medical preserves potential and actual rotects confidentiality of donor information, and ins the availability of records. T is not met as evidenced view and facility document and that the facility staff | EO | 3. The emergency preparedness pla more accurately reflect the facility's procedures regarding the preservation patient information and medical recommendation will be educated on update emergency preparedness plan to increvised requirements to the regulation be educated on the updated emergency. 4. The Administrator/designee will updating the emergency plan as nee preparedness program will be monit Committee on a quarterly basis for a that need to be made. 5. Completion Date: May 11, 2018 | s policies and on and protectic cords. The Safe ting and revising and revising and revising the cords. Facility stancy plan. be responsible add. The emergenced by the QA any changes/add. | on of ty g the nd/or aff will for gency |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB NO | 0. 0938-039 |
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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 03 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION OATE |
| E 023 | information, and se availability of record The findings include On 3/28/18 at 3:47 preparedness plan (administrative stafadministrator), ASM | cures and maintains ds. e: p.m., the facility's emergency was reviewed with ASM f member) # 1 (the II #2 (the director of nursing) | E | 023 | | | |
| | manager). Review preparedness plan documentation of p the facility preserve confidentiality of pa and maintains avail ASM #2 and ASM # concern. | olicies and procedures of how is patient information, protects tient information, and secures ability of records. ASM #1, #3 were made aware of this on was obtained prior to exit. s-Volunteers and Staffing | ΕŒ |)24 | E024 1. The facility has an emergency prepplace. The plan will be revised to inclelements so that it meets the requirem regulations. | lude any mis ents of the | ssing |
| 33-0 | [(b) Policies and prodevelop and implened policies and proced plan set forth in parassessment at para and the communicathis section. The poreviewed and update minimum, the policies address the following (6) [or (4), (5), or (7)] | ocedures. The [facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of dicies and procedures must be ted at least annually. At a less and procedures must | | | 2. Current facility residents have the affected by the alleged deficient pract 3. The emergency preparedness plan include the policy and procedure for tif needed, in the event of an emergency Chairman will be educated on updating emergency preparedness plan to inclurevised requirements to the regulation be educated on the updated emergency 4. The Administrator/designee will be updating the emergency plan as need preparedness program will be monitor. | will be updathe use of vocy. The Safeing and revisible any newns. Facility by plan. The responsible d. The emored by the Company of the Comp | ated to olunteers, ety ing the and/or staff will le for ergency QA |

staffing strategies, including the process and role

for integration of State and Federally designated

that need to be made.

5. Completion Date: May 11, 2018

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION IG | (X3) DATE SURVE COMPLETED | | |
| | | 495142 | B. WING _ | | 03/30/201 | 18 | |
| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | , | 03/30/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPL | ETION | |
| | during an emergen *[For RNHCIs at §4 procedures. (6) The emergency and oth strategies to addres emergency. This REQUIREMED by: Based on staff inter review it was deter failed to have a cor preparedness plan The facility staff fai | sionals to address surge needs cy. 403.748(b):] Policies and e use of volunteers in an are emergency staffing ss surge needs during an NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency | E 02 | 24 | | | |
| E 026 | The findings included On 3/28/18 at 3:47 preparedness plan (administrative state administrator), ASI and OSM (other stampager). Review preparedness plandocumentation of puse of volunteers in #1, ASM #2 and ASI this concern. No further information Roles Under a War CFR(s): 483.73(b) (conservance) | p.m., the facility's emergency was reviewed with ASM if member) # 1 (the M #2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency failed to evidence colicies and procedures for the in the emergency plan. ASM SM #3 were made aware of the color was obtained prior to exit. Ever Declared by Secretary (8) | E 0 | E026 1. The facility has an emergency prepar place. The plan will be revised to include elements so that it meets the requirement regulations. 2. Current facility residents have the positions. | de any missing ats of the | | |
| | [(b) Policies and pr | ocedures. The [facilities] must | | affected by the alleged deficient practice | ential to be | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 3. The emergency preparedness plan will be updated to E 026 Continued From page 17 E 026 include facility policies and procedures for the provision of develop and implement emergency preparedness care and treatment of patients if they have to be moved to policies and procedures, based on the emergency an alternate care site if 50 mandated by emergency plan set forth in paragraph (a) of this section, risk management officials. The Safety Chairman will be assessment at paragraph (a)(1) of this section. educated on updating and revising the emergency and the communication plan at paragraph (c) of preparedness plan to include any new and/or revised this section. The policies and procedures must be requirements to the regulations. Facility staff will be reviewed and updated at least annually. At a educated on the updated emergency plan. minimum, the policies and procedures must address the following:] 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency (8) [(6), (6)(C)(iv), (7), or (9)] The role of the preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions [facility] under a waiver declared by the Secretary. in accordance with section 1135 of the Act, in the that need to be made. provision of care and treatment at an alternate 5. Completion Date: May 11, 2018 care site identified by emergency management officials. *[For RNHCls at §403.748(b):] Policies and procedures. (8) The role of the RNHCl under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM

The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-039 |
|--------------------------|--|---|-------------------------|---|---|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING _ | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | ' | STREET ADDRESS, CITY, STATE, ZIP | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | ON SHOULD BE COMPLETION E APPROPRIATE DATE |
| E 026 | and OSM (other stamanager). Review preparedness plan documentation of pemergency plan that providing care and sites under an 1135 | f member) # 1 (the ## 4 (the director of nursing) ## 5 member) # 1 (the dietary of the facility's emergency | E 02 | ?6 | |
| SS=C | Methods for Sharin CFR(s): 483.73(c)(4) [(c) The [facility] multiple emergency prepare that complies with Fland must be review annually.] The comall of the following: (4) A method for shadocumentation for pare, as necessary maintain the continual to the following: (5) A means, in the release patient information for pare the following: | 4)-(6) ust develop and maintain an edness communication plan Federal, State and local laws yed and updated at least imunication plan must include aring information and medical patients under the [facility's], with other health providers to | E 03 | 1. The facility has an emergency place. The plan will be revised elements so that it meets the requegulations. 2. Current facility residents have affected by the alleged deficient of the series of | to include any missing purements of the ve the potential to be to practice. Is plan will be updated to communication plan information and medical ents with other healthcare in facility will communicate. The Safety Chairman will be ing the emergency in your wand/or revised. Facility staff will be ency plan. It will be responsible for saneded. The emergency |
| ! | (6) [(4) or (5)]A means of providing information | | | preparedness program will be n | nonitored by the QA |

under 45 CFR 164.510(b)(4).

about the general condition and location of

patients under the [facility's] care as permitted

that need to be made.

5. Completion Date: May 11, 2018

Committee on a quarterly basis for any changes/additions

| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | | | APPROVED 0, 0938-0391 |
|--------------------------|--|--|----------------------|------------|---|----------|----------------------------|
| TATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | , | 495142 | B. WING | . ŧ | · | 1 | C / 30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | 1 | REET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | OU, AU . C |
| EVERGR | REEN HEALTH AND RI | EHAB | ļ | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| E 033 | Continued From pa | age 19 | Ε | 033 | | | |
| : | sharing information patients under the F with care providers care, based on the made by the patient representative. | | | | | | |
| | of providing information and location and location facility's care as per 164.510(b)(4). This REQUIREMENT by: Based on staff inter | | | | | | |
| : | The facility staff faile documentation that included a method f medical documenta facility's care, as ne providers to maintai reviewing the comm documentation that policies and proceduthe facility will use to include the gener | led to provide evidence of the communication plan for sharing information and ation for patients under the ecessary, with other health ain the continuity of care by | | | | | |
| | The findings include | ə: | | | | | · |
| : | | p.m., the facility's emergency was reviewed with ASM f member) # 1 (the | : | | | | |

| | | AND HUMAN SERVICES | | | | M APP R OVED O. 0938-0391 |
|--|---|--|------------------------|--|---|--|
| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | TIPLE CONSTRUCTION NG | (X3) D | ATE SURVEY DMPLETED | |
| | | 495142 | B. WING_ | | 0 | 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | STREET ADDRESS, CITY, STATE, ZIP C | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5] COMPLETION DATE |
| E 033 | and OSM (other stamanager). Review preparedness plan documentation that included a method medical documenta facility's care, as ne providers to maintareviewing the communicies and proceed the facility will use to include the gene patients by reviewing | #2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency | E 0: | 33 | | |
| | LTC and ICF/IID SI CFR(s): 483.73(c)([(c) The [LTC facility and maintain an encommunication plants State and local law | y and ICF/IID] must develop nergency preparedness n that complies with Federal, s and must be reviewed and nually.] The communication | E 0 | E035 1. The facility has an emergency place. The plan will be revised to elements so that it meets the requiregulations. 2. Current facility residents have | o include any mi irements of the the potential to | ssing |
| | (8) A method for shemergency plan, the is appropriate, with families or represe This REQUIREMED by: Based on staff into | paring information from the at the facility has determined residents [or clients] and their ntatives. NT is not met as evidenced erview and facility document mined that the facility staff | | affected by the alleged deficient p 3. The emergency preparedness p include documentation that the co- includes a method for sharing inf emergency with patients and their representatives. The Safety Chair updating and revising the emerge include any new and/or revised re regulations. Facility staff will be emergency plan. | plan will be upd ommunication p formation from t r families or rman will be ed ency preparedne equirements to t | lan he ucated on ss plan to he |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ΙD (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULO BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 035 Continued From page 21 4. The Administrator/designee will be responsible for E 035 updating the emergency plan as needed. The emergency preparedness plan. preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions The facility staff failed to provide evidence of that need to be made. documentation that the communication plan includes a method for sharing information from 5. Completion Date: May 11, 2018 the emergency plan with residents or clients and their families or representatives. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency with residents or clients and their families or representatives. ASM #1, ASM #2 and ASM #3 were made aware of this concern. E036 No further information was obtained prior to exit. E 036 EP Training and Testing E 036 1. The facility has an emergency preparedness plan in SS=C CFR(s): 483.73(d) place. The plan will be revised to include any missing elements so that it meets the requirements of the (d) Training and testing. The [facility] must regulations.

(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

- 2. Current facility residents have the potential to be affected by the alleged deficient practice.
- 3. The emergency preparedness plan will be updated to include a written training and testing program that meets the requirements of the regulation. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | · · · · | ' | STI | REET ADDRESS, CITY, STATE, ZIP CODE | 1 03/30/2010 |
| EVERGR | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE NCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY) | D BE COMPLÉTION |
| | testing. The ICF/IID an emergency prep program that is bas forth in paragraph (assessment at parapolicies and proced section, and the corparagraph (c) of this testing program muleast annually. The requirements for ev §483.470(h). *[For ESRD Facilities testing, and orientated develop and maintal preparedness training orientation program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation program updated at least and This REQUIREMENT. | 83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, ures at paragraph (b) of this munication plan at a section. The training and st be reviewed and updated at ICF/IID must meet the acuation drills and training at as at §494.62(d):] Training, ion. The dialysis facility must in an emergency ng, testing and patient that is based on the forth in paragraph (a) of this ment at paragraph (a)(1) of and procedures at paragraph nd the communication plan at a section. The training, testing arm must be reviewed and | ΕO | | 4. The Administrator/designee will be re updating the emergency plan as needed. preparedness program will be monitored Committee on a quarterly basis for any classic that need to be made. 5. Completion Date: May 11, 2018 | The emergency by the QA |
| | | view and facility document nined that the facility staff plete emergency | | | | |
| ! | documentation that | ed to provide evidence of the facility has a written program that meets the regulation. | | : | | i |

The findings include:

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | • | M APPROVED D. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | TE SURVEY MPLETED |
| | | 495142 | B. WING | | _0: | C 3/30/2018 |
| | PROVIDER OR SUPPLIER EEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | JX5J COMPLETION DATE |
| E 036 | Continued From pa | ge 23 | E 03 | 36 | | |
| | preparedness plan (administrative staff administrator), ASM and OSM (other stamanager). Review preparedness plan documentation that training and testing requirements of the | ##2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency | | | | |
| | No further informat EP Training Progra CFR(s): 483.73(d)(| | E 0 | 37 _{E037} | | |
| 33-0 | (1) Training program ASCs, PACE organ | m. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following: | | The facility has an emergency place. The plan will be revised to elements so that it meets the requiregulations. | include any mis | an in ssing |
| | policies and proced staff, individuals pro arrangement, and vexpected role. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. *[For Hospitals at § at §491.12:] (1) Tra or RHC/FQHC] mu (i) Initial training in opolicies and proced staff, individuals pro- | emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ency preparedness training at mentation of the training. aff knowledge of emergency 482.15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: emergency preparedness lures to all new and existing oviding on-site services under volunteers, consistent with their | | Current facility residents have affected by the alleged deficient process. The emergency preparedness princlude initial emergency prepare emergency preparedness training provision of documenting such the Chairman will be educated on uperferency preparedness plan to it revised requirements to the regulate be educated on the updated emergency preparedness program will be more committee on a quarterly basis for that need to be made. Completion Date: May 11, 20 | plan will be updated and will be updated and standing and revisional and revision | ated to nd annual with the fety ing the and/or staff will le for ergency |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | | FORM APPROVED OMB NO. 0938-0391 |
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| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED C |
| | 495142 | B. WING | | 03/30/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | |
| EVERGREEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| PRÉFIX (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI | ACTION SHOULD BE COMPLETION THE APPROPRIATE OATE |
| least annually. (iii) Maintain docum (iv) Demonstrate st procedures. *[For Hospices at § hospice must do al (i) Initial training in policies and procedures are expected roles. (ii) Demonstrate staprocedures. (iii) Provide emerge least annually. (iv) Periodically revemergency prepare employees (including special emphasis procedures necess others. *[For PRTFs at §44 program. The PRT (i) Initial training in policies and procedures arrangement, and vexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staprocedures. | ency preparedness training at the nentation of the training. The staff knowledge of emergency at 18.113(d):] (1) Training. The lof the following: emergency preparedness dures to all new and existing and individuals providing angement, consistent with their aff knowledge of emergency ency preparedness training at eleast plan with hospice and nonemployee staff), with placed on carrying out the early to protect patients and at 1.184(d):] (1) Training F must do all of the following: emergency preparedness dures to all new and existing poviding services under volunteers, consistent with their and, provide emergency ing at least annually, aff knowledge of emergency mentation of all emergency | EO | 37 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | | E & MEDICAID SERVICES | | C | FORM APPROVED MB NO. 0938-0391 |
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| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | (X3) DATE SURVEY |
| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | | COMPLETED |
| | | 495142 | B. WING _ | | C 03/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY) | D BE COMPLÉTION |
| E 0 37 | Continued From pa | age 25 | E 03 | 7 | |
| , | *[Eor DACE of \$460 |) 94/4) 1/1) The DACE | | | : |
| | | 0.84(d):] (1) The PACE do all of the following: | | | |
| | (i) Initial training in | emergency preparedness | | | <u>;</u> |
| | | dures to all new and existing | | | a · |
| | | oviding on-site services under actors, participants, and | | | |
| | volunteers, consiste | ent with their expected roles. | | | i - |
| | ` , | ncy preparedness training at | | | : : : |
| | least annually. | aff knowledge of emergency | | | : |
| | | ng informing participants of | | | |
| : | | o go, and whom to contact in | | | 1 |
| : | case of an emerger | ncy. nentation of all training. | | | |
| | (1V) IVIAII ILAIII UUCUII | remanding of all training. | | | • |
| | | 85.68(d):](1) Training. The | | | |
| | CORF must do all o (i) Provide initial tra | | | | |
| | | ies and procedures to all new | | | |
| | and existing staff, in | ndividuals providing services | | | |
| : | under arrangement with their expected | t, and volunteers, consistent | | | |
| : | | ncy preparedness training at | | | |
| : | least annually. | | | | |
| | | nentation of the training. | | | |
| | • • | aff knowledge of emergency v personnel must be oriented | | | |
| | | ific responsibilities regarding | | | |
| ! | the CORF's emerge | ency plan within 2 weeks of | | | |
| | | The training program must n the location and use of | | | : |
| : | | signals and firefighting | | | i |
| | equipment. | | | | |
| | *IFor CAHe at 8/85 | 5.625(d):] (1) Training program. | | | |
| | The CAH must do a | | | • | E |
| ! | (i) Initial training in e | emergency preparedness | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | ON | FORM APPROVED MB NO. 0938-0391 | | |
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| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495142 | B. WING | \$ | 03/30/2018 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGREEN HEALTH AND REHAB | | | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | BE COMPLÉTION | | |
| E 037 | reporting and exting and where necessal personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, con roles. (ii) Provide emerged least annually. (iii) Maintain docum (iv) Demonstrate structures. *[For CMHCs at §44] CMHC must provide preparedness policiand existing staff, ir under arrangement with their expected documentation of the demonstrate staff k procedures. Therea | ures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster and existing staff, g services under arrangement, asistent with their expected ancy preparedness training at entation of the training. aff knowledge of emergency [85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new adviduals providing services, and volunteers, consistent | E | 037 | | | |
| | by: Based on staff inte | | | | : | | |
| | documentation of the preparedness training preparedness training preparedness training training preparedness training preparedness training training preparedness training prepa | ed to provide evidence of ne facility's initial emergency ng and annual emergency ng offerings for volunteers and facility volunteers have | | | | | |

| | | E & MEDICAID SERVICES | | | (| | M APPROVED 0. 0938-0391 |
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| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | "TIPLE (| CONSTRUCTION | | ATE SURVEY |
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | co | MPLETED |
| | , | 495142 | B. WING | 3 | | ₀ ; | C 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | <u></u> | | STR | REET ADDRESS, CITY, STATE, ZIP CODE | 1 |)/00/E0 (U |
| EVERGR | REEN HEALTH AND RI | EHAB | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | =iX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| E 037 | Continued From pa received initial & an preparedness traini | nnual emergency iing. | E! | 037 | | | |
| F 000 | preparedness plan (administrative staff administrator), ASM and OSM (other stamanager). Review preparedness plan documentation of the preparedness training preparedness training documentation that received initial & an preparedness training ASM #3 were made No further information INITIAL COMMENT An unannounced Managurey was conducted to complaint was survey. Corrections with the following 42 | p.m., the facility's emergency was reviewed with ASM ff member) # 1 (the M #2 (the director of nursing) aff member) #1 (the dietary of the facility's emergency failed to evidence the facility's initial emergency sing and annual emergency sing offerings for volunteers and tracility volunteers have annual emergency sing. ASM #1, ASM #2 and e aware of this concern. Medicare/Medicaid standard cated 3/27/18 through 3/30/18. In investigated during the sare required for compliance is are required for compliance ments. The Life Safety Code | | 000 | | | |
| : | The census in this 138 at the time of the consisted of 28 cur (Residents # 236, 274, 55, 83, 3, 61, 1138, 95, 384, 73, 66, | 176 certified bed facility was the survey. The survey sample trent resident reviews 235, 234, 132, 90, 133, 89, 97, 14, 130, 99, 69, 17, 37, 105, 57, 47 and 98) and three two (Residents # 334, 135 and | | | | | |

| DEPARTMENT OF HEALTH | | | | F | ארט: 04/13/2018 FORM APPROVED |
|--|---|-----------------------|-------------|---|---|
| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | | | MB NO. 0938-0391 |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | (X3) DATE SURVEY COMPLETED | |
| | 495142 | B. WING | | | C 03/30/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | 1 03/30/2016 |
| EVERGREEN HEALTH AND R | EHAB | | 380 N | MILLWOOD AVENUE CHESTER, VA 22601 | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | k | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE COMPLÉTION I |
| F 000 Continued From pa 134). | ge 28 | F 0 | 00 | | |
| F 580 Notify of Changes (| Injury (Decline (December) | | | | |
| ES-D: CER(s): 483 10(a)(a | injury/Decline/Room, etc.) | F 5 | | F580 | |
| (i) A facility must im consult with the resistent with his consistent with a negative facility in a new formula commence and commence and facility in a facility in a new formula commence and facility in a new f | fication of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident nen there is- oliving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or s); reatment significantly (that is, we an existing form of overse consequences, or to orm of treatment); or nsfer or discharge the | | 1. 2. 3. 4. | the alleged deficient practice in regar resident #130, resident has discharged facility. | ds to d from the tential to ractice. MD oss April 13, s will then thly x 2 ged de: otification nee will d report in sting s to |
| §483.15(c)(1)(ii). (ii) When making notification under paragraph (g (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is— (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. | | | 5. | recommend, based on outcomes/trend identified from date. Completion Date: May 11, 2018 | S |

| | | AND HUIVIAN SERVICES | | | | RM APPROVED NO. 0938-0391 | | |
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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| | | 495142 | B. WING | 3 | | C 03/30/2018 | | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (| | | | |
| EVERGR | EEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE | (X5) COMPLETION OATE | | |
| F 580 | Continued From pa update the address | ge 29 (mailing and email) and | F 5 | 580 | | | | |
| | phone number of the representative(s). | ne resident | | | | : | | |
| | that is a composite §483.5) must disclosite physical configurations that compart, and must spectroom changes betworder §483.15(c)(9). This REQUIREMENT by: Based on staff intered and clinical record in the facility staff failed nurse practitioner) of condition for one of sample, Resident # | rview, facility document review review, it was determined that at to notify the physician (or of a resident's change in 31 residents in the survey 130. ed to notify Resident #130's ctitioner of significant weight | | | | | | |
| | The findings include: | | | | | | | |
| | 1/11/18 and readmit #130's diagnoses in pneumonia, diabete Resident #130's modata set), a quarterl (assessment refere resident as cognitive documented Reside weight loss of five p | admitted to the facility on ted on 2/2/18. Resident acluded but were not limited to as and urinary tract infection. The second MDS (minimum of assessment with an ARD named ate) of 3/9/18, coded the ely intact. Section Kent #130 presented with a tercent or more in the last of or more in the last six | | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | O | FORM APPROVED MB NO. 0938-0391 |
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| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ' ' | TIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| EVERG | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | BE COMPLÉTION |
| F 580 | Continued From pa | ige 30 | F 5 | 580 | : |
| | Review of Resident revealed the following 1/23/18- 204 pound 2/2/18- 188.5 pound 2/10/18- 183.5 pound 2/22/18- 175.5 pound 3/10/18- 173 pound 3/13/18- 178 pound | ds ds nds nds ds | | | |
| | 2/10/18 documente (ideal body weight) obesity; BMI (body has lost 15.5lb (poutimes) 10 days since Received Lasix (1) likely the cause of I mouth) intakes typic only eats 25% of a and meds (medicate) | e registered dietician on ed, "Resident is 188.5% of IBW for ht (height), which denotes mass index) 36.8. Resident unds)/7.6% of wt (weight) x ce being in the hospital. during hospital stay, which is ner wt (weight) loss. Po (By cally 75-100%, but sometimes meal. Labs (labratory tests) tions) reviewed. Skin intact. P current diet regimen. 2. is as available" | | | |
| | 3/17/18 do cumente for ht (height), whic Resident has lost 1 since readmission. noted as well. Had stay, however Po (be 75-100%, but so meds reviewed. Sk monitor wts. May n | e registered dietician on ad, "Resident is 178% of IBW h denotes obesity; BMI 34.8. 0.5lb/5.6% of wt x 1 month Wt loss during hospital stay received Lasix during hospital by mouth) intakes continues to ometimes eats less. Labs and kin intact. Will continue to leed nutrition supplement if wt (Plan): 1. Continue current | | | · · · |

diet regimen. 2. Monitor wts and labs as available..."

| CENTERS FOR | <u>ME</u> DICARE | & MEDICAID SERVICES | | | | | ON | | APPROVED . 0938-0391 |
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| STATEMENT OF DEFICAND PLAN OF CORRECT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ONSTRUCTION | | - | (X3) DAT COM | E SURVEY IPLETED |
| | | 495142 | B. WING | | | | | | C 30/2018 |
| NAME OF PROVIDER | | ЕНАВ | | 3 80 N | ET ADDRESS, O MILLWOOD AV CHESTER, V | ENUE | P CODE | | 00/2010 |
| | CH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH COR | R'S PLAN OF (RECTIVE ACTI RENCED TO T DEFICIENC | ION SHOULD I HE APPROPR | BE | (X5) COMPLETION DATE |
| (includinurse p #130's made a Resider initiated regardir On 3/29 conduct membe was ask when a loss. At her rega she war the staff supplen been m | review of R ng nurses' n ractitioner n ohysician (o ware of the nt #130's co on 1/11/18 ng physician n/18 at 1:15 red with ASN r) #5 (the nu ked if she waresident pre SM #5 state arding a sign nts to prescrit takes it up nents. ASN ade aware of | ge 31 esident #130's clinical record otes, physician notes and otes) failed to reveal Resident record the nurse practitioner) was above weight loss. Imprehensive care plan failed to document information notification of weight loss. In many interview was failed to deciment was failed to document information notification of weight loss. In many interview was failed as supposed to be notified esents with a significant weight desents with a significant weight desents with a significant weight desents with a significant weight loss to see if the sibe an appetite stimulant but on themselves to initiate the staff normally notifies and appetite stimulant but on themselves to initiate the staff she had of Resident #130's weight loss rch. ASM #5 stated she had | F 5 | 580 | | | | | |
| conduct LPN #6 resident LPN #6 departm the nurs stated b | ed with LPN was asked presents w stated the rent should e practition ecause the nents and the presents and the presents and the was asked to be asked | p.m., an interview was I (licensed practical nurse) #6. who should be notified when a ith a significant weight loss. nurse practitioner and dietary be notified. When asked why er should be notified, LPN #6 resident may need more lere may be other "issues" | : | į | | | | | |
| adminis | trator) and A | om., ASM #1 (the ASM #2 (the director of aware of the above concern. | | | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | FORM APF B NO. 093 | |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | | (X3) DATE SURVEY COMPLETED | | |
| | | 495142 | B. WING_ | | | 03/30/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | " | | STREE | ET ADDRESS, CITY, STATE, Z | IP CODE | | |
| EVERGR | REEN HEALTH AND R | EHAB | | | IILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TON SHOULD B THE APPROPRI | - : | (X5) MPLETION DATE |
| F 584 | dietary supervisor, notified when any of a. Weight variance month b. Weight variance three month period c. Weight variance month period" No further information with other blood pressure. Further edema (fluid retentified tissues) caused by including heart, kidd furosemide is in a diuretics ('water pille kidneys to get rid of from the body into the was obtained from https://medlineplus.tml Safe/Clean/Comfor CFR(s): 483.10(i)(1) §483.10(i) Safe Environment of the president has a comfortable and ho | ant titled, "WEIGHT AL MANAGEMENT mented, "3. The physician, the and consulting dietitian will be f the following occurs: of 5% or greater in any one of 7.5% or greater over any of 10% or greater over any six on was presented prior to exit. The six) is used alone or in the medications to treat high rosemide is used to treat on; excess fluid held in body various medical problems, ney, and liver disease. Class of medications called siy. It works by causing the funneeded water and salt the urine." This information the website: gov/druginfo/meds/a682858.httable/Homelike Environment. right to a safe, clean, melike environment, including ceiving treatment and | F 5 | | F584 | n accomplished in regards to re and organizing ted. For reside cleaned and sa | esidents patient's nts #105 nitized by | |
| 1 | The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and | | | · · · · · · · · · · · · · · · · · · · | affected by the alleged de audit of resident rooms we rooms were clean, organiz | as completed a | ssuring | |
| DRM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: QP4M | <u> </u> | Facility II | D: VA02 t8 | f continuation | sheet Page | 33 of 328 |

| CENTERS FOR MEDICARI | E & MEDICAID SERVICES | | | (| FORM APPROVED DMB NO. 0938-0391 |
|--|--|---------------------|----------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 495142 | B. WING | · | | C 03/30/2018 |
| NAME OF PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | 03/30/2010 |
| EVERGREEN HEALTH AND R | | | | MILLWOOD AVENUE ICHESTER, VA 22601 | |
| PRÉFIX (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY) | DBE COMPLÉTION |
| use his or her pers possible. (i) This includes en receive care and se physical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) Hous services necessary and comfortable in good condition; §483.10(i)(3) Clear in good condition; §483.10(i)(4) Private resident room, as segment room, as segmen | nent, allowing the resident to sonal belongings to the extent insuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. If exercise reasonable care for he resident's property from loss sekeeping and maintenance by to maintain a sanitary, orderly, terior; in bed and bath linens that are the closet space in each especified in §483.90 (e)(2)(iv); the uate and comfortable lighting fortable and safe temperature tially certified after October 1, in a temperature range of 71 to the maintenance of comfortable NT is not met as evidenced too, resident interview, staff y document review it was cility staff failed to maintain a homelike environment for four ne survey sample, Residents | F 5 | 3. 4. 5. | deficient practice does not recur inclumanagers will audit 20 residents room x 4 weeks, then 50 rooms per month to validate rooms are clean, organized like. Nursing staff and housekeeping reeducated in regards to cleaning poliproviding a home-like environment. The Director of Nursing and/or designanalyze/review for patterns/trends and the Quality Assurance committee mequarterly for a minimum of six month evaluate the effectiveness of the planadjust the plan as the committee may recommend, based on outcomes/trend from date. | ude: Unit ms per week x 2 months d, and home- will be icy and gnee will d report in setting hs to and will |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
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| | | 495142 | B. WING_ | | | 0 | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | | ET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| EVERGR | REEN HEALTH AND R | EHAB | | | IILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | ILD BE | (X5) COMPLETION OATE |
| F 584 | Continued From pa | ge 34 | F 58 | 34 | | | |
| | | ailed to assist Resident #38 and organizing their room as | | | | | |
| | 2. The facility staff failed to ensure a clean environment in Resident #105's bathroom. | | | | | | : |
| | | ailed to ensure a clean ident #47's bathroom. | | | | | |
| | The findings include | 9: | | | | | |
| | 2/18/17 with diagno | s admitted to the facility on ses that included but were not | | | | | |
| | circulation in the leg | nigh blood pressure, poor gs, diabetes and elevated ost recent MDS (minimum | | | | | |
| | (assessment refere the resident as havi | y assessment, with an ARD nce date) of 11/13/17 codeding scored a 15 out of 15 on rview for mental status) | | : | | | |
| | indicating the reside make daily decision requiring the assista | ent was cognitively intact to is. The resident was coded as ance of two staff for all | | : | | | |
| : | | ing except for eating which the orm after the tray was | | | | | |
| | 2/17/16 and readmithat included but we | admitted to the facility on tted on 3/3/18 with diagnoses are not limited to: intestinal enia, heart failure and | | | | | |
| • | diabetes. The most quarterly assessme coded the resident a | recent complete MDS, a nt, with an ARD of 2/23/18 as having scored a 15 out of | : | | | | |
| | cognitively intact to | cating the resident was make daily decisions. The as requiring supervision for | | | • | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED |
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| STATEMENT | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 2260 | 01 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORRECTIV CROSS-REFERENCEI | AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE ICIENCY) |
| F 584 | Continued From pa activities of daily livi Resident #38 and F room in the facility. | = | F 5 | 584 | |
| | An observation was of the residents' roor room, a gray bin ha stacked on top. The bags with bed pads bin. There was an it halfway under a charoom, there were twon the floor next to clothes lying on the | a made on 3/27/18 at 2:30 p.m. om. In the left corner of the d clothes and bed pads are were two opened plastic lying on the floor next to the tem grabber on the floor air. On the right side of the two books and some cards lying the dresser. There were floor next to the bed and lying over the oxygen | | | |
| | p.m. with Resident a stated that they had cleaning up and org not get assistance. Ithem to hang up my housekeeper finally Resident #38 stated the bin next to my be things, I can't get to asked what staff say assistance, Resident #95 dresser, which woul stated, "They haven week. It's supposed shower." When asked sheets to be change "They say they will be | anducted on 3/29/18 at 2:50 #38 and #95. The residents asked staff to assist them in tanizing their room but they do Resident #38 stated, "I asked a coat last Friday and the did it today." (Six days later). It is asked them to move ed so I can organize my anything by myself." When any when they request a the #38 stated, "We don't have a stated, "I asked for another dreally help." Resident #95 and to be changed after every ed if she had requested her ed, Resident #95 stated, but they don't come back." I, "They always say this is | | | |

home. Does this look like home? They won't let

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 584 Continued From page 36 F 584 me hang a calendar. I'd like to have a calendar." The walls in the residents' room was bare of any decoration. Resident #38 stated. "That reacher (on the floor) is mine but I can't pick it up. How can I use it?" An observation was conducted on 3/29/18 at 3:30 p.m. Resident #38 and #95's room with LPN (licensed practical nurse) #6. When asked what the facility was to the residents, LPN #6 stated. "Home." When asked how the resident's room looked, LPN #6 stated, "It doesn't look like home. The cluttered things should be hung up." When asked who was to assist residents in keeping their room clean, LPN #6 stated, "We are." When asked if it was acceptable to have opened plastic bags of bed pads on the floor, LPN #6 stated. "They're getting dirty. The floors are the dirtiest place." An interview was conducted on 3/29/18 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what the facility was to the residents, ASM #2 stated, "Their home." When asked if residents requested help to clean up their room would they get assistance, ASM #2 stated, "Yes." When asked if

On 3/29/18 at 6:00 p.m. ASM #1, the

opened plastic bags containing bed pads were to be on the floor, ASM #2 stated, "No." When asked why, ASM #2 stated, "Because the risk of it getting infected." When asked about residents hanging things on the walls, ASM #2 stated, "We're asking them not to. It's okay if our staff put it up." When informed of Resident #95 wanting a calendar hung up, ASM #2 did not have a response. ASM #2 was made aware of the

findings at that time.

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| STATEMEN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 495142 | B. WING | | 0.2 | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | ······································ | | STREET ADDRESS, CITY, STATE, ZI | | 7,001,2010 |
| EVERG | REEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 584 | : Continued From pa | age 37 | F 5 | 584 | | |
| | administrator, ASM ASM #7, the owner | #2, the director of nursing and were made aware of the tated, "I knew they had asked | | | | |
| | a.m. with CNA (cert When asked if oper could be left on the they can't be on the closet or on the who cross contaminated When asked what shave their room cle stated, "We are to be Resident #38's requand organized, CNA | onducted on 3/30/18 at 9:05 tified nursing assistance) #4. ned plastic bags of bed pads floor, CNA #4 stated, "Oh no, e floor. We put them in the eelchair. They can become d with whatever's on the floor. staff do, if residents ask to eaned and organized, CNA #4 help them." When asked about uest to have the room cleaned A #4 stated, "I'm not her aide that bed until we can get her blikes her things." | | | | |
| | 2. The facility staff t | failed to clean a brown bilet seat for Resident #105. | | | | |
| | 4/23/10 and readmidiagnoses that incluanemia, diabetes, has speaking and depression a quarterly assessment on the BIMS (breif indicating the resident make daily decision | admitted to the facility on itted on 6/17/13 with uded but were not limited to: nigh blood pressure, difficulty ession. The most recent MDS, nent, with an ARD of 3/5/18 as having scored 15 out of 15 nterview for mental status) ent was cognitively intact to is. The resident was coded as an assistance for all activities | | · · · · · · · · · | | |

An observation was made on 3/27/18 at 2:46 p.m.

PRINTED: 04/13/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: COMPLETEO A. BUILOING _ 495142 B. WING 03/30/2018 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) IO SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION 10 (X5) COMPLETION (EACH OFFICIENCY MUST BE PRECEOED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULO BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 584 Continued From page 38 F 584 of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat. An observation was made on 3/27/18 at 4:05 p.m. of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat An observation was made on 3/28/18 at 7:55 a.m. of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat. An observation was made on 3/28/18 at 8:05 a.m. of Resident #105's bathroom, with OSM (other staff member) #6, the housekeeper. OSM #6 stated, "Oh that needs to be cleaned up. I'll take care of it." When asked how often bathrooms are cleaned, OSM #6 stated, "Everyday and as needed." When asked how she was made aware that a toilet needed to be cleaned, OSM #6

findings.

stated, "The staff should call us or if we see it

administrator, ASM #2, the director of nursing and ASM #7, the owner were made aware of the

when we make our rounds."

On 3/29/18 at 6:00 p.m. ASM #1, the

| | | TAND HOWAN SERVICES | | | | | M APPROVED |
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| | | E & MEDICAID SERVICES | | | | | <u> 0938-0391</u> |
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILC | | CONSTRUCTION | | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | à | | 0: | C 3/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | <u> </u> | STR | REET ADDRESS, CITY, STATE, ZIP CODE | 1 | 1/30/2010 |
| | REEN HEALTH AND R | | · | 380 | MILLWOOD AVENUE NCHESTER, VA 22601 | | <u></u> _ |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX : | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 584 | Continued From pa | age 39 | : : F ! | 584 | | | |
| | | onducted on 3/30/18 at 9:02 | | | | | |
| | | tified nursing assistant) #4, the | | : | | | |
| | resident's aide. Wh | nen asked what staff did if the | | | | | |
| | resident's bathroon | n needed cleaning; CNA#4 | | i | | | • |
| į | | n the wing I'll go up to the | | : | | | |
| - ! | | et them know. They can't do | | | | | |
| : | | clean it up and they sanitize | | : | | | |
| : | | hat staff would do if the | | | | | |
| | | at was soiled, CNA #4 stated, "I | | * | | | |
| į. | | Sani wipes. If I am here I | | | | | |
| | | eck my residents' rooms." | | | | | |
| | | the observations in Resident | | | | | • |
| | | CNA #4 stated, "Not all CNAs | | 1 | | | : |
| | | " When asked why staff | | | | | |
| : | | CNA #4 stated, "Because it | | | | | |
| | | It's very important for us to hey're not stinking. They need | | | | | |
| | | resident and family members | | | | | : |
| | Review of the facili | ity's policy titled, "DAILY WORK | | | | | |
| : | ROUTINE - LIGHT | | | | | | |
| | documented, "705a | | | | | | |
| | | fy and fix; spills, odors, debris, | | | | | |
| | | I soap supplies resident rooms, | | | | | |
| | | g areas. 2:00 PM Lunch | | | | | |
| | | fy and fix; spills, odors, debris, | | | | | |
| | | ent rooms, bathrooms, nursing | | | | | |
| | | m all nursing areas." | | | | | |
| | No further informat | tion was provided prior to exit. | | | | | |
| | | failed to ensure a clean | | | | | |
| | | sident #47's bathroom. | | | | | • |
| • | Dacidest #47 | Constants Constants | | | | | |
| | | admitted to the facility on | | | | | 1 |
| | | oses that included but were not | : | | | | |
| | | isorder, Alzheimer's disease, | | | | | |
| | | itia without behavioral | | | | | |
| | -oisiuinance nion m | anno pressure muscie | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
|--------------------------|--|--|-----------------------|-----|---|---------|----------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | (X3) D. | ATE SURVEY DMPLETED C |
| | | 495142 | B. WING | | <u> </u> | 0 | 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERG | REEN HEALTH AND R | EHAB | | | 0 MILLWOOD AVENUE INCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | ζ ! | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPR CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 584 | Resident #47's mos set) assessment wa ARD (assessment i | or depressive disorder. of recent MDS (minimum data as annual assessment with an reference date) of 1/1/18. | F 5 | 84 | | | |
| | impaired in the abili scoring 03 out of 15 for Mental Status) of coded as requiring | coded as severely cognitively ity to make daily decision on the BIMS (Brief Interview exam. Resident #47 was extensive assistance from two th most ADLS (activities of | : | | | | |
| | #47's bathroom was | p.m., observation of Resident s conducted. A brown ing feces was observed dried or. | | | | | |
| | | a.m., observation of Resident s conducted. The brown d on the floor. | | | | | ; ; ; |
| | conducted with CNA #5. When asked he residents, CNA #5 s | a.m., an interview was A (certified nursing assistant) ow often CNA's round on their stated she was not sure | | | | | ! : |
| | stated she passes of stated that when CI should be checking rooms. CNA#5 stat | ot technically a CNA. CNA #5 but water, snacks etc. CNA #5 NAs first get onto the unit they their residents and the ted checking the rooms | | | | | |
| | also check the room asked if she had be that morning, CNA asked if she had ch bathroom, CNA #5 | oms. CNA #5 stated she will ns for cleanliness. When the sen in Resident #47's room with the stated that she had. When the secked Resident #47's stated she had not. CNA #5 writer to Resident #47's | | | | | |

bathroom. When CNA #5 was asked what she saw on the bathroom floor, CNA #5 confirmed

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | 0 | | 1APPROVED 0.0938-0391 |
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| TATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | PLE CONSTRUCTION | (X3) DAT COM | TE SURVEY MPLETED |
| | | 495142 | B. WING | ; | | 1 | C / 30/20 18 |
| NAME OF | PROVIDER OR SUPPLIER | | | Γ | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| EVERGR | REEN HEALTH AND RI | ЕНАВ | | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | could not identify what she uses a lift to go no reason why that she was implying the feces, CNA #5 states. On 3/28/18 at 7:46 conducted with LPN Resident #47's nurse first starts her rounds attended that first she rounds, looking at reasked who was respresident's bathroom stated, "We are all reaccompanied this we bathroom. LPN #1 brown substance or identify what the sult that she had not yet LPN #1 stated she was respected." | substance on the floor but that it was. CNA #5 stated, go to the bathroom, so there is is on the floor." When asked if he brown substance was ed, "It better not be." a.m., an interview was N (licensed practical nurse) #1, se. When asked when she ding in the morning, LPN #1 ewill get report, and then do residents and rooms. When sponsible for checking the his for cleanliness, LPN #1 responsible." LPN #1 vriter to Resident #47's confirmed that there was a n the floor. LPN #1 could not obstance was. LPN #1 stated it been in Resident #47's room. was not sure how often ided on the unit. LPN #1 | F | 58 | 4 | | |
| | conducted with LPN cleaned the brown seems. Resident #47's bath and then told house her. When asked if was a clean environ | a.m., further interview was N #1. When asked who substance off the floor of proom, LPN #1 stated she did, ekeeping to sanitize behind f Resident #47's bathroom ment, LPN #1 stated, "No I a clean environment." | | | | | |
| 4 : : : : : : : : : : : : : : : : : : : | conducted with OSM Director of Houseke housekeeping sche | a.m., an interview was M (other staff member) #9, the eeping. When asked the edule, OSM #9 stated that her in the morning until breakfast | : | | | | : |

| | | & MEDICAID SERVICES | | | | | 1 APPROVED 1. 0938-0391 | |
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| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | COMPLETED | | |
| | | 495142 | B. WING | | | 03/30/2018 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | _ | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | TILLWOOD AVENUE CHESTER, VA 22601 | | | |
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| F 584 | staff will clean office stated when the tra will go back to clear what cleaning entail will sweep, and mo bathrooms, dust an stated her staff will throughout the day trash, things on the staff leave at 3 p.m will call/alert them it that on the bathrootypically nursing stated then housekee and sanitize. OSM alerted in order for sanitize. OSM #9 stated her the brown substant | e floor. During breakfast, her es and the lobby. OSM #9 ys are off the floor; her staff ning the rooms. What asked led, OSM #9 stated her staff p both the floors, including the id collect trash. OSM #9 make several rounds and check the rooms for floor. etc. OSM #9 stated her. When asked if nursing staff f there is feces or anything like in floor, OSM #9 stated aff clean up any bodily fluids ping will come behind them #9 stated they have to be them to know which room to stated she has a floor tech that D p.m. that can sanitize rooms. staff were not made aware of the in Resident #47's bathroom. | | 584 | | | | |
| | staff member) #1, t DON (director of no owner were made a Transfer and Disch CFR(s): 483.15(c)(§483.15(c) Transfe §483.15(c)(1) Facil (i) The facility must remain in the facility discharge the resid (A) The transfer or | 1)(i)(ii)(2)(i)-(iii) r and discharge- | Fé | 622 1. | F622 Corrective action has been accomalleged deficient practice in regarway, 74, and 97. The NP has documentries for the residents noted related reason for the transfer and the reason son to manageable in this facility. | ds to resider nented late ated to the son their can | nts | |

| | | & MEDICAID SERVICES | | | | FORM APPROVED OMB NO. 0938-0391 |
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| NAME OF | PROVIDER OR SUPPLIER | | · | STREE | TADDRESS, CITY, STATE, ZIP CODE | |
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| EVENGE | REEN HEALTH AND R | EHAB | | WINC | HESTER, VA 22601 | |
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| | because the resider sufficiently so the reservices provided by (C) The safety of interest and the endangered due to status of the resider (D) The health of in otherwise be endand (E) The resident has appropriate notice, under Medicare or Information of the endangered due to status of the resident has appropriate notice, under Medicare or Information of the endicare or Medicare in the facility resident while the appropriate in the facility in the facility. The facility in that failure to transfer in the Medicare in the facility in the facility in the facility in that failure to transfer in the facility in the facili | e facility; discharge is appropriate int's health has improved esident no longer needs the by the facility; dividuals in the facility is the clinical or behavioral int; dividuals in the facility would gered; is failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. Is if the resident does not ry paperwork for third party interpretation of the party interpretation of the facility is the facility may charge a ble charges under Medicaid; es to operate. Interpretation of the facility pursuant to apter, when a resident right to appeal a transfer or inthe facility pursuant to § is chapter, unless the failure to ir would endanger the health dent or other individuals in the must document the danger er or discharge would pose. | | 3. 4. 5. | be affected by the alleged deficied Moving forward, the NP on call the facility will give a verbal ord appropriate, then remotely write resident. A 100% audit of reside the hospital will be completed st and ending on 3/31/18, then 100 reported at risk meeting x 3 mon Measures put into place to assure deficient practice does not recur Medical Director will in-service procedure. The Director of Nursing and/or analyze/review for patterns/trend the Quality Assurance committed quarterly for a minimum of six in evaluate the effectiveness of the adjust the plan as the committee recommend, based on outcomes/identified from date. | ent practice. or covering for der, if a note on the nt transferred to arting on 3/1/18 % weekly and ths. e alleged include: NP's on designee will des and report in the meeting nonths to plan and will may trends |

| | | HAIND HUIVIAIN SERVICES | | | | 0. | FORM APP | |
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| | | & MEDICAID SERVICES | | | | <u>Or</u> | <u>//B NO. 09</u> | <u> 38-0391</u> |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | JLTIPLE CO | ONSTRUCTION | | (X3) DATE SU COMPLE | |
| | | 495142 | B. WING | 3 | | _ | C 03/30/ 2 | 2018 |
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| EVERGR | REEN HEALTH AND R | EHAB | | 380 M | IILLWOOD AVENUE CHESTER, VA 2260 | , | | |
| | DI 18 48 45 DV 0.74 | TELEPIT OF DESIGNATIONS | | | | | | · |
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| F 622 | Continued From pa | ae 44 | F | 622 | | | : | |
| | | must ensure that the transfe | | ULL | | | | |
| | | umented in the resident's | | 1 | | | : | |
| | | appropriate information is | | : | | | : | |
| | | ne receiving health care | | | | | | |
| | institution or provide | | | | | | : | |
| | | n the resident's medical reco | rd | | | | | |
| | must include: | | | | | | : | |
| | (A) The basis for th | e transfer per paragraph (c)(| 1) | 4 | | | | |
| : | (i) of this section. | | | | | | | |
| | (B) In the case of page | aragraph (c)(1)(i)(A) of this | | | | | | |
| | section, the specific | resident need(s) that canno | ot | | | | | |
| | be met, facility attempts to meet the resident | | | | | | | |
| | | vice available at the receiving | 3 | | | | : | |
| | facility to meet the r | | | | | | | |
| : | | tion required by paragraph (c | :) | | | | | |
| | (2)(i) of this section | | | | | | | |
| | | physician when transfer or | | | | | | |
| : | | sary under paragraph (c) (1) | | | | | | |
| | (A) or (B) of this sec | ction, and en transfer or discharge is | | | | | | |
| | | aragraph (c)(1)(i)(C) or (D) of | : | | | | | |
| | this section. | | | | | | | |
| | | vided to the receiving provide | er | | | | | |
| | | mum of the following: | | | | | | |
| : | | tion of the practitioner | | | | | | |
| | responsible for the | | | | | | | |
| | | sentative information includin | g | | | | | |
| | contact information (C) Advance Directi | | | | | | | |
| | | | | | | | | |
| : | ongoing care, as ap | uctions or precautions for | | | | | | |
| : | (E) Comprehensive | • | | | | | | |
| i | | sary information, including a | | | | | : | |
| : | | t's discharge summary, | | ; | | | | |
| | | 3.21(c)(2) as applicable, and | | | | | | |
| | | tation, as applicable, to ensu | | | | | | |
| | a safe and effective | | | | | | | |
| | | NT is not met as evidenced | | | | | | |
| : | by: | IS not mot as evidenced | | i | | | | |
| RM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: QP4 | 4M11 | Facility If | D: VA0218 | If continuation | sheet Page | 45 of 328 |
| 2 _0 | , , | E CONTROL ON | | | | n continuation | aneer raye | 70 01 320 |

DELAKTIMENT OF DEALTH AND DOMAN SEKVICES

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | 0 | FORM API MB NO. 09 | |
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| | | 495142 | B. WING | | | | 03/30/2 | 2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 M | T ADDRESS, CITY, STATE, ILLWOOD AVENUE CHESTER, VA 22601 | ZIP CODE | 1 00,00, | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD THE APPROPI | BE CO | (X5) PMPLETION OATE |
| | and clinical record record record record record residents staff failed physician document when three of 31 record record residents staff failed physician. 1. Resident staff a was the hospital. 1. Resident staff a was the hospital on 3/17 to evidence any docregarding the reason rationale for how the manage the resident staff and staf | rview, facility document review review, it was determined that and to provide evidence of tation in the clinical record sidents in the survey sample; and #97, were transferred to transferred and admitted to the transferred and admitted to the transfer, and the facility was not able to a transferred and admitted to the transfer, and the facility was not able to a transferred and admitted to the transferred and the transferred to evidence any in an ontes regarding the fer, and rationale for how the to manage the resident's transferred to hospital for the transferred in the clinical reason for the transfers and not able to manage the | F 6 | 522 | BLIMEN | | | |
| | the hospital on 3/17 to evidence any dooregarding the reaso | transferred and admitted to /18. The clinical record, failed cumented physician notes n for the transfer, and e facility was not able to | | | | | i | |
| M CMC 25 | 37(02-99) Previous Versions | Obsolete Event ID: OP4M1 | | E:1910 | | 16 12 12 . | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-0391 |
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| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| EVERGE | REEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
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| F 622 | Continued From pa | ge 46 | F 6 | 22 | |
| | 9/10/16 with the dia atrial fibrillation, mo disease, systemic it syndrome, bladder heart disease, schizdisease, diabetes, bipolar disorder. The (Minimum Data Set with an ARD (Asses 3/14/18. The reside cognitively intact in decisions. The residence for bathing dressing, toileting, a for eating; and as in having an indwelling. A review of the clinic following nurse's not a sident stated that there is nothing Resident continues pain and discomforme, he uses his bla | olled self out into nursing ns of) all over body pain. t Tylenol [1] does not help and that the staff can do for him. to blame "Trump" for all over stating, "he is trying to hurt ck box to hurt my head and BP (blood pressure) was | | | |

(temperature) 98.1, R (Respirations) 22. Pain of 10/10 (ten out of ten on a zero to ten scale) all throughout. Pupils were not equal, Left [sic] greater than Right [sic], both do constrict with light but Right [sic] more than Left [sic]. (ASM #8)

(Administrative Staff Member, the Nurse Practitioner) contacted at 1938 (7:38PM) and agreed to send resident out for further eval

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | C | | APPROVED 0, 0938-0391 |
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| F 622 | Continued From pa | | E 6 | 500 | | | |
| 1 022 | (evaluation). Wife of 911 contacted 2000 | contacted at 1941 (7:41PM). 0 (8:00PM). Arrived at 2005 eft with resident. Will contact | F0 | 322 | | | |
| | reveal a note by the the reason for the tr | ne clinical record failed to e facility physician regarding transfer and rationale for why ition could not be managed at | | | | | |
| | #5 (a Nurse Practiti the hospital, she sta building, she will se note. If it is after ho facility calls her, she she did not see the | p.m., in an interview with ASM ioner), regarding transfers to ated that if she is in the ee the resident and write a curs, she is at home, and the e will not write a note because resident. ASM #5 stated that all make quick note about it." | : | | | | |
| | Procedures Regard to reveal any criteria note describing why | lity policy "Policy and ding Physician Services" failed a for the physician to write a y a resident was transferred to by the resident's condition ged at the facility. | | | | | |
| | the Administrator, A Member) #1, Direct the facility owner (A | PM at the end of day meeting, ASM (Administrative Staff etor of Nursing (ASM #2), and ASM #7) were made aware of orther information was provided Urvey. | : | | | | : |
| | Information obtained | o treat mild to moderate pain. d from .gov/druginfo/meds/a681004.h | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | 1APPROVED 0.0938-0391 |
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| F 622 | Continued From pa | ge 48 | F 6 | 22 | | |
| | the hospital on 3/22 The clinical record, documented physic reason for the trans facility was not able condition. Resident #74 was a 8/26/13 with the dia stroke, intestinal dis encephalopathy, de disorder, dysphagia cataracts, presbyop schizophrenia, bipo high blood pressure obstructive pulmons MDS (Minimum Da assessment with ar Reference Date) of coded as severely of make daily life decis coded as requiring dressing, and hygie and as incontinent of | s transferred and admitted to 2/18, 12/24/17, and 12/8/17. failed to evidence any ian notes regarding the afer, and rationale for how the sto manage the resident's admitted to the facility on gnoses of but not limited to sease, depression, metabolic amentia, schizoaffective a, gastrostomy feeding tube, bia, Parkinson's disease, lar disorder, angina, diabetes, a, hypothyroidism, and chronic ary disease. The most recent ta Set) was a quarterly a ARD (Assessment 2/16/18. The resident was cognitively impaired in ability to sions. The resident was total care for transfers, ne; extensive care for eating; of bowel and bladder. | | | | |
| | following nurse's not - 3:00PM: "Reside pressure) 138/68 P (temperature), R (re @ (at) 83% BP [sic] (Administrative Staf | nt is Lethargic BP (blood (pulse) 86, 97.9 espirations) 18, O2 (oxygen) 282. New Order (ASM #5) f Member, a Nurse | | | | |
| ! | mask. V.O. (verbal | D2@2L (oxygen at 2 liters) via order) (ASM #5) send to ER for evaluation for Hypoxia. | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | M APPROV E D D. 0938-0391 |
|--------------------------|--|---|----------------------|---|----------|-------------------------------------|
| TATEMENT | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DA | TE SURVEY |
| | | 495142 | B. WING | | 0: | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 622 | arrived at facility @ |) notified @ 1455 (2:55PM) 1505 (3:05PM) report given to | F6 | 22 | | |
| | 1515 (3:15PM). Re (emergency medica with daughter [siccalled to ER (emergency medical) | al technician). Daughter went mother] to (hospital). Report gency room) @1530 (3:30PM)). Daughter agreed to bed | | | | |
| | reveal a note by the the reason for the t | ne clinical record failed to e facility physician regarding ransfer and a rationale for why ition could not be managed at | | | | |
| : | | cal record revealed the otes dated 12/24/17: | | | | |
| | upon arrival onto sh was asking questio for the past couple nurse had just com yesterday and thing didn't really want to self. Daughter ther swallow that was do went. Advised that had one done but well. Family agreed she would pass as mashed potatoes a resident is listed as admitted to feeding | urse went in to visit resident nift. Family was present and ns about residents behaviors of days. Advised that this e on but had resident is seemed fine. Advised she talk but seemed her normal nasked about the cookie one and wanted to know how it this nurse did not realize she youldn't be surprised if it went d and then stated that they feel they have recently brought in and gravy. Family aware that NPO (nothing by mouth) but it to her and stating that she practitioner) and assigned | | | | |

- 4:04PM: Temp 100.3 tympanic pulse 72 R

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | 10 | | APPROVED . 0938-0391 |
|--------------------------|--|---|----------------------|---|----------------------------|-----------------|----------------------------|
| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DAT COM | E SURVEY IPLETED |
| | | 495142 | B. WING | | | | 30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | IP CODE | · · · · | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD THE APPROPE | BE | (X5) COMPLETION DATE |
| | sounds) positive. Lyelling out and hittir hand when I was as denies pain or discoshe didn't feel well. concerned about the appear red and slig NP telephoned." - 4:22PM: (ASM # (wasn't on call) but (gram) IM (intramus wants her mometogiven. - 6:13PM: Informe she wants her mometogiven. - 10:13PM: Resident letting EMTS take her mometogiven. - 10:17PM: (Hospin resident. Admitted parotitis. (salivary grants) | Jonlabored. BS (bowel ungs clear, Resident was ing this nurse with her right is sessing her lungs. Resident omfort. Asked three times if Daughter here and is e left side of her neck which hitly swollen. Warm to touch. 5) telephoned (hospital) back. ordered Rocephin [1] 1 gm scular) now and if daughter go to hospital later on order is did daughter that NP stated if it to go to the hospital then she gave consent for her to go. telephoned. Necessary did. Resident is alert and me with gentle coaxing by edside. Resident answers opropriately. HOB (Head of Its arrived, all paperwork given its somewhat non compliant with her vitals going to hit them, but sful after several attempts. Out of Facility x2 EMTS and Idaughter following to tall) telephoned on update of to step down with diagnosis of land). | | 322 | | | |
| | reveal a note by the | e clinical record failed to facility physician regarding ransfer and rationale for why | | | | | |

| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
|--------------------------|---|---|----------------------|------------|---|---------|---------------------------------------|
| TATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DA | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | з | | 0 | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND R | (EHAB | · | | 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | LDBE | (X5) COMPLETION DATE |
| F 622 | Continued From pa | age 51 | F | 622 | | | |
| • - | | lition could not be managed at | | <i>322</i> | | | · · · · · · · · · · · · · · · · · · · |
| : | A review of the clini following nurse's no | otes dated 12/8/17: | | | | | |
| | (Administrative State Practitioner) to send evaluation due to vostaff reported no vovSS (vital signs state) Daughter aware of (at) 1504 (3:04PM) (3:10PM). Resident two spheres). | rerbal order) (ASM #8) aff Member, a Nurse and resident to (hospital) for romiting and nausea x2 days. comiting or nausea this shift. able). Afebrile at this time. It transfer to ER. 911 notified @ and arrived to facility @ 1510 ant A&Ox2 (alert and oriented to | | | | | |
| : | | tal) notified 2 [sic] 1520 in route to ER for evaluation. ospital staff). | | : | | | |
| : | Resident admitted t | e with (hospital) with nurse. to room (room number) with Colonic Mass. Notified (ASM nation." | | | | | |
| | reveal a note by the the reason for the ti | he clinical record failed to e facility physician regarding transfer and why the resident's t be managed at the facility. | | | | | |
| | #5 (a Nurse Practiti the hospital, she state building, she will se note. If it is after he facility calls her, she she did not see the | p.m., in an interview with ASM tioner), regarding transfers to tated that if she is in the ee the resident and write a ours, she is at home, and the le will not write a note because e resident. ASM #5 stated that all make quick note about it." | | | | | |

| | | AND HUMAN SERVICES | | | | | M APPROVED |
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| | · | & MEDICAID SERVICES | | | (| | <u> 0938-0391</u> |
| | OF OEFICIENCIES OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) OA CO | TE SURVEY |
| | | 495142 | B. WING | i | | ₀ , | C 3/30/2018 |
| NAME OF I | PROVIOER OR SUPPLIER | L | ! | STRE | EET AOORESS, CITY, STATE, ZIP COOE | 1 0 | 0/30/2010 |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | 380 | MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) IO PREFIX TAG | (EACH OEFICIENCY | TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION) | IO PREF TAG | | PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROPRIED OFFICIENCY) | O BE | (X5) COMPLETION DATE |
| F 622 | Continued From pa | ge 52 | F | 522 | | | : |
| | Procedures Regard to reveal any criteria note describing why the hospital and who could not be manage On 3/29/18 at 6:058 the Administrator As | ity policy "Policy and ling Physician Services" failed a for the physician to write a a ransferred to y the resident was transferred to y the resident's condition ged at the facility. PM at the end of day meeting, SM (Administrative Staff or of Nursing (ASM #2), and | | | | | |
| | the facility owner (A | SM #7) were made aware of their information was provided | | | | | |
| | [1] Rocephin is an a Information obtaine https://medlineplus. tml | | | | | | |
| | on 2/2/18 and 2/28/ ensure the physicia record to justify the | es transferred to hospital for 18. The facility staff failed in documented in the clinical reason for the transfers and not able to manage the | | | | | |
| | 11/19/17, with a mo 3/15/18 with diagno limited to: bladder in blood pressure), madifficulty sleeping, a The most recent ML assessment, a Med with an assessment | admitted to the facility on st recent readmission on ses that included but were not affections, hypotension (too low alnutrition, depression, sthma, and has a colostomy. OS (minimum data set) icare 14 day assessment, a reference date of 2/27/18, as scoring a 15 on the BIMS | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | ſ | | APPROVED 0.0938-0391 |
|---|--|---|----------------------|--|----------|----------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | ULTIPLE CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | | 495142 | B. WING | 3 | | / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERG | REEN HEALTH AND RI | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTIVE ACTION SHOUL | D BE | (X5) COMPLETION OATE |
| F 622 | she was capable of The resident was concerns. New ord (emergency room) services) called and aware. 911 left arrival am. (Daughter's but will call later after for her mother." | mental status) score, indicating f making her daily decisions. oded as requiring limited to be for her activities of daily revealed a nurse's note dated, at that documented in part, plained of) dizzy feeling this blood pressure) obtained noted urse practitioner) aware new odrine (used to elevate blood (milligrams) now and then quirdered 1 liter of d5 (dextrose of the pressure) placed to left to infuse resident c/o left the pressure. B/P 76/50 at this bied sob (shortness of breath) not had this pain before and spital. NP aware of new ler noted to send to er 11 (emergency medical daughter (name of daughter) ved assessed and left around name) is aware of bed hold er she knows what the plan is all record did not reveal a note the nurse practitioner of her on 2/2/18 or a note related to as transferred to the hospital | F | 622 | | |
| : | needs. The clinical record of dated, 2/28/18 at 10 | documented a nurse's note 0:13 a.m. "At Approximately nt #97)'s CNA (certified | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | RM APPROVED IO. 0938-0391 |
|--------------------------|--|--|----------------------|-----|---|--------|------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) E | DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | | (| 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGE | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 622 | (Resident #97) 'Yell This nurse immedia and noted that she SOB (shortness of pressure was 56/48 immediately elevate notified. NP assess this nurse to send to 911 for eval (evalua symptomatic hypote second nurse and vapproximately 10:14 and noted her blood continued symptom to keep eyes open and answering quesaccordingly/approprof transfer to ED we (temperature), 75 (I (blood pressure) 95 on room air). (Resiper resident requesting the clinic note by the nurse per some some some side of the clinic note by the nurse per some some some some some some some some | notified this nurse that ing for a nurse and crying.' ately assessed (Resident #97) was pale and clammy with breath) at rest. Blood B. (Resident #97)'s legs were ad and NP (nurse practitioner) sed (Resident #97) and order to ED (emergency department) ation) and tx (treatment) due to the ension. BP was taken by was noted to be 70/42. At DO AM, rescue squad arrived dipressure to be 72/42 with the ensions (Resident #97) was unable but was responding verbally stions riately. VS (vital signs) at time the ension at the ensions of t | F6 | 522 | | | |
| | staff member (ASM 3/29/18 at 1:20 p.m note when a resider hospital, ASM #5 st do. If it's after hour the medical director that it would be a go | nospital. onducted with administrative l) #5, the nurse practitioner, on . When asked if she writes a nt is transferred to the ated, "If I am in building, yes I s, I usually don't. (ASM #6) r and I spoke yesterday and bod idea to write a note as to whoever gets the call." | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
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| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | NSTRUCTION | (X3) D. | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | | | 0 | C 3/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODI | = - | |
| EVERGR | EEN HEALTH AND R | EHAB | | | ILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | C | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 622 | ASM #2, and ASM | ge 55 ASM #1, director of nursing #7, the owner were made findings on 3/29/18 at 6:10 | F 6 | 22 ⁻ | | | |
| | (1) This information following website: https://www.ncbi.nlr T0011219/?report=Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care Or (ii) Record the reasdischarge in the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative of the Long-Term Care Or (iii) Record the reasdischarge in the resident representative | ts Before Transfer/Discharge 3)-(6)(8) the before transfer. Insfers or discharges a mustinate and the resident's fithe transfer or discharge and move in writing and in a mer they understand. The copy of the notice to a the Office of the State mbudsman. The constant of the State mbudsman. The copy of the transfer or sident's medical record in tragraph (c)(2) of this section; The copy of the items described in this section. | F 6 | 23 1. 2. 3. | alleged deficient practice in regresidents #66, 57, 73, 130, 3, 74. These residents have returned to Current facility residents have the affected by the alleged deficient Service worker will do a 100% transferred residents starting on r/t the transfer/discharge notificant assuring the resident or the residents representative is given the information of the done daily x 3 months. | ards to 4, 95, 99, and be the facility the potential a practice. So audit of 4/1/18 to 4/ ation sheet, lent's mation, then e alleged include: So ted to notify tive of transf facility. designee will ds and report ttee meeting nonths to plan and will | to be ocial 15/18 will cial the fer |
| : | resident is transferr | at least 30 days before the ed or discharged. made as soon as practicable | | 5. | recommend, based on outcomes/ from date. Completion Date: May 11, 2018. | | ified |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | C | | APPROVED . 0938-0391 |
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| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DAT | TE SURVEY MPLETED | |
| | | 495142 | B. WING | | | | /3 0/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | · | STF | REET ADDRESS, CITY, STATE, ZIP CODE | , | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| | be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's hallow a more imme under paragraph (c) (D) An immediate the required by the resident has required by the resident has required by the resident has reduced by the resident has re | ischarge when- dividuals in the facility would ler paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of mealth improves sufficiently to diate transfer or discharge, (1)(i)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs, (1)(i)(A) of this section; or not resided in the facility for 30 dents of the notice. The written paragraph (c)(3) of this section llowing: ransfer or discharge; the of transfer or discharge; which the resident is parged; the resident's appeal rights, address (mailing and email), ber of the entity which easts; and information on how form and assistance in and submitting the appeal dess (mailing and email) and of the Office of the State mbudsman; lity residents with intellectual disabilities or related ing and email address and of the agency responsible for | F 6 | 523 | | | |
| | | advocacy of individuals with | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | 0 | | APPROVED |
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| TATEMENT | T OF OEFICIENCIES OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | 1'' | | PLE CONSTRUCTION | (X3) DAT | . 0938-0391 E SURVEY IPLETEO |
| | | 495142 | A. BUILO | | 3 | (| С |
| NAME OF I | PROVIOER OR SUPPLIER | <u> </u> | | .= | STREET AOORESS, CITY, STATE, ZIP COOE | USI | 30/2018 |
| | | | J | | 380 MILLWOOD AVENUE | | |
| EVERGR | REEN HEALTH AND RI | EHAB | | | WINCHESTER, VA 22601 | | |
| (X4) IO PREFIX TAG | (EACH OEFICIENCY | ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION) | IO PREFI TAG | -IX | PROVIOER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | Continued From pa | age 57 | : F1 | 623 | . ! 3 : | | |
| • | • | abilities established under Part | | ع کے ک | | | |
| | | ental Disabilities Assistance | 1 | | | | |
| | | act of 2000 (Pub. L. 106-402, | | | | | |
| | | C. 15001 et seq.); and | | | | | |
| : | | cility residents with a mental | | | | | : |
| | disorder or related of | disabilities, the mailing and | ; | | | | |
| | email address and t | telephone number of the | | | | | |
| | | e for the protection and | | | | | • |
| : | | luals with a mental disorder | | | • | | |
| : | | the Protection and Advocacy | | | | | |
| | for Mentally III Indivi | iduals Act. | | | | | |
| | 9499 4E(a\(G\) Char | t- the method | : | | • | | |
| | §483.15(c)(6) Chan | nges to the notice. If the notice changes prior to | : | | | | • |
| | | er or discharge, the facility | | | | | |
| : | | cipients of the notice as soon | : | | | | • |
| i | | e the updated information | • | | | | • |
| | becomes available. | | | | | | |
| | | | | | | | |
| : | | ce in advance of facility closure | | | | | |
| | In the case of facility | ty closure, the individual who is | | | | | |
| | | f the facility must provide | | | | | • |
| : | | prior to the impending closure | | | | | : : |
| | | Agency, the Office of the | | | | | • |
| | _ | Care Ombudsman, residents of | | | | | : |
| | | resident representatives, as | | | | | : |
| | | the transfer and adequate sidents, as required at § | | | | | |
| | 483.70(I). | sidents, as required at 3 | | | | | |
| | ` ' | NT is not met as evidenced | | | | | |
| | by: | The field of the state of the s | | | | | |
| | | erview, and clinical record | | | | | : |
| | | mined that the facility staff | | | : | | : |
| | failed to provide the | e required written notifications | | | | | 1 |
| | | ility initiated transfer for 9 of 31 | | | | | • |
| | | vey sample, Resident #66, | | | | | |
| | #57, #73, #130, #3, | , #74, #95, #99 and #97. | | | | | · : |
| | 1. Resident #66 wa | s discharged to the hospital | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED D. 0938-0391 | |
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| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILC | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
| | | 495142 | B. WING | i | | 0: | 3/30/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | · | STR | EET ADDRESS, CITY, STATE, ZIP CODE | • | | |
| EVERGR | EEN HEALTH AND RI | EHAB | | | MILLWOOD AVENUE ICHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDSHOUND THE APPROPRICED TO T | JLD BE | (X5) COMPLETION DATE | |
| F 623 | written notification of discharge to the resident #57 was on 1/16/18. The fact written notification of discharge to the resident #73 was on 1/15/18. The fact written notification of discharge to the resident #130 di 1/26/18. The facility notification of the fact resident #3 was the hospital on 3/17 provide written notification the fact the hospital on 3/22 The facility did not put fact the responsible part transfer. | sillity staff failed to provide of the facility initiated sident's representative. Is discharged to the hospital sillity staff failed to provide of the facility initiated sident's representative. Is discharged to the hospital sillity staff failed to provide of the facility initiated sident's representative. Is discharged to the hospital on the facility initiated sident's representative. Is charged to the hospital on the stative of the facility initiated discharge to the facility initiated admitted to facility in the facility did not facility for the transfer. Is transferred and admitted to facility 12/24/17, and 12/8/17. The facility into the reason for the failed to provide a written dent #95 or the resident's facility initiated emergency | . F | 623 | | | | |
| | 8. The facility staff f notification to Resid | ailed to provide a written lent #99's representative for a ergency room transfer on | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | | A MEDICALD SERVICES | | | | | |
|--------------------------|---|--|------------------------------|---|---|----------------------------|--|
| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO | <u> </u> | |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DA | MPLETED | |
| | | 495142 | B. WING | | n: | | |
| NAME OF | PROVIDER OR SUPPLIER | | s- | FREET ADDRESS, CITY, STATE, ZIP CO | CORRECTION (X5) ON SHOULD BE COMPLE HE APPROPRIATE DATE | 5/00/2010 | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | 38 | 80 MILLWOOD AVENUE /INCHESTER, VA 22601 | ENUE | | |
| (X4) IO PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIOER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 623 | Continued From pa | age 59 | F 623 | | | | |
| ; | documentation that representative were | failed to provide written Resident 97 or the resident's notified in writing when she the hospital on 2/2/18 and | | | | | |
| | The findings include | e: | | | | : | |
| | 4/19/17 and readm that included but we dementia without be failure, gout, major blood pressure and #66's most recent in a quarterly assess (assessment references Resident #66 was dimpaired in the abil | ence date) of 2/13/18. coded as severely cognitively ity to make daily decisions on the BIMS (Brief Interview | | | | | |
| | that she went to the following note was a.m.) resident sittin resident (sic) leaning up. staff (sic) direct started going to reslean forward and fe nurse and CNA (certification) (Name of CNA) to rand able to speak cand answers questi | t #66's clinical record reveled to hospital on 2/27/18. The documented, "0450 (4:50 g in chair in common area. In graph of the forward to pick something the desident to sit back and ident. resident (continued) to all face first onto floor. this (sic) ortified nursing assistant) resident. resident (sic) alert the follow (sic) instructions ons appropriately. PERRLA and, Reactive to light), and the enied (sic) | | | | | |
| | headache/nausea/d | lizziness. resident (sic) face at time of fall, residents | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | RM APPROVED NO. 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|---------|------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | | CONSTRUCTION | | DATE SURVEY COMPLETED |
| | | 495142 | B. WING | · | · | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION OATE |
| F 623 | large (sic) laceratio (sic) amounts of blomotion) performed (sic) denied that ne Tylenol (1). resider current position. sitt (sic) and kling (sic) (Name of NP (nurse above information. (Name of ED (emer (evaluation) and tre son both RP (respomessages (sic) left. Further review of th RP was notified of the evidence that the rewriting of the reason of | onto forehead during fall. In noted to forehead, copious on onted. ROM (range of with minimal difficulty, resident ed for PRN (as needed) at (sic) refusing to lay in ting (sic) up on floor, gauze wrap applied to forehead, expractitioner)) notified of order (sic) obtained to send to regency department)) for evaluat, resident (sic) husband and insible party) to be contacted. The enursing notes revealed the he transfer. There was not exponsible party was notified in for transfer to the hospital. The p.m., an interview was at (licensed practical nurse) #6, the notifies the family of a the emergency room or ated the family is always N #6 stated the nurses do not fication to the responsible the reason for transfer. The p.m., ASM (administrative the administrator, ASM #2, the raing) and ASM #7, the facility ware of the above concerns, the provided regarding the further information was | F | 523 | | | |

(1) Tylenol Tablet 325 mg (Acetaminophen) treats minor aches and pains and also reduces fever.

| | | & MEDICAID SERVICES | | | | | M APPROVED |
|--------------------------|-----------------------------------|---|-------------------|------|--|-------|----------------------------|
| | | | | | | | <u>). 0938-0391</u> |
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | CONSTRUCTION | | TE SURVEY |
| | | 495142 | B. WING | i | | 0; | C 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | EUAB | | 380 | MILLWOOD AVENUE | | |
| EVERGR | REEN HEALTH AND R | <u> </u> | | WIN | ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION OATE |
| F 623 | Continued From pa | | г (| 200 | | | - |
| 1 020 | | — | F | 323 | | | İ |
| | Inis information was | s obtained from The National | | | | | |
| | | m.nih.gov/pubmedhealth/PMH | | | | | |
| | T0008785/?report= | details | | | | | |
| | 1 10000100, 10port | dotano. | | | | | |
| | | | | | | | |
| | 2. Resident #57 wa | s discharged to the hospital | | | | | |
| | | ility staff failed to provide | | | | | |
| | | of the facility initiated | | * | | | |
| | discharge to the res | sident's representative. | | | | | • |
| | Dooldoot #57 was a | admitted to the English one | | | | | : |
| | | admitted to the facility on itted on 1/22/18 with | | | | | • |
| | | uded but were not limited to | | | | | |
| | | avioral disturbance, muscle | | | | | |
| | | er's disease and mood | | | | | |
| | | #57's most recent MDS | | | | | |
| | (minimum data set) | assessment was a quarterly | | | | | |
| | | ARD (assessment reference | | | | | |
| | | sident #57 was coded as | | | | | |
| | | aired in cognitive function | | | | | |
| | | ossible 15 on the BIMS (Brief | | | | | |
| | Interview for Menta | Status) exam. | | | | | |
| | Review of Resident | #57's clinical record revealed | | | | | |
| | | the the hospital on 1/16/18. | | | | | |
| | | was documented: "1/15/18 at | | | | | ı |
| | | was leaning to the left in his | | | | | |
| | | id respirations noted. Prior to | | | | | |
| | | ident ate well for breakfast | | | | | : |
| : | | ling himself up and down the | | | | | |
| | | ing like his normal behavior. | • | | | | |
| | | 130/80, P (pulse) 98, R | | : | | | • |
| | | 2 (sic) (oxygen saturation) 91 | | : | | | |
| | | emperature) 98.9. NP (nurse | | | | | · |
| | | ed resident and requested we see if she would like us to | | | | | |
| : | | ntinue to monitor him she was | | | | | ļ |
| | | lers given by NP for 1 time | | | | | |
| | , J | gr. ar. ar. i ar i arii v | | | | | |

| | | & MEDICAID SERVICES | | | | | APPROVED 0. 0938-0391 |
|-------------------|---|---|-------------|----------|--|------|--------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X3) MUI | TIDI E (| CONSTRUCTION | | TE SURVEY |
| | OF CORRECTION | IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | | MPLETED |
| | | 495142 | B. WING | | | Us | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | 730/2018 |
| EVERGF | EEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID PREFI | v | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5] COMPLETION |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROF | | DATE |
| F 623 | Continued From pa | ge 62 | Fθ | 623 | | | |
| | mouth) for BIL (bila |) mg (milligrams) p.o. (by teral) LE (lower extremity) | | : | | | |
| | | to be completed today, s (2) BID (two times a day) x 7 | | | | | |
| | daysdaughter (na | me of daughter) came to visit | | : | | | |
| | | ted the chest xray had been o.m. and we were waiting | | | | | |
| | | he appears stable at this time noted with resident to call her | | | | | |
| | at any time during t | | | | | | |
| · | following: "Res. (Res Neurology apt (appropriate (resident) and aske be canceled due to | d 1/16/18 documented the esident) due to go out to cointment). NP seen res d that res. apt (appointment) res being very lethargic and | | | | | |
| | res unable to stay upain routine (sic) pa | Res. was repositioned x 2 and ip right. Res. c/o (complained) ain meds (medications) given prology Dept. (department) to | | | | | |
| : | cancel appt. (sic) S rethinking sending revaluation). dtr. sta | poke to dtr (daughter) about res to hosp (hospital) for eval ated it would be ok to send him | | | | | |
| : | out" | | | | | | |
| : | Resident #57 arrive | e clinical record revealed that d back to the facility on ary diagnosis of a UTI (urinary | | | | | |
| : : | | ence that the responsible partying of the reason for transfer to | | | | | : |
| : : | conducted with LPN When asked how sl | p.m., an interview was I (licensed practical nurse) #6. the notifies the family of a | | : | | | |
| | | the emergency room or ated the family is always | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | 0 | | APPROVED |
|--------------------------|--|--|--------------------|-----|--|-----|----------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (٧٥) • 411 | | | | 0938-0391 |
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | CONSTRUCTION | СОМ | E SURVEY IPLETED |
| | | 495142 | B. WING | | | | C 30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | EEN HEALTH AND RI | EHAB | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | Continued From page | ge 63 | F 6 | 523 | | | |
| ! | notified verbally. LP | N #6 stated the nurses do not ication to the responsible | | , | | | |
| | | the reason for transfer. | - | : | | | |
| : | staff member) #1, the DON (director of nu | p.m., ASM (administrative ne administrator, ASM #2, the rsing) and ASM #7, the facility ware of the above concerns. | - | : | | | |
| | | on was presented prior to exit. | | | | | : |
| | in patients with hear kidney disease. This | crease edema (excess fluid) rt failure, liver impairment or is information was obtained Guide for Nurses, 11th edition, | | | | | |
| | information was obt | to open up the lungs. This ained from n.nih.gov/pubmedhealth/PMH | | | | | |
| | on 1/15/18. The faci written notification of | s discharged to the hospital lity staff failed to provide f the facility initiated ident's representative. | | | | | |
| | 12/12/16 and readm diagnoses that inclu muscle weakness, of disturbance, major of | dmitted to the facility on litted on 1/21/18 with ded but were not limited to dementia with behavioral depressive disorder, and high | | | | | : |
| | (minimum data set) assessment with an date) of 2/15/18. Rebeing cognitively into | sident #73's most recent MDS assessment was a quarterly ARD (assessment reference esident #73 was coded as act in the ability to make daily out of 15 on the BIMS (Brief Status) exam. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | <u>40</u> | <u>MB NO.</u> | <u>0938-0391</u> |
|--------------------------|---|---|--------------------|-----------------------------|---------------------------------|---------------|-----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION DING | | | E SURVEY PL E TED |
| | | 495142 | B. WING | | | | C 3 0/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE | E, ZIP CODE | | |
| EVERGE | REEN HEALTH AND R | FHAR | | 380 MILLWOOD AVENUE | | | |
| | | | | WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ACTION SHOULD TO THE APPROPR | BĘ | (X5) COMPLETION DATE |
| F 623 | Continued From pa | ge 64 | : F6 | 623 | | | |
| | the following note d the following: "This observed Resident her back against the was crying and her Resident stated she stayed with Resider (temperature) 92 (p (blood pressure), 02 (room air). Resider called 911. EMS (er transported Resider Center) via stretche | #73's nursing notes revealed ated 1/15/18 that documented nurse was entering room and to be sitting on the floor with e bathroom door. Resident right leg was drawn up. e could not move her leg. Staff at. VS (vital signs): 98.1 ulse) 30-respirations, 158/82 (oxygen) 100 percent RA at was not moved. This nurse mergency staff) x 2 at to (Name of Medical r at 18:15 (6:15) p.m. (Name of POA) notified. On-call nurse | | | | | |
| | revealed that she ar | Resident #73's clinical record rived back to the facility on ses of fracture to her right | | | | | |
| | | nce that the responsible party og of the reason for transfer to | | | | | |
| | conducted with LPN When asked how sh resident transfer to thospital, LPN #6 stanotified verbally. LPI provide written notified | o.m., an interview was (licensed practical nurse) #6. he notifies the family of a the emergency room or ted the family is always N #6 stated the nurses do not cation to the responsible he reason for transfer. | | | | | |
| : | On 3/29/18 at 5:47 p staff member) #1, th | o.m., ASM (administrative ne administrator, ASM #2, the | | | | | Tur |

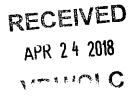
ORM CMS-2567(02-99) Previous Versions Obsolete

DON (director of nursing) and ASM #7, the facility

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 65 of 328



| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED O. 0938-0391 |
|--------------------------|--|---|----------------------|-----|---|--------|----------------------------|
| TATEMENT | OF OEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILC | | CONSTRUCTION | (X3) D | ATE SURVEY DMPLETED |
| | | 495142 | B. WING | · | | o | 3/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE O MILLWOOD AVENUE INCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH OEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 623 | 4. Resident #130 di 1/26/18. The facilit notification of the faresident's represent Resident #130 was 1/11/18 and readmi #130's diagnoses in pneumonia, diabete Resident #130's modata set), a quarter (assessment refere resident as cognitiv Review of Resident revealed a nurse's documented, "Resident revealed a nurse's documented revealed a nurse's documented revealed a nurse's documented revealed a nurse's documented revealed r | aware of the above concerns. ion was presented prior to exit. ischarged to the hospital on y staff failed to provide written acility initiated discharge to the tative. admitted to the facility on atted on 2/2/18. Resident included but were not limited to be and urinary tract infection. Out recent MDS (minimum ly assessment with an ARD ence date) of 3/9/18, coded the rely intact. if #130's clinical record indeed to be lethargic VS (Vital Signs) - 97.3 (pulse) - 20 (respirations) - ure) - 92% (oxygen saturation) oxygen). bs (blood sugar) 236 NP (Nurse Practitioner) aware ion. New order to send to ER) via 911. Son (name) aware hold voiced if gets admitted he | . F6 | 623 | | | |
| | 1/26/18 and returned Further review of R failed to reveal the | admitted to the hospital on ed to the facility on 2/2/18. esident #130's clinical record resident's representative was reason for the discharge in | | | | | : |
| | On 3/29/18 at 2:17 | p.m., an interview was | | | | | |

| | | HAND HUMAN SERVICES E & MEDIÇAID SERVICES | | | | FOF | RM APPROVED |
|--------------------------|--|---|----------------------|-------|---|-----------|---|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | DNSTRUCTION | (X3) D | NO. 0938-0391 DATE SURVEY COMPLETED |
| | ! | 495142 | B. WING | à | | , | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | ь, | STREF | ET ADDRESS, CITY, STATE, ZIP CO | | 1010012010 |
| EVERGR | REEN HEALTH AND RI | ЕНАВ | | | NILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION OATE |
| | regarding the nurse to the hospital. LPN resident's family is rhospital. LPN #6 st asked if any written resident's represent On 3/29/18 at 2:59 conducted with OSN (social worker). OS provides written not representative when hospital. OSM #3 s On 3/29/18 at 5:48 member) #1 (the addirector of nursing) above concern. On 3/30/18 at 12:30 facility did not have and discharges. No further information in the hospital on 3/17 provide written notific party regarding the resident #3 was ad 9/10/16 with the diagatrial fibrillation, more disease, systemic in syndrome, bladder of heart disease, chiz disease, diabetes, his syndrome, diabetes, his diabetes, h | N (licensed practical nurse) #6 es' role when a resident is sent N #6 was asked how the notified of transfers to the stated, "By phone." When notification is provided to the notative, LPN #6 stated, "No." p.m., an interview was M (other staff member) #3 SM #3 was asked if she etification to the resident en a resident is sent to the estated, "I do not." pm., ASM (administrative staff dministrator) and ASM #2 (the were made aware of the D p.m., ASM #2 stated the en a policy regarding transfers ion was presented prior to exit. It transferred and admitted to 7/18. The facility did not fication to the responsible reason for the transfer. dmitted to the facility on agnoses of but not limited to orbid obesity, chronic kidney inflammatory response obstruction, chronic ischemic zophrenia, Parkinson's high blood pressure, and | F | 623 | | | |
| : | bipolar disorder. Th | ne most recent MDS | | | | | |

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | | | RM APPROVED NO. 0938-0391 |
|--------------------------|---|---|----------------------|-----|--|-----------|------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | | CONSTRUCTION | (X3) | DATE SURVEY COMPLETED |
| | | 495142 | B. WING | i | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CO | | |
| EVERG | REEN HEALTH AND R | EHAB | | | NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 623 | Continued From pa | nge 67 | : : F6 | 323 | | | : |
| | with an ARD (Asset 3/14/18. The residence cognitively intact in decisions. The residence bathing; extensive of the control of | t) was a quarterly assessment ssment Reference Date) of ent was coded as being ability to make daily life ident required total care for care for transfers, dressing, ne; was independent for | | : ! | | | |
| | eating; and was inc indwelling catheter | ontinent of bowel and had an for bladder. cal record revealed the | | | | | |
| | station c/o (compla Resident stated that that there is nothing Resident continues pain and discomfor me, he uses his bla groin." Resident's I 158/102, P (pulse) (temperature) 98.1, 10/10 (ten out of tet throughout. Pupils greater than Right [light but Right [sic] (Administrative Stat practitioner) contac agreed to send resi (evaluation). Wife of | R (Respirations) 22. Pain of n on a zero to ten scale) all were not equal, Left [sic] sic], both do constrict with more than Left [sic]. (ASM #8) | | | | | |
| : | (8:05PM) and just le (hospital) for update Further review of the reveal any evidence | eft with resident. Will contact | | | | | : |

in writing.

| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | Ol | | APPROVED . 0938-0391 |
|--------------------------|--|---|----------------------|-----|---|------------------|----------------------------|
| TATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE COM | E SURVEY IPLETED |
| | , | 495142 | B. WING | | | l . | C 3 0/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| EVERGR | REEN HEALTH AND RI | EHAB | | | 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | ·· <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 623 | Continued From pa | ige 68 | F€ | 323 | | _ | : |
| | #6 (Licensed Practi the process staff fol the hospital, she sta the doctor or nurse complete the paper family, and call 911. notified verbally by facility provides any she stated, "No. I d provides any writter | p.m., in an interview with LPN tical Nurse), when asked about ollow for sending a resident to eated, check the vital signs, call a practitioner, get an order, rwork, chart on it, notify the l. She stated the family is phone. When asked if the y written notification to family, don't believe that the facility n notification." | : | | | | |
| | meeting, the Admin Staff Member) #1, I and the facility owne of the findings. A pe notifications was red | p.m., at the end of day nistrator, ASM (Administrative Director of Nursing (ASM #2), ner (ASM #7) were made aware colicy regarding written equested. No further ovided by the end of the | | | | | |
| | Information obtaine | to treat mild to moderate pain. ed from .gov/druginfo/meds/a681004.h | | | | | |
| | the hospital on 3/22 The facility did not p | as transferred and admitted to 2/18, 12/24/17, and 12/8/17. provide written notification to rty regarding the reason for the | | : | | | |
| : | 8/26/13 with the dia | admitted to the facility on agnoses of but not limited to sease, depression, metabolic | | ; | · | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | FORM APPROVE OMB NO. 0938-039 | | | | | |
|--------------------------|--|---|----------------------------------|-----|---|---|--------|----------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | | | CONSTRUCTION | (X3) D | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | ; | | | 0: | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | |] | | EET ADDRESS, CITY, STATE, ZIP CODE | · | |
| EVERGR | REEN HEALTH AND R | EHAB | | 1 | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | 1 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| F 623 | disorder, dysphagia cataracts, presbyop schizophrenia, bipo high blood pressure obstructive pulmona MDS (Minimum Dai assessment with ar Reference Date) of coded as severely omake daily life decistotal care for transferent extensive care for ebowel and bladder. A review of the clinic following nurse's not a single pressure of the clinic following nurse's not a single pr | ementia, schizoaffective a, gastrostomy feeding tube, bia, Parkinson's disease, lar disorder, angina, diabetes, e, hypothyroidism, and chronic ary disease. The most recent ta Set) was a quarterly a ARD (Assessment 2/16/18. The resident was cognitively impaired in ability to sions. The resident required ers, dressing, and hygiene; eating; and was incontinent of cal record revealed the bite dated 3/22/18: Int is Lethargic BP (blood (pulse) 86, 97.9 espirations) 18, O2 (oxygen) [282. New Order (ASM #5) if Member, a Nurse D2@2L (oxygen at 2 liters) via order) (ASM #5) send to ER for evaluation for Hypoxia. Inotified @ 1455 (2:55PM) 1505 (3:05PM) report given to ied @ 1505 and arrived at iport given to EMT al technician). Daughter went mother] to (hospital). Report gency room) @1530 (3:30PM) Daughter agreed to bed we nurses." | F | 623 | 3 | | | |
| | reveal any evidence | e clinical record failed to that the responsible party easons for the hospitalization | | | : | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | 0 | | APPROVED . 0938-0391 |
|--------------------------|---|--|--|-----|--|-----------------|----------------------------|
| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DAT COM | E SURVEY MPLETED |
| | | 495142 | B. WING | | | l | C /30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | • | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T | BE | (X5) COMPLETION DATE |
| F 623 | Continued From pa | ge 70 | F6 | 323 | | | |
| | | cal record revealed the tes dated 12/24/17: | | : | | | |
| | upon arrival onto sh was asking question for the past couple nurse had just composite yesterday and thing didn't really want to self. Daughter their swallow that was downt. Advised that had one done but well. Family agreed she would pass as mashed potatoes a resident is listed as admitted to feeding did well. NP (nurse nurse made aware | urse went in to visit resident aft. Family was present and as about residents behaviors of days. Advised that this e on but had resident as seemed fine. Advised she talk but seemed her normal asked about the cookie one and wanted to know how it this nurse did not realize she wouldn't be surprised if it went d and then stated that they feel they have recently brought in and gravy. Family aware that NPO (nothing by mouth) but it to her and stating that she practitioner) and assigned of families [sic] comments." | | | | | |
| | (respirations) 22. Nounds) positive. Lyelling out and hittir hand when I was as denies pain or discoushe didn't feel well. concerned about the | 200.3 tympanic pulse 72 R Ionlabored. BS (bowel ungs clear, Resident was ing this nurse with her right issessing her lungs. Resident comfort. Asked three times if Daughter here and is e left side of her neck which htly swollen. Warm to touch. | | | | | |
| | (wasn't on call) but (gram) IM (intramus | 5) telephoned (hospital) back. ordered Rocephin [1] 1 gm scular) now and if daughter go to hospital later on order is | | : | | | : |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | APPROVED 0. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 495142 | B. WING | <u> </u> | 03 | C / 30/2018 |
| | PROVIDER OR SUPPLIER EEN HEALTH AND RI | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | BE | (X5) COMPLETION DATE |
| F 623 | given. - 6:13PM: Informe she wants her mome can go. Daughter go 911 (nine one one) paperwork prepared verbalizing at this till granddaughter at be simple questions apped) elevated. EMI to EMTS. Resident letting EMTS take he EMTs were success Transported safely daughter and grand - 10:17PM: (Hospi resident. Admitted parotitis. (salivary given for the reveal any evidence was notified of the rin writing. A review of the clinic following nurse's notified of the rin writing. | d daughter that NP stated if a to go to the hospital then she gave consent for her to go. telephoned. Necessary d. Resident is alert and me with gentle coaxing by edside. Resident answers oppropriately. HOB (Head of Is arrived, all paperwork given a somewhat non compliant with her vitals going to hit them, but sful after several attempts. Out of Facility x2 EMTS and Idaughter following to hospital. Ital) telephoned on update of to step down with diagnosis of land). The clinical record failed to be that the responsible party reasons for the hospitalization cal record revealed the lates dated 12/8/17: | | 523 | | |
| | (Administrative Staf Practitioner) to send evaluation due to vo Staff reported no vo VSS (vital signs stal Daughter aware of t (at) 1504 (3:04PM) | | : | | | |

| | | AND HUMAN SERVICES | | | | | RM APPROVED | |
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| | | & MEDICAID SERVICES | | | | 1 | <u>IO. 0938-0391</u> | |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | DNSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | | C 03/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP COD | Ē | <u>.</u> | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE | |
| F 623 | Continued From pa | ge 72 | F 6 | 23 | | | | |
| | (3:20PM) resident in Report given to (ho: - 11:55PM: Spoke Resident admitted t DX (diagnosis) of C #8) with this information. | with (hospital) with nurse. to room (room number) with colonic Mass. Notified (ASM ation." | | | | | | |
| | | e that the responsible party reasons for the hospitalization | | : | | | | |
| | #6 (Licensed Practi process for sending stated, check the vi nurse practitioner, g paperwork, chart or 911. She stated the phone. When aske written notification to | p.m., in an interview with LPN cal Nurse), when asked the garesident to the hospital, she tal signs, call the doctor or get an order, complete the nit, notify the family, and call efamily is notified verbally by diff the facility provides any ofamily, she stated, "No. I efacility provides any written | | | | | | |
| | meeting, the Admin Staff Member) #1, E and the facility owne of the findings. A po- notifications was red | p.m., at the end of day istrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware olicy regarding written quested. No further vided by the end of the | | | | | | |
| ; | [1] Rocephin is an a Information obtained | | | | | | ! | |

https://medlineplus.gov/druginfo/meds/a685032.h

| | · · · · · · · · · · · · · · · · · · · | _ | _ | O | | 1 APPROVED 0. 0938-0391 | |
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| OF OEFICIENCIES | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | l`' | | LE CONSTRUCTION | (X3) OATE SURVEY COMPLETEO | | |
| | 495142 | B. WING | ; | | 03 | /30/2018 | |
| | ЕНАВ | | ; | 380 MILLWOOD AVENUE | | | |
| (EACH OEFICIENCY | MUST BE PRECEOEO BY FULL | | | (EACH CORRECTIVE ACTION SHOULO | BE | (X5) COMPLETION DATE | |
| tml 7. The facility staff of notification to Resider representative for a room transfer on 2/2 Resident #95 was a 2/17/16 and readmithat included but we bleeding, schizophridiabetes. The most recent consessment, with a resident as having a BIMS (breif interview the resident was condecisions. The resident was condecisions. The resident was condecisions. The resident was four. Review of the nurse documented that the was four. Review of the nurse 2/28/18 documented that the was four. Further review of the resident of the emergency resident's represent of the emergency residentiation, ASM administrator, ASM | railed to provide a written lent #95 or the resident's a facility initiated emergency 28/18. admitted to the facility on a litted on 3/3/18 with diagnoses are not limited to: intestinal enia, heart failure and a lenia, heart failure and lenia, he | F | 523 | | | | |
| | omior word made aware or | | | | | : | |
| | RS FOR MEDICARE OF OEFICIENCIES OF CORRECTION PROVIOER OR SUPPLIER EEN HEALTH AND R SUMMARY STA (EACH OEFICIENCY REGULATORY OR LE Continued From pa tml 7. The facility staff f notification to Resident and readmit that included but we bleeding, schizophr diabetes. The most recent co assessment, with a resident as having a BIMS (breif interviet the resident was co decisions. The resident supervision for active Review of the nurse documented that th was four. Review of the nurse documented that th was four. Review of the nurse documented that th was four. Further review of th evidence document resident's represent of the emergency re On 3/29/18 at 6:00 administrator, ASM | PROVIDER OR SUPPLIER EEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 tml 7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS (breif interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living. Review of the nurse's notes dated 2/28/18 documented that the resident was to be sent to the hospital for treatment of the hemoglobin. Further review of the clinical record did not evidence documentation that the resident or the resident's representative were notified in writing of the emergency room transfer. On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of | REPORMEDICARE & MEDICAID SERVICES TOP OFFICIENCIES TOP OFFICIENCY MUST BE PRECEODO BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73 tml 7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. 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On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of | RS FOR MEDICARE & MEDICAID SERVICES OF OEFICIENCIES OF OEFICIENCY OF OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION) COntinued From page 73 tml 7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS (breif interview for mental status) indicating the resident was cognitively intact to make daily decisions. 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The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18, heart failure and diabetes. The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident was cognitively inlact to make daily decisions. The resident was coded as requiring supervision for activities of daily living. Review of the nurse's notes dated 2/28/18 documented that the resident's hemoglobin (1) was four. Review of the nurse practitioner's note dated 2/28/18 documented that the resident was to be sent to the hospital for treatment of the hemoglobin. Further review of the clinical record did not evidence documentation that the resident or the resident's perpresentative were notified in writing of the emergency room transfer. On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of | AS FOR MEDICARE & MEDICAID SERVICES OMB PROVIDERS (X1) PROVIDERS (X2) PARTICIPATION NUMBER: A BUILDING ROWOER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY) MUST BE PRECEDE BY PULL RESULTATORY OR LSC MENTIFYING INFORMATION) Continued From page 73 tril 7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. 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| | | & MEDICAID SERVICES | | | FORM APPROVE OMB NO. 0938-039 |
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| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING |) | 03/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | CTION SHOULD BE COMPLÉTIO THE APPROPRIATE OATE |
| F 623 | 1 Hemoglobin — He contained in red blodelivery of oxygen to was obtained from: https://www.ncbi.nlr 8. The facility staff to notification to Residential facility initiated emet 2/5/18. Resident #99 was a 6/9/17 and readmitto that included but we pneumonia, anemia communication deformation deformation of the most recent MI assessment, with a resident as 99 on the mental status) indicable to complete the coded as understar understood and have memory. The residential assistance for all accommented that the shortness of breath | on was provided prior to exit. Imagination (Hb) is the protein and cells that is responsible for the tissues. This information m.nih.gov/books/NBK259/ Italied to provide a written lent #99's representative for a progency room transfer on admitted to the facility on the ed on 2/26/18 with diagnoses the error of the entity on the ed on a constitute to the entity on the ed on a constitute to the entity on the ed on a constitute to the entity on the entity of th | F 6 | 623 | |
| | Review of the nurse 2/5/18 documented | e practitioner's note dated that due to the resident's low nd pneumonia the resident | | | |

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | | FORM APPROVED B NO. 0938-0391 |
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| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | LTIPLE CONSTRUCTION DING | | (3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | · | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | EHAB | | STREET ADDRESS, CITY, STAT 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVE | TO THE APPROPRIA | |
| | treatment. On 3/29/18 at 2:17 #6 (Licensed Practi the process staff fol the hospital, LPN #6 call the doctor or nu complete the paper family, and call 911. notified verbally by facility provides any LPN #6 stated, "No. facility provides any On 3/29/18 at 6:00 administrator, ASM ASM #7, the facility the findings. No further information of the finding of the findi | p.m., in an interview with LPN ical Nurse), when asked about allow for sending a resident to 6 stated, check the vital signs, arse practitioner, get an order, twork, chart on it, notify the . She stated the family is phone. When asked if the y written notification to family, a. I don't believe that the y written notification." | F6 | 623 | | |
| | 11/19/17, with a mos | admitted to the facility on est recent readmission on eses that included but were not | : | : | | |

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| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | 1 | 30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND RI | EHAB | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
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| F 623 | Captinuad From no | 70 | | 1 | | | |
| F 023 | i | _ | F 6 | 23 | | | |
| i | | infections, hypotension (too low | | | | | |
| ! | blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy. | | ; | | | | ! |
| - | dimodity olooping, a | istillia, and has a coloctomy. | | | | | • |
| | The most recent M | DS (minimum data set) | | • | | | • |
| | assessment, a Med | dicare 14 day assessment, | | | | | |
| : | | at reference date of 2/27/18, | | : | | | |
| | | as scoring a 15 on the BIMS | | | | | |
| : | | mental status) score, indicating f making her daily decisions. | | | | | |
| | Stie was cahanie or | Hidking her daily decisions. | | | | | |
| : | The clinical record | revealed a nurse's note dated, | | | | | |
| | 2/2/18 at 11:07 a.m | i. documented in part, | | | | | i |
| | | plained of) dizzy feeling this | | | | | i |
| | | plood pressure) obtained noted | | | | | |
| | | urse practitioner) aware new | | | | | |
| | | lodrine (used to elevate blood g (milligrams) now and then qd | | | | | |
| | | ordered 1 liter of d5 (dextrose | | | | | 1 |
| | | gth) normal saline). Medication | | | | | |
| | administered and IN | V (intravenous) placed to left | | | | | |
| : | | c) to infuse resident c/o left | | | | | |
| | • | ith pressure. B/P 76/50 at this | | | | | : |
| | | nied sob (shortness of breath) n't had this pain before and | | | | | |
| | | spital. NP aware of new | | | | | 1 |
| | | der noted to send to er | | | | | |
| | | 911 (emergency medical | | | | | |
| | services) called and | d daughter (name of daughter) | | | | | 1 |
| | | ived assessed and left around | | | | | |
| : | | name) is aware of bed hold er she knows what the plan is | | | | | |
| | for her mother." | st alle knows what the high is | | | | | |
| | | | | | | | |
| | Review of the clinic | al record did not reveal | | | | | |
| | | the resident or their | | | | | |
| : | representative were | | | | | | |
| : | documentation as to transferred to the ho | o why the resident was being ospital. | | | | | |
| | transferred to the in | sopiidi. | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | M APP R OVED D. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION ING | (X3) DA | ATE SURVEY DMPLETED |
| | | 495142 | B. WING | | 0: | 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | · |
| EVERGR | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | SHOULD BE | (X5) COMPLETION OATE |
| F 623 | Continued From pa | ge 77 | F6 | 523 | | ! ! |
| | dated, 2/28/18 at 10 10:00 a.m. (Reside nursing assistant) r (Resident #97) 'Yell This nurse immedia and noted that she SOB (shortness of pressure was 56/48 immediately elevate notified. NP assess this nurse to send to 911 for eval (evalua symptomatic hypote second nurse and vapproximately 10:10 and noted her blood continued symptom to keep eyes open to keep eyes open and answering quesaccordingly/appropriof transfer to ED we (temperature), 75 (p. (blood pressure) 95 | riately. VS (vital signs) at time ere as follows: 97.5 pulse) 18 Respirations), 72/42 6% RA (95% oxygen saturation dent #97)'s husband notified | | | | |
| : | documentation that representative were | why the resident was being | | | | |
| | practical nurse) #6 asked about the nu | onducted with LPN (licensed on 3/29/18 at 2:25 p.m. When rse's responsibility when a ne hospital, LPN #6 stated, "I | | | | |

get vital signs, call the doctor or nurse practitioner

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | I APPROVED . 0938-0391 | | |
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| ATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONST | RUCTION | (X3) DAT COM | (X3) DATE SURVEY COMPLETED | | |
| | | 495142 | B. WING | | | 1 | /30/2018 | | |
| | (EACH DEFICIENC | | ID PREFI TAG | | | (X5) COMPLETION OATE | | | |
| F 623 | family and call 911 notifies the family, phone." When ask notification to the family, phone." When ask notification to the family part in the bed "We ask if they wa (cost) of the hold. or declination of the and sign the bed his done for every r LPN #6 stated, "If asked if the family documents, LPN to bed hold signed it." | I in the paperwork, call the ." When asked how she LPN #6 stated, "Verbally by ed if she provides any written amily, LPN #6 stated, "I don't cility does that with written a sked if any, nursing plays I hold policy, LPN #6 stated, ant the bed hold and the amount We have either an acceptance be bed hold. Two nurses verify hold paper." When asked if this esident sent to the hospital, they are admitted." When for resident is given any written #6 stated, "No, once we get the goes to the front office." I director of nursing and ASM e made aware of the above | | 523 | | | | | |
| | (1) This information following website: https://www.ncbi.rr T0011219/? Preparation for Sa CFR(s): 483.15(c) §483.15(c)(7) Orion discharge. A facility must propreparation and consideration and consideration and consideration. | nlm.nih.gov/pubmedhealth/PMH afe/Orderly Transfer/Dschrg | | 624 | F624 Corrective action has been for the alleged deficient pracegards to residents #3 and residents have since return facility. | actice in 74. The | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PKINI ED: U4/13/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 624 Continued From page 79 Current facility residents have the F 624 potential to be affected by the alleged understand. deficient practice. The quality assurance This REQUIREMENT is not met as evidenced nurse will do a 100% audit of residents bv: transferred to the hospital since 4/1/18 r/t Based on staff interview and clinical record documentation stating the resident's nurse review, it was determined that the facility staff has explained to the resident or resident's failed to orient, prepare, and document the same. representative the reasoning the resident a resident for transfer to the hospital for two of 31 is being transferred to the hospital, residents in the survey sample; Residents #3, orienting and preparing him or her for the and #74. Measures put into place to assure alleged 1. The facility staff failed to document that deficient practice does not recur include: Resident #3 was properly oriented and prepared Nurses and Social Service will be for a hospital transfer that occurred on 3/17/18. reeducated on proper documentation when transferring a resident. 2. The facility staff failed to document that The Director of Nursing and/or designee Resident #74 was properly oriented and prepared will analyze/review for patterns/trends for a hospital transfer that occurred on 3/22/18, and report in the Quality Assurance 12/24/17, and 12/8/17. committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust The findings include: the plan as the committee may recommend, based on outcomes/trends identified from date. 1. The facility staff failed to document that Resident #3 was properly oriented and prepared Completion Date: May 11, 2018. for a hospital transfer that occurred on 3/17/18.

Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrill ation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for

PRINI ED: U4/13/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY) F 624 Continued From page 80 F 624 bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and was incontinent of bowel and had an indwelling catheter for bladder. A review of the clinical record revealed the following nurse's note dated 3/17/18: - 8:08: "Resident rolled self out into nursing station c/o (complains of) all over body pain. Resident stated that Tylenol [1] does not help and that there is nothing that the staff can do for him. Resident continues to blame "Trump" for all over

pain and discomfort stating, "he is trying to hurt me, he uses his black box to hurt my head and groin." Resident's BP (blood pressure) was 158/102, P (pulse) 80 reg (regular) T (temperature) 98.1, R (Respirations) 22. Pain of 10/10 (ten out of ten on a zero to ten scale) all throughout. Pupils were not equal, Left [sic] greater than Right [sic], both do constrict with light but Right [sic] more than Left [sic]. (ASM #8) (Administrative Staff Member, a nurse practitioner) contacted at 1938 (7:38PM) and agreed to send resident out for further eval (evaluation). Wife contacted at 1941 (7:41PM). 911 contacted 2000 (8:00PM). Arrived at 2005 (8:05PM) and just left with resident. Will contact (hospital) for update in a few hours."

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.

On 3/29/18 at 2:27p.m., in an interview with LPN #6 (Licens ed Practical Nurse), when asked about preparing and orienting residents for transfer to the hospital, she stated if they are alert, tell them they are going to the hospital, let them know what

DEPARTMENT OF HEATTH AND HUMAN SERVICES

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| F 624 | understanding in nu | cument the resident's | F 62 | 24 | | | |
| | meeting, the Admin Staff Member) #1, I and the facility own of the findings. A p | istrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware olicy regarding written quested. No further | | | | | |

[1] Tyleno1 is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml

information was provided by the end of the

survey.

2. The facility staff failed to document that Resident #74 was properly oriented and prepared for a hospital transfer that occurred on 3/22/18, 12/24/17, and 12/8/17.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, clysphagia, gastrostomy feeding tube. cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Min imum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for transfers, dressing, and hygiene; extensive care for eating, and was incontinent of

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | M APPROVEI <u>). 093</u> 8-039 |
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| F 624 | following nurse's not a 3:00PM: "Reside pressure) 138/68 P (temperature), R (re @ (at) 83% BP [sic] (Administrative Staf Practitioner) apply (mask. V.O. (verbal (emergency room) (Name of daughter) arrived at facility @ daughter. 911 notif 1515 (3:15PM). Re (emergency medica with daughter [sic-realled to ER (emergency | cal record revealed the ote dated 3/22/18: ent is Lethargic BP (blood (pulse) 86, 97.9 espirations) 18, O2 (oxygen) 282. New Order (ASM #5) Member, a Nurse D2@2L (oxygen at 2 liters) via order) (ASM #5) send to ER for evaluation for Hypoxia. In notified @ 1455 (2:55PM) 1505 (3:05PM) report given to ied @ 1505 and arrived at | F 624 | | | |
| : | reveal any documer prepared and orient A review of the clinic following nurse's no - 4:00PM: Thus, no | e clinical record failed to ntation that the resident was ted for transfer. | | | | |

was asking questions about residents behaviors for the past couple of days. Advised that this nurse had just come on but had resident

yesterday and things seemed fine. Advised she didn't really want to talk but seemed her normal self. Daughter then asked about the cookie swallow that was done and wanted to know how it

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| | had one done but well. Family agreed she would pass as mashed potatoes at resident is listed as admitted to feeding did well. NP (nurse nurse made aware - 4:04PM: Temp 10 (respirations) 22. Nounds) positive. Lyelling out and hittin hand when I was as denies pain or discoshe didn't feel well. concerned about the appear red and sligl NP telephoned." - 4:22PM: (ASM #6 (wasn't on call) but 6 (gram) IM (intramus wants her mom to given. - 6:13PM: Informed she wants her mom can go. Daughter generous paperwork prepared verbalizing at this tingranddaughter at be simple questions ap | ge 83 this nurse did not realize she rouldn't be surprised if it went of and then stated that they feel they have recently brought in and gravy. Family aware that NPO (nothing by mouth) but it to her and stating that she practitioner) and assigned of families [sic] comments." 20.3 tympanic pulse 72 R fonlabored. BS (bowel lungs clear, Resident was ig this nurse with her right esessing her lungs. Resident offort. Asked three times if Daughter here and is the left side of her neck which intly swollen. Warm to touch. 35 telephoned (hospital) back. Ordered Rocephin [1] 1 gm cular) now and if daughter to to hospital later on order is daughter that NP stated if to go to the hospital then she ave consent for her to go. elephoned. Necessary I. Resident is alert and the with gentle coaxing by edside. Resident answers propriately. HOB (Head of sarrived, all paperwork given | F | i24 | | | |

to EMTS. Resident somewhat non compliant with letting EMTS take her vitals going to hit them, but EMTs were successful after several attempts.

PRINTED: 04/13/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

EVERGREEN HEALTH AND REHAB

380 MILLWOOD AVENUE
WINCHESTER, VA 22601

(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 624 Continued From page 84

Transported safely out of Facility x2 EMTS and daughter and granddaughter following to hospital.

- 10:17PM: (Hospital) telephoned on update of resident. Admitted to step down with diagnosis of parotitis. (salivary gland).

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.

A review of the clinical record revealed the following nurse's notes dated 12/8/17:

- 3:05PM: V.O. (verbal order) (ASM #8) (Administrative Staff Member, a Nurse Practitioner) to send resident to (hospital) for evaluation due to vomiting and nausea x2 days. Staff reported no vomiting or nausea this shift. VSS (vital signs stable). Afebrile at this time. Daughter aware of transfer to ER. 911 notified @ (at) 1504 (3:04PM) and arrived to facility @ 1510 (3:10PM). Resident A&Ox2 (alert and oriented to two spheres).
- 3:19PM: (Hospital) notified 2 [sic] 1520 (3:20PM) resident in route to ER for evaluation. Report given to (hospital staff).
- 11:55PM: Spoke with (hospital) with nurse. Resident admitted to room (room number) with DX (diagnosis) of Colonic Mass. Notified (ASM #8) with this information."

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.

On 3/29/18 at 2:27p.m., in an interview with LPN #6 (Licens ed Practical Nurse), when asked about

F 624

PRINTED: 04/13/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ١D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 624 Continued From page 85 F 624 preparing and orienting residents for transfer to the hospital, she stated if they are alert, tell them they are going to the hospital, let them know what is going on, and document the resident's understanding in nurses notes. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2). and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey. [1] Rocephin is an antibiotic. Information obtained from https://me.dlineplus.gov/druginfo/meds/a685032.h F 625 Notice of Bed Hold Policy Before/Upon Trnsfr F 625 SS=E CFR(s): 483.15(d)(1)(2) F625 Corrective action has been accomplished for the §483.15(d) Notice of bed-hold policy and return-

- Corrective action has been accomplished for the alleged deficient practice in regards to residents #130, #73, #57, #74, #97, and #95: Staff has been reeducated on the bed hold policy. 100% audit of residents currently in the hospital will be completed assuring a bed hold has been completed and if not it will be offered
- Current facility residents have the potential to be affected by the alleged deficient practice.
 Auditing of transferred pts regarding the bed hold policy will be done daily during morning meeting and documented on report sheet.
- Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nurses to follow the bed hold policy.

specifies-

facility:

§483.15(d)(1) Notice before transfer. Before a

the resident goes on the rapeutic leave, the

the resident or resident representative that

(i) The duration of the state bed-hold policy, if

any, during which the resident is permitted to

(ii) The reserve bed payment policy in the state

return and resume residence in the nursing

plan, under § 447.40 of this chapter, if any:

(iii) The nursing facility's policies regarding

nursing facility transfers a resident to a hospital or

nursing facility must provide written information to

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| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | T (20) MIII | | | | | <u>0938-0391</u> |
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| | bed-hold periods, w paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed-hold the time of transfer hospitalization or the facility must provide resident represental specifies the duration described in paragra. This REQUIREMEN by: Based on staff internant clinical record rethe facility staff failernotice for a facility in residents in the surve #73, #57, #74, #97 and 1. The facility staff failernotification of the bear sident was dischard 1/26/18. 2. The facility staff faor the resident's reprnotice for a facility-in 3. The facility staff faor the resident's reprnotice for a facility-in 4. The facility staff failernotice for a facility-in 4. The facility staff failernotice for a facility staff failernotice for a facility-in 4. The facility staff failernotice for a facility-in 4. The facility staff failernotice for a facility staff failernotice failer | which must be consistent with a this section, permitting a sand and a specified in paragraph (e)(1) whold notice upon transfer. At a for a resident for perapeutic leave, a nursing to the resident and the sative written notice which on of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced erview, facility document review review, it was determined that the dot oprovide a written bed hold nitiated transfer for six of 31 evey sample, Residents #130, and #95. Failed to provide Resident the arged to the hospital on failed to provide Resident #73 presentative a written bed hold nitiated transfer on 1/15/18. Failed to provide Resident #57 presentative a written bed hold nitiated transfer on 1/16/18. | F 6 | 3 25 | The Director of Nuranalyze/review for p the Quality Assurance quarterly for a mining evaluate the effective adjust the plan as the recommend, based of from date. Completion Date: Moreover, and the plan is the plan as the recommend. | patterns/trends and race committee meeti mum of six months veness of the plan and the committee may on outcomes/trends | report in ing to nd will | |
| | | dent representative was d hold policy/notification, | | | | | | |

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| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CIT | • | | |
| EVERGR | REEN HEALTH AND R | .EHAB | l | 380 MILLWOOD AVEI WINCHESTER, VA | | | |
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| | 5. The facility staff of hold notice for a face Resident #97. 6. The facility staff of the resident's represent notice for the 2/28/2. The findings include 1. The facility staff of #130 or the resident notification of the best of the staff of the process of the staff of the s | a transfer and admission to the 17 and 12/8/17. failed to provide written bed cility initiated transfer for failed to give Resident #95 or esentative a written bed hold 18 hospital admission. | F | 625 | | | |
| | 1/11/18 and readmi #130's diagnoses in pneumonia, diabete Resident #130's modata set), a quarterl (assessment refere resident as cognitiv Review of Resident | t #130's clinical record | : | | | | |
| | documented, "Residunable to wake up. (temperature) - 67 (90/50 (blood pressuwith 3L (liters) o2 (odid not eat lunch. Nof change in conditi (Emergency Room) | note dated 1/26/18 that ident noted to be lethargic VS (Vital Signs) - 97.3 (pulse) - 20 (respirations) - ure) - 92% (oxygen saturation) oxygen). bs (blood sugar) 236 NP (Nurse Practitioner) aware ion. New order to send to ER) via 911. Son (name) aware hold voiced if gets admitted he | i | | | | ļ |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE OATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 625 Continued From page 88 F 625 would not like bed hold." Further review of Resident #130's clinical record revealed a notice of bed hold policy dated 1/26/18 that documented, "(Name of Resident #130) has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home..." A handwritten "X" was documented beside, "No. I do not wish to hold the resident's bed." The handwritten word, "Decline" was written. The handwritten words, "Son- (First name)" was written on the Responsible Party/Legal Representative signature line and the form was signed by a nurse. Although the nurse's note documented Resident #130's representative was notified of the bed hold policy, the clinical record failed to reveal the written bed hold document was provided to the representative.

Resident #130 was admitted to the hospital on 1/26/18 and returned to the facility on 2/2/18.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the nurses' role in providing bed hold notification. LPN #6 stated, "We have to ask if they want the bed hold; tell them how much a day and do a decline or acceptance and give to the

| STATEMEN ⁻ | RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES | (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) C | O. 0938-039 PATE SURVEY OMPLETED |
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| | PROVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | 386 | REET ADDRESS, CITY, STATE, ZIP CODE D MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (| PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 625 | is provided over the the telephone notification policy. When asked offered and/or provided and/or provided with oscillation." On 3/29/18 at 2:43 conducted with OSI business office man policy process. OS explain the bed hold form to a reside the hospital so the non and can sign the should follow up with attorney or next of I resident does not with the resident is stated the policy is signed when a resident in the resident represed and sign the bed how wishes to hold the bid does not provide with the resident represed and sign the bed how wishes to hold the bid does not provide with the resident represed and sign the provide with the provided with the bed how wishes to hold the bid one provide with the resident provide with the | the stated if the bed hold notice is phone then two nurses verify cation and sign the bed hold different witten documentation is ided to resident in #6 stated, "If they are there think the front office has them p.m., an interview was in Mother staff member) #2 (the hager) regarding the bed hold in #2 stated staff should different when he/she is going out resident knows what is going it form. OSM #2 stated nurses the a resident's power of kin and explain the policy if the resident representative is tice of the bed hold policy is sent to the hospital, OSM #2 provided and contracts are dent is first admitted to the ated the business office has entative come to the facility old notice if the representative and the form if the representative the form if the representative | F6 | 25 | | | |
| | On 3/29/18 at 5:48 | pm., ASM (administrative staff | | | | | : |

above concern.

member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the

The facility document titled, "Policy & Procedure

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPROVED OMB NO. 0938-039 | |
|--------------------------|--|--|---------------------|---|-----------------------------------|---|
| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | 03/30/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | | _ |
| EVERGR | EEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE COMPLÉTION | 1 |
| F 625 | Relating to Facility documented, "Policy responsible party/le notified of the facility the resident is transversident/responsible writing of the facility of admission. There being transferred to Hold Policy will be ethe resident will ack information by signification on the notice and presponsible party/le responsible party/le responsible party/le responsible party/le responsible party/le responsible party/le Notice of Bed Hold If the responsible party/le Notice of Bed Hold If the responsible party/le nurse and a copy of the policy will be donurse and a copy of the responsible party of the notices. No further information to facility in the resident's Business No further information to facility-information of the resident's responsible party of the resident's responsible party of the resident's Business No further information of the resident's responsible for a facility-information of the resident's responsible for a facility of the resident's responsible for a facility of the resident's responsible for a facility-information of the resident's responsible for a facility of the resident's responsible for a facility of the resident's responsible for a facility of the resident facility of the resident facility of the resident facilit | bed Hold Practices" by The resident and gal representative will be y's bed hold practices when sferred to the hospital and bital. Procedure-The e party will be notified in y's bed hold policy at the time eafter, prior to the resident to the hospital the Notice of Bed explained to the resident and knowledge receipt of the ing the notice. In the event the y'unable to acknowledge e, the nurse will document this roceed with notifying the egal representative. The fill be notified as soon as st within 24 hours of the time rs to the hospital. The gal representative will have Policy explained by the nurse. arty/legal representative heir verbal understanding of cumented on the form by the f the notice will be mailed to ty/legal representative. will be retained in the Office file." on was presented prior to exit. failed to provide Resident #73 oresentative a written bed hold nitiated transfer on 1/15/18. | F 6 | | | |
| : | 12/12/16 and readn | Idmitted to the facility on nitted on 1/21/18 with uded but were not limited to | | | | |

| | | E& MEDICAID SERVICES | | | | • • | M APPROVED 0. 0938-0391 |
|--------------------------|--|---|----------------------|-------------|--|---------|----------------------------|
| TATEMEN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILC | | CONSTRUCTION | (X3) DA | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | ; | | 0 | C 3/3 0/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STR | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERG | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 625 | disturbance, major blood pressure. Re (minimum data set assessment with an date) of 2/15/18. Re being cognitively in decisions scoring 1 Interview for Mental Review of Resident the following: "This observed Resident her back against the was crying and her Resident stated she stayed with Reside (temperature) 92 (p (blood pressure), 0 (room air). Reside called 911. EMS (etransported Reside Center) via stretche of NP) and (Name notified. On-call nur There was no evide Resident #73 was present the stayed of the stayed with Reside Center) via stretche of NP) and (Name notified. On-call nur There was no evide Resident #73 was present the stayed with Resident #73 was present the stayed resident #73 was present #73 was present the stayed resident #73 was present #73 was present the stayed resident #73 was present #73 w | dementia with behavioral depressive disorder, and high sident #73's most recent MDS assessment was a quarterly ARD (assessment reference esident #73 was coded as tact in the ability to make daily 5 out of 15 on the BIMS (Brief I Status) exam. It #73's nursing notes revealed lated 1/15/18 that documented nurse was entering room and to be sitting on the floor with e bathroom door. Resident right leg was drawn up. It e could not move her leg. Staff Int. VS (vital signs): 98.1 pulse) 30-respirations, 158/82 (oxygen) 100 percent RA and was not moved. This nurse mergency staff) x 2 and to (Name of Medical er at 18:15 (6:15) p.m. (Name of POA [power of attorney]) | F (| 625 | | | |
| : | On 3/29/18 at 2:17 conducted with LPN When asked if she notification to the restated, "No, I don't. have to ask them if | p.m., an interview was N (licensed practical nurse) #6. provided written bed hold esponsible party, LPN #6 Not written notification. We they want the bed held document a decline or | | 1 1 1 | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | (| | APPROVED 0. 0938-0391 |
|--------------------------|--|---|----------------------|----------|--|----------|----------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 1 | C / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STR | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | K | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 625 | verify over the phor and sign the bed ho it is supposed to be transfer. On 3/29/18 at 2:43 conducted with OSI business office mar policy process. OS explain the bed hold form to a resid the hospital so the non and can sign the should follow up wit attorney or next of he resident does not with When asked if the resident with the resident is stated the policy is signed when a residential facility. OSM #2 stated the resident representative sign does not wish to hold the bed how is not provide with the resident representative sign does not wish to hold the bed how is not provide with the resident representative sign does not wish to hold the bed how is not provide with the policy is signed when a resident representative sign does not wish to hold the bed how is not provide with the policy is signed when a resident representative sign does not wish to hold the bed how is not provide with the policy is signed when a resident representative sign does not wish to hold the bed how is not provide with the policy is signed when a resident representative sign does not wish to hold the bed how is not provide with the policy is signed when a resident representative sign does not wish to hold the bed how is not provide with the policy | if 6 stated that two nurses will be with the responsible party old policy. LPN #6 stated that done with every resident done with every resident p.m., an interview was M (other staff member) #2 (the nager) regarding the bed hold M #2 stated staff should dipolicy and provide the bed ent when he/she is going out resident knows what is going a form. OSM #2 stated nurses ha resident's power of kin and explain the policy if the resident representative is side of the bed hold policy as sent to the hospital, OSM #2 provided and contracts are dent is first admitted to the lated the business office has entative come to the facility old notice if the representative bed but the business office itten notification or has the the form if the representative | , F6 | 25 | | | |
| | On 3/29/18 at 5:47 staff member) #1, the DON (director of nu | p.m., ASM (administrative ne administrator, ASM #2, the rsing) and ASM #7, the facility ware of the above concerns. | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | RM APPROVED IO. 0938-0391 | |
|--------------------------|--|---|-------------------------|--|------------------------------|------------------------------|--|
| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVÍĎEŘ/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) E | OATE SURVEY OMPLETED | |
| | | 495142 | B. WING_ | | |)3/30/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 625 | or the resident's reportice for a facility-incomplete for a facility-i | failed to provide Resident #57 presentative a written bed hold initiated transfer on 1/16/18. Admitted to the facility on itted on 1/22/18 with uded but were not limited to avioral disturbance, muscle er's disease and mood #57's most recent MDS assessment was a quarterly a ARD (assessment reference sident #57 was coded as aired in cognitive function possible 15 on the BIMS (Brief | F 62 | T | | | |
| | treat him here or coupdated on new ord dose of Lasix (1) 20 mouth) for BIL (bilatedema, chest x-ray scheduled duonebst daysdaughter (na | ontinue to monitor him she was ders given by NP for 1 time of mg (milligrams) p.o. (by teral) LE (lower extremity) to be completed today, as (2) BID (two times a day x 7 me of daughter) came to visit ted the chest xray had been | | | | | |

completed at 2:30 p.m. and we were waiting

| | | E & MEDICAID SERVICES | | | | | MAPPROVED 0. 0938-0391 |
|--------------------------|---|--|---------------------|-----|--|---------|----------------------------|
| TATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTA. BUILDI | | ONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 03 | 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (; | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 625 | results. She stated | he appears stable at this time noted with resident to call her | F6 | 25 | | | |
| | following: "Res. (Research Neurology apt (approximate) asked that res. aptropositioned x 2 and Res. c/o (complained meds (medications Neurology Dept. (de (sic) Spoke to dtr (complained sending res to hosper) | ed 1/16/18 documented the esident) due to go out to ointment). NP seen res and be canceled due to res being eaning to left side. Res. was d res unable to stay up right. ed) pain routine (sic) pain) given earlier. Notified epartment) to cancel appt. daughter) about rethinking o (hospital) for evaluated it would be ok to send him | | | | | |
| : | Resident #57 arrive | ne clinical record revealed that ed back to the facility on ary diagnosis of a UTI (urinary | | | | | |
| | Resident #57's resp | ence in the clinical record that consible party was provided a tice for his facility- initiated cital. | | | | | |
| | conducted with LPN When asked if she notification to the re | p.m., an interview was N (licensed practical nurse) #6. provided written bed hold esponsible party, LPN #6 | | | | | |
| | have to ask them if verbally. We either acceptance." LPN # | Not written notification. We they want the bed held document a decline or #6 stated that two nurses will | | | | | |
| : | and sign the bed ho | ne with the responsible party old policy. LPN #6 stated that done with every resident | | : | | | |

| | | A MEDICALD SERVICES | | | | | MAPPROVED |
|--------------------------|--|--|---------|------|---|---------|----------------------------|
| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB NO | <u> </u> |
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | i | | 0: | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | I | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | 0/00/2010 |
| | | | | | MILLWOOD AVENUE | - | |
| EVERGR | REEN HEALTH AND R | EHAB | | | CHESTER, VA 22601 | | |
| (Y4) ID | SHIMMARYSTA | TEMENT OF DEFICIENCIES | . ID | | PROVIDER'S PLAN OF CORRE | CTION | · (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF | | (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 625 | Continued From patransfer. | ge 95 | F | 625 | | | |
| | in direction. | | | | | | |
| | On 3/29/18 at 2:43 | p.m., an interview was | | | | | |
| | | M (other staff member) #2 (the | 1 | | | | |
| | business office mai | nager) regarding the bed hold | : | | | ٠ | |
| | | SM #2 stated staff should | į | | | | 1 |
| | | d policy and provide the bed | | | | | |
| | | lent when he/she is going out | | | | | |
| | | resident knows what is going | 1 | | | | |
| | | form. OSM #2 stated nurses | | | | | |
| | | th a resident's power of | | | | | : |
| | | kin and explain the policy if the | | | | | |
| | | ant to sign the bed hold form. resident representative is | | | | | |
| | | tice of the bed hold policy | | | | | |
| | | s sent to the hospital, OSM #2 | | | | | |
| | | provided and contracts are | | | | | : |
| | | dent is first admitted to the | | | | | i |
| | | ated the business office has | | • | | | |
| | _ | entative come to the facility | | • | | | |
| : | | old notice if the representative | | | | | |
| : | wishes to hold the t | ped but the business office | | | | | : |
| | does not provide wi | ritten notification or has the | | | | | |
| : | , | the form if the representative | | | | | |
| | does not wish to ho | ld the bed. | | | | | |
| | A bed hold notice of Resident #73. | ould not be provided for | | : | | | |
| : | staff member) #1, t DON (director of nu | p.m., ASM (administrative he administrator, ASM #2, the ursing) and ASM #7, the facility aware of the above concerns. | | | | | • |
| | Resident #74's resident provide a written be | failed to evidence that dent representative was de hold policy/notification, transfer and admission to the 7 and 12/8/17. | | | | | |

| | | & MEDICAID SERVICES | | | | | M APPROVED |
|--------------------------|---|--|-------------------|------|--|---------|----------------------------|
| | OF DEFICIENCIES | l | (%0) 1411 | | CONCERNATION | | O. 0938-0391 |
| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | CONSTRUCTION | | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | i | | 0 | C 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | | 0,00,2010 |
| EVERGR | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 625 | Continued From pa | ge 96 | . F6 | 625 | | | |
| | 8/26/13 with the dia stroke, intestinal dis encephalopathy, de disorder, dysphagia cataracts, presbyop schizophrenia, bipo high blood pressure obstructive pulmon MDS (Minimum Da assessment with an Reference Date) of coded as severely omake daily life decitotal care for transference and bladder. | | | | | | |
| | following nurse's no | ent is Lethargic BP (blood | | : | | | : |
| : | @ (at) 83% BP [sic (Administrative Sta | espirations) 18, O2 (oxygen)] 282. New Order (ASM #5) ff Member, a Nurse | | | | | |
| : | mask. V.O. (verbal | O2@2L (oxygen at 2 liters) via order) (ASM #5) send to ER for evaluation for Hypoxia. | | | | | |
| | (Name of daughter) arrived at facility @ daughter. 911 notiff 1515 (3:15PM). Reference medical facility (emergency medical) |) notified @ 1455 (2:55PM) 1505 (3:05PM) report given to ied @ 1505 and arrived at | | i | | | |
| | called to ER (emerg | gency room) @1530 (3:30PM) Daughter agreed to bed | | | | | |

| | | & MEDICAID SERVICES | | | | | MAPPROVED). 0938-0391 |
|--------------------------|--|--|----------------------|-----|--|---------|--|
| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 03 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| | | | | WIN | NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION OATE |
| F 625 | Continued From pa | ge 97 | F | 625 | | | • |
| | | ence in the clinical record that entative was provided with a licv. | | | | | · |
| | A review of the clini | cal record revealed the test dated 12/24/17: | | | | | : |
| | upon arrival onto sh was asking questio for the past couple nurse had just com yesterday and thing didn't really want to self. Daughter ther swallow that was do went. Advised that had one done but well. Family agrees she would pass as mashed potatoes a resident is listed as admitted to feeding did well. NP (nurse nurse made aware | urse went in to visit resident nift. Family was present and ns about residents behaviors of days. Advised that this e on but had resident as seemed fine. Advised she talk but seemed her normal asked about the cookie one and wanted to know how it this nurse did not realize she wouldn't be surprised if it went d and then stated that they feel they have recently brought in nd gravy. Family aware that NPO (nothing by mouth) but it to her and stating that she e practitioner) and assigned of families [sic] comments." | | | | | |
| | (respirations) 22. It sounds) positive. Le yelling out and hitting hand when I was as denies pain or discoushe didn't feel well. Concerned about the | 00.3 tympanic pulse 72 R Jonlabored. BS (bowel aungs clear, Resident was ag this nurse with her right assessing her lungs. Resident comfort. Asked three times if Daughter here and is a left side of her neck which the https://www.asked.com/security/securit | | | · | | |
| : | - 4:22PM: (ASM # | 5) telephoned (hospital) back. | | | | | • |

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | O | MB NO. 09 | 38-0391 |
|---|--|---|--|-----|--|---------------------------------|-------------------------------|---------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ONSTRUCTION | ** | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | · | C 03/30 / | 2018 |
| | PROVIDER OR SUPPLIER EEN HEALTH AND R | ЕНАВ | | 380 | EET ADDRESS, CITY, STATE MILLWOOD AVENUE ICHESTER, VA 22601 | E, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD TO THE APPROPE | BE C | (X5) OMPLETION DATE |
| F 625 | (wasn't on call) but (gram) IM (intramus wants her mom to given. - 6:13PM: Informe she wants her mom can go. Daughter go 911 (nine one one) paperwork preparer verbalizing at this ti granddaughter at be simple questions apbed) elevated. EMTs device EMTS. Resident letting EMTS take he EMTs were success Transported safely daughter and grand - 10:17PM: (Hospi | ge 98 ordered Rocephin [1] 1 gm scular) now and if daughter go to hospital later on order is d daughter that NP stated if a to go to the hospital then she gave consent for her to go. telephoned. Necessary d. Resident is alert and me with gentle coaxing by edside. Resident answers opropriately. HOB (Head of Ts arrived, all paperwork given a somewhat non compliant with her vitals going to hit them, but eful after several attempts. out of Facility x2 EMTS and Idaughter following to hospital. tal) telephoned on update of to step down with diagnosis of | F6 | 625 | | | | |
| | the resident represe written bed hold pole written bed hold pole A review of the clinic following nurse's not a 3:05PM: V.O. (ve (Administrative Staff Practitioner) to send evaluation due to vo Staff reported no vo VSS (vital signs staff staff reported signs signs staff reported signs si | ence in the clinical record that entative was provided with a icy. cal record revealed the stes dated 12/8/17: erbal order) (ASM #8) | | | | | | |

| | | AND HUWAN SERVICES & MEDICAID SERVICES | | | | | M APPROVED D. 0938-0391 | |
|------------------------------|--|---|--|--|---|---------|------------------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DA | (X3) DATE SURVEY COMPLETED C | |
| | | 495142 | B. WING | | | 0: | 3/30/2018 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGR | EEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE | |
| F 625 | (at) 1504 (3:04PM) (3:10PM). Resident two spheres). - 3:19PM: (Hospita (3:20PM) resident in Report given to (howard to the resident admitted to the resident representation of the resident representation representa | and arrived to facility @ 1510 at A&Ox2 (alert and oriented to al) notified 2 [sic] 1520 an route to ER for evaluation. spital staff). with (hospital) with nurse. To room (room number) with colonic Mass. Notified (ASM action." ence in the clinical record that entative was provided with a cicy. | F6 | 325 | | | | |
| | providing a written I staff asks them if the much a day, and do LPN #6 stated if it is hear it and sign decibed hold policy. Wildocumentation of bestated she thinks the She didn't know whom 3/29/18 at 2:43F #2 (Other Staff Mermanager), she stated given when a reside The staff should be them the bed hold sthemselves so they #2 stated if they dor | Nurse), when asked about bed hold policy, she stated the bey want the bed hold, how a decline or an acceptance. It is over the phone, two nurses blined or accepted and sign hen asked if any written hed hold provided, LPN #6 for effort office gives it to them. It is at happens after that. PM, in an interview with OSM on the business office hed that a bed hold policy is ent is going out to the hospital. It talking to them and showing sheet so they can sign it know what is going on. OSM on't want to sign it, nursing to should be a state of the party regarding a bed | | | | | | |

| | | AND HUMAN SERVICES | | | FORM | APPROVED | |
|---|--|--|--|---|-------------------|---|--|
| CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING_ | | 03 | C / 30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE | · · · · · · · · · | | |
| EVERGR | EEN HEALTH AND R | EHAB | | WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 625 | business office. Os supposed to provide the hospital and she When asked if the frontice of bed hold in nursing probably is transfer. If they dor probably not getting On 3/29/18 at 6:05 meeting, the Admin Staff Member) #1, I and the facility own of the findings. A protifications was re- | In the sheet and bring it to the SM #2 stated they are e one each time they go out to e gets the signed papers. Family is being provided written notice, OSM #2 stated that notice a copy on each of want a bed hold, they are | F 6: | 25 | | | |
| : | tml 5. The facility staff f | | | | | : | |
| a non-comme | 11/19/17, with a mo 3/15/18 with diagno limited to: bladder ir blood pressure), ma | admitted to the facility on st recent readmission on ses that included but were not affections, hypotension (too low alnutrition, depression, sthma, and has a colostomy. | | | | | |

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment,

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 625 Continued From page 101 F 625 with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions. The clinical record revealed a nurse's note dated, 2/2/18 at 11:07 a.m. documented in part. "Resident c/o (complained of) dizzy feeling this am (morning) bp (blood pressure) obtained noted to be 64/40. NP (nurse practitioner) aware new order noted for Midodrine (used to elevate blood pressure) (1), 5 mg (milligrams) now and then qd (every day). Also ordered 1 liter of d5 (dextrose 5%) 1/2 (half strength) normal saline). Medication administered and IV (intravenous) placed to left arm. IV to start (sic) to infuse resident c/o left sided chest pain with pressure. B/P 76/50 at this time. Resident denied sob (shortness of breath) but stated she hadn't had this pain before and wanted to go to hospital. NP aware of new concerns. New order noted to send to er (emergency room) 911 (emergency medical services) called and daughter (name of daughter) aware. 911 left arrived assessed and left around 11 am. (Daughter's name) is aware of bed hold but will call later after she knows what the plan is for her mother." Review of the clinical record failed to evidence a copy of a written bed hold notice for the facility initiated transfer to the hospital on 2/2/18.

The clinical record documented a nurse's note dated, 2/28/18 at 10:13 a.m. "At Approximately 10:00 a.m. (Resident #97)'s CNA (certified nursing assistant) notified this nurse that (Resident #97) 'Yelling for a nurse and crying.' This nurse immediately assessed (Resident #97) and noted that she was pale and clammy with

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| AND I LAN OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
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NAME OF PROVIDER OR SUPPLIER

EVERGREEN HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

380 MILLWOOD AVENUE WINCHESTER, VA 22601

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**)

(X5) COMPLETION DATE

F 625 Continued From page 102

SOB (shortness of breath) at rest. Blood pressure was 56/48. (Resident #97)'s legs were immediately elevated and NP (nurse practitioner) notified. NP assessed (Resident #97) and order this nurse to send to ED (emergency department) 911 for eval (evaluation) and tx (treatment) due to symptomatic hypotension. BP was taken by second nurse and was noted to be 70/42. At approximately 10:10 AM, rescue squad arrived and noted her blood pressure to be 72/42 with continued symptoms. (Resident #97) was unable to keep eyes open but was responding verbally and answering questions accordingly/appropriately. VS (vital signs) at time of transfer to ED were as follows: 97.5 (temperature), 75 (pulse) 18 Respirations), 72/42 (blood pressure) 95% RA (95% oxygen saturation on room air). (Resident #97)'s husband notified per resident request."

Review of the clinical record failed to evidence a copy of a written bed hold notice for the facility initiated transfer to the hospital on 2/2/18.

An interview was conducted with LPN (licensed practical nurse) #6 on 3/29/18 at 2:25 p.m. When asked about the nurse's responsibility when a resident is sent to the hospital, LPN #6 stated, "I get vital signs, call the doctor or nurse practitioner to get the order, fill in the paperwork, call the family and call 911." When asked how she notifies the family, LPN #6 stated, "Verbally by phone." When asked if she provides any written notification to the family, LPN #6 stated, "I don't believe that the facility does that with written notification." When asked if any, nursing plays any part in the bed hold policy, LPN #6 stated. "We ask if they want the bed hold and the amount (cost) of the hold. We have either an acceptance

F 625

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIE | |
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| AND PLAN OF CORRECTION | |

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

(X3) DATE SURVEY COMPLETED

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C 03/30/2018

NAME OF PROVIDER OR SUPPLIER

EVERGREEN HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)COMPLETION DATE

F 625 Continued From page 103

or declination of the bed hold. Two nurses verify and sign the bed hold paper." When asked if this is done for every resident sent to the hospital. LPN #6 stated, "If they are admitted." When asked if the family or resident is given any written documents, LPN #6 stated, "No, once we get the bed hold signed it goes to the front office."

An interview was conducted with other staff member (OSM) #2, the business office manager, on 3/29/18 at 2:42 p.m. When asked her role in issuing a bed hold, OSM #2 stated, "Our bed hold policy is that a patient going out to the hospital. We should be talking to them and give them the sheet, if they are capable of signing it. If they go out and come back, they don't need one. The nursing staff follows up with the POA (power of attorney) or next of kin on going out and letting them know the policy for bed hold that is once they are admitted." When asked if this is done each time a resident goes to the hospital, OSM #2 stated, "Yes." When asked if the resident and or responsible party are given the written copy of the bed hold paper, OSM 2 stated, "We ask them to come in and sign. If we have an unsigned bed hold paper, and they want to hold the bed, when it is paid we make every attempt to get it signed." When asked if they are being given the written copy each time a resident goes out to the hospital, OSM #2 stated, "They are not being provided a copy from the facility. If the family is not here, then they are not getting a copy."

The administrator, director of nursing and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

F 625

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OATE DEFICIENCY) F 625 Continued From page 104 F 625 (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0011219/?report=details 6. The facility staff failed to give Resident #95 or the resident's representative a written bed hold notice for the 2/28/18 hospital admission. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. The most recent complete MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/18 coded the resident as having a 15 out of 15 on the BIMS (breif interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living. On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the nurses' role in providing bed hold notification. LPN #6 stated, "We have to ask if they want the bed hold; tell them how much a day and do a decline or acceptance and give to the front office." LPN #6 stated if the bed hold notice

ORM CMS-2567(02-99) Previous Versions Obsolete

sign."

offered and/or provided to resident

is provided over the phone then two nurses verify the telephone notification and sign the bed hold policy. When asked if written documentation is

representatives, LPN #6 stated, "If they are there they can sign but I think the front office has them

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | ,, 04, ,0,20 ,0 APPROVED), 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
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| F 625 | business office mar policy process. OS explain the bed hold hold form to a resid the hospital so the ron and can sign the should follow up wit attorney or next of k resident does not w When asked if the r provided written not when the resident is stated the policy is signed when a resid facility. OSM #2 stated the resident represent a sign the bed howishes to hold the bedoes not provide wr representative sign does not wish to hoo On 3/29/18 at 6:00 member) #1, the addirector of nursing a | M (other staff member) #2 (the nager) regarding the bed hold M #2 stated staff should dipolicy and provide the bed ent when he/she is going out resident knows what is going a form. OSM #2 stated nurses that resident's power of kin and explain the policy if the rant to sign the bed hold form. The resident representative is sice of the bed hold policy is sent to the hospital, OSM #2 provided and contracts are dent is first admitted to the lated the business office has entative come to the facility and notice if the representative bed but the business office ritten notification or has the the form if the representative | F6 | 25 | | |

were made aware of the findings.

No further information was obtained prior to exit.

F 641 Accuracy of Assessments

SS=B | CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record

F641

It is the policy of this facility to code all resident MDS assessments correctly per the current RAI manual utilizing the information provided in the resident EMR as well as direct observation and interview with resident. Corrective action has been accomplished for the alleged deficient practice in regards to accurate documentation for restraint use for Residents # 105, 95, 37, 69, 99, 90, 89, 130, 132, 133, 47, 66, 57, 3, 74, 114, 87, 83 and 55 for MDS assessments with ARD dates

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| EVERGR | REEN HEALTH AND R | EHAB | | | CHESTER, VA 22601 | |
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| | maintain an accurate assessment for nine survey sample, Res #99, #90, #89, #130 #3, #74, #114, #87, 1. The facility staff f quarterly (minimum with an ARD (asses 3/5/18, accurately for external urinary cath 2. The facility staff f quarterly MDS asses 2/23/18, accurately 3. The facility staff f quarterly MDS (minimized minimized minim | mined the facility staff failed to the minimum data set (MDS) between of 31 residents in the sidents #105, #95, #37, #69, 0, #132, #133, #47, #66, #57, #83 and #55 ailed to code Resident #105's data set) MDS assessment, sment reference date) of or the use of a restraint and an enter. ailed to code Resident #95's assment, with an ARD of for the use of a restraint. ailed to code Resident #37's imum data set) assessment, #18, accurately for the use of courate dental assessment. ailed to code Resident #69's imum data set) assessment, #18, accurately for the use of courate dental assessment, #18, accurately for the use of alled to code Resident #99's MDS (minimum data set) and ARD of 3/5/18, accurately resint. | F 641 | 3. | affected by the alleged deficient prace audit of resident MDS assessments quarter of 2018 will be conducted to incorrect coding of Sections "P", "H' Corrections will be made as necessar Measures put into place to assure all deficient practice does not recur inclust Coordinators have been re-educated reviewed the current RAI Manual redefinition of restraint use and correct bladder and dental issues. The Director of Nursing and/or designed to the correct coding of Section and "L". Any non-compliance discondiscussed at weekly Risk Manageme and an action plan developed. Ongo non-compliance will be discussed at Quality Assurance meetings and an will be adjusted as the committee matericommend based on outcomes identifications. | at practice in external ded for been factice in dental or resident # otential to be tice. An for the first o identify dentify
| : | MDS assessment, a | railed to code Resident #90's a quarterly assessment, with rence date of 2/22/18, | | : | | I |

accurately for the use of a restraint.

7. The facility staff failed to code Resident #89's quarterly MDS assessment, with an assessment

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| F 641 | | ge 107 /22/18, accurately for the use | F6 | 41 | | | |
| | inaccurately as hav quarterly MDS (min | coded Resident #130 ing a physical restraint on a imum data set) assessment ssment reference date) of | ı | | | | |
| | #132 as having a pl significant change i | naccurately coded Resident nysical restraint on a n status MDS (minimum data th an ARD (assessment 1/15/18. | | ٠, | | | |
| : | #133 as having a phadmission MDS (mi | inaccurately coded Resident nysical restraint on an nimum data set) assessment sment reference date) of | | · | | | |
| | annual MDS (minim an ARD (assessmen | coded the Resident #47's um data set) assessment with nt reference date) of 1/1/18 in se of restraints when in fact have restraints. | | | | | |
| ! | quarterly MDS (mini with an ARD (asses 2/13/18, in accurate | coded Resident #66's mum data set) assessment sment reference date) of ly for the use of restraints, ident did not have restraints. | | : | | | : |
| | | coded Resident #57's mum data set) assessment | | | | | : |

with an ARD (assessment reference date) of 2/8/18, inaccurately for the use of a restraint, when in fact the resident did not have restraints.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION tD (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 641 Continued From page 108 F 641 14. The facility staff coded Resident #3's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/14/18, inaccurately for the use of restraints. when in fact the resident did not have restraints. 15. The facility staff coded Resident #74's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/16/18, inaccurately for the use of restraints. when in fact the resident did not have restraints. 16. The facility staff coded Resident #114's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/6/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. 17. The facility staff coded Resident #87's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/12/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. The facility staff coded Resident #83's MDS assessment correctly for the use of restraints. when in fact the resident did not have restraints. 19. The facility staff coded Resident #55's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints. when in fact the resident did not have restraints.

The findings include:

1. Resident #105 was admitted to the facility on

diagnoses that included but were not limited to:

4/23/10 and readmitted on 6/17/13 with

| | | Law SERVICES | | | | OMB N | O. 0938-0391 |
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| F 641 | Continued From paranemia, diabetes, h speaking and depre | igh blood pressure, difficulty | F | 341 | | | |
| | with an ARD (asses 3/5/18 coded the resident of the BIMS (brid indicating the resident make daily decision of daily living. The rean external urinary of Restraints and Alarn documented, "Physimethod or physical of material or equipment resident's body that easily which restricts | cal restraints are any manual or mechanical device, nt attached or adjacent to the the individual cannot remove a freedom of movement or e's body." The resident was | | | | | |
| i i | documented, "1/2 side or safety every shift: | ian's March 2018 orders de rails to aide in position and Start Date 9/27/2018." There on regarding an external | | | | | |
| : : : | side rails to aide in po shift Start Date 9/27/ the side rails were in | 2018 treatment I (TAR) documented, "1/2 osition and or safety every 2018." It was documented place each shift." There was garding an external urinary | | | | | |
| (| Review of the care pl documentation regard external urinary cathe | ding the side rails or an | | | | | : |

| CTATEMEN | | WEDICAID SERVICES | T | | | <i>).</i> 0938-0391 |
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| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | <u> </u> | <i>3</i> |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 641 | evaluation dated 8/2 Resident Evaluation representative has rails. Yes (was mark physically able to us | ge 110 ail and entrapment risk 29/17 documented, "B. a. 1. The resident/resident requested use of the side (ed). 2. The resident is the the side rails for bed er independently or with | F 64 | | | |
| | assistance. Yes (wa able to recognize sa side rails. Yes (was Observations were | s marked). 3. The resident is fety hazards when using the | ; | : | | : |
| : | catheter seen. The wheelchair and the seen and the seen and the seen and the seen an interview was cop.m. with LPN (licen resident's nurse. Whan external catheter | resident was always in the side rails were lowered. Inducted on 3/28/18 at 4:30 sed practical nurse) #6, the nen asked if the resident had LPN #6 stated, "No. He les to the bathroom." | | | | · • |
| : | p.m. with RN (registre coordinator. When a P of the MDS quarter (assessment referer stated she did. Whe triggered for a physic "The first question uralls, the majority of rails it triggers for a repolicy or manual she RN #1 stated, "The Finstrument)." RN #1 the RAI for section P#1 returned she state | nducted on 3/29/18 at 12:48 ered nurse) #1, the MDS sked who completed section rly assessment, with an ARD noted ate) of 3/5/18, RN #1 asked why the resident cal restraint, RN #1 stated, nder section P is for side our residents have half side estraint." When asked what a used to complete section P, RAI (resident assessment was asked to bring a copy of to the surveyors. When RN ed, "I just talked to (name of | | | | |
| ! | director of nursing). | She said if the use of the bed tion of a physical restrain | | | | |

| STATEMEN AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | (X3) D | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | | C 3/30/3048 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 | EET ADDRESS, CITY, STATE, ZIP MILLWOOD AVENUE ICHESTER, VA 22601 | CODE | 3/30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 641 | meet those required restraint." When as were considered a | ge 111 n as a restraint but if they don't ments we don't code it as a ked if the resident's side rails restraint, RN #1 stated, "No." MDS was coded correctly, RN | F 6 | 641 | | | |
| | On 3/29/18 at 6:00 administrator, ASM ASM #7, the facility the findings. | p.m. ASM #1, the #2, the director of nursing and owner were made aware of | : | | | | |
| | a.m. with CNA (cert resident's aide. Who | inducted on 3/30/18 at 9:05 ified nursing assistant) #4, the en asked if the resident had r, CNA #4 stated, "Never." | | ÷ | | | : : |
| : | p.m. with RN #1. W 3/5/18 MDS for the | nducted on 3/30/18 at 1:30 hen asked to review the external catheter, RN #1 nistake. He doesn't have an | | i | | | |
| : | 2. The facility staff faquarterly MDS asset | on was provided prior to exit. ailed to code Resident #95's ssment, with an ARD of for the use of a restraint. | | ; | • | | |
| 1 | 2/17/16 and readmit that included but we | dmitted to the facility on ted on 3/3/18 with diagnoses re not limited to: intestinal enia, heart failure and | | : | | | |
| | assessment, with an resident as having so | nplete MDS, a quarterly ARD of 2/23/18 coded the cored 15 out of 15 on the esident was cognitively intact | | | · | | : |

| | | & MEDICAID SERVICES | | | | OMB N | <u>0. 0938-0391</u> |
|---------------|--|---|---------------------|-----|--|--------|----------------------------|
| AND PLAN | IT OF DEFICIENCIES OF C O RRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | i | | | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | 3/30/2018 |
| EVED OF | DEENIUEALTH AND D | | | | MILLWOOD AVENUE | | |
| EVERGI | REEN HEALTH AND R | EHAB | | | NCHESTER, VA 22601 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ۵i | | PROVIDER'S PLAN OF CORRECT | CON | 1 |
| PREFIX TAG | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BF | (X5) COMPLETION OATE |
| F 641 | Continued From pa | ge 112 | F | 641 | | | : |
| | | ions. The resident was coded | . ' ' | , T | | | |
| | as requiring superv | ision for activities of daily | | | | | ! |
| | living. In Section P | Restraints and Alarms the | | ! | | | : |
| | following was docur | nented, "Physical restraints | | | | | |
| | are any manual me | thod or physical or mechanical | | | | | |
| | device, material or | equipment attached or | | | | | į. |
| | adjacent to the resid | dent's body that the individual | | | | | • |
| | movement or norma | ly which restricts freedom of | | | | | |
| | resident was coded | al access to one's body." The as using the bed rails daily. | | : | | | · • |
| | i | as doing the bed rails daily. | | | | | |
| | Review of the Marcl | n 2018 physician's orders | | | | | |
| | documented, "use o | of bilateral rails for positioning | | | | | |
| | and safety every shi | ft for House prot(protocol) | | | | | |
| : | Start Date 3/5/2018 | 31 | | : | | | |
| | Doubless of the Me. | 0040 740 84 | | | | | |
| ! | documentation rega | 1 2018 TAR did not evidence | | | | | ; |
| : | documentation rega | rung the side rails. | | | | | |
| | Review of the care production regard | plan did not evidence rding the use of the side rails. | | : | | | : |
| | Review of the side r | ail and entrapment risk | | | | | |
| | evaluation dated 3/3 | /18 documented, "B. | | | | | |
| İ | | . 1. The resident/resident | | | | | ĺ |
| • | representative has r | equested use of the side | | | | | 1 |
| 1 | rails. Yes (was mark | ed). 2. The resident is | | | | | Î |
| | physically able to us | e the side rails for bed | | | | | : |
| | positioning or transfe | er independently or with | | | | | ı |
| : | assistance. Yes (was | s marked). 3. The resident is | | | | | - |
| | side rails. Yes (was i | fety hazards when using the | | : | | | |
| • | Side rails. TES (Was ! | narkeo). | | | | | |
| | An interview was cor | nducted on 3/29/18 at 12:48 | | : | | | * |
| | | ered nurse) #1, the MDS | | | | | ĺ |
| ! | coordinator. When a | sked who completed section | | | | | . |
| 1 | P of Resident #95's | quarterly MDS assessment. | | | | | |
| : | with an ARD of 2/23/ | 18, RN #1 stated she did. | | | | | . [|
| | When asked why the | resident triggered for a | | | | | |

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| | | * MEDICAID SERVICES | | | | OMB N | O. 0938-039 |
|--------------------------|---|--|----------------------|------|--|--------|----------------------------|
| AND PLAN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | CONSTRUCTION | (X3) D | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | | | | С |
| NAME OF | PROVIDER OR SUPPLIER | | 1 5: 11:10 | | EET ADDDESS OF THE | 0 | 3/30/2018 |
| | | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERG | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE | | |
| (VA) ID | SI MANA DV CTA | TEMENT OF DESIGNATION | | AAII | NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 641 | Continued From pa | ne 113 | | ! | | | |
| | | N #1 stated, "The first | F 6 | 41 | | | |
| | question under sect majority of our resid triggers for a restrai | tion P is for side rails, the lents have half side rails it nt." When asked what policy | | : | | | |
| | stated, "The RAI (re | to complete section P, RN #1 sident assessment | | | | | · |
| | ∃ the RAI for section I | was asked to bring a copy of to the surveyors. When RN | | | | | |
| | #1 returned she star | ted, "I just talked to (name of She said if the use of the bed | | I | | | |
| | rails meets the defir | nition of a physical restrain | | : | | | |
| | then we count them | as a restraint but if they don't | | : | | | |
| | restraint." When ask were considered a r | nents we don't code it as a ked if the resident's side rails estraint, RN #1 stated, "No." | | | | | |
| | When asked if the Name of the | MDS was coded correctly, RN | | | | | |
| | On 3/29/18 at 6:00 p administrator, ASM a ASM #7 the facility of the findings. | o.m. ASM #1, the #2, the director of nursing and owner were made aware of | | | | | |
| | . 3. The facility staff fa | ailed to accurately code | | | | | |
| | Resident #37's quar | terly MDS (minimum data | | | | | |
| | ˈset) assessment, wit | th an ARD of 1/22/18 for the | | | | | |
| | use of a restraint and assessment. | d an accurate dental | | • | | | |
| | Resident #37 was ac | dmitted to the facility on | | | | | · : |
| į | 1/17/17 and readmitt | ted on 12/11/17 with | | • | | | ı |
| | diagnoses that include | ded but were not limited to: | | | | | ļ |
| | and kidney disease. | ss of breath, diabetes, stroke | | | | | : |
| | The most recent MD | S, a quarterly assessment, | | | | | |
| : | with an ARD of 1/22/ | 18 coded the resident as | | | | | , |
| | having scored 15 out indicating the resider | of 15 on the BIMS, at was cognitively intact to | | | | | : |

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | NO. 0938-0391 |
|--------------------------|--|--|---------------------|-----------|--|----------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CON | STRUCTION | | DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET | ADDRESS, CITY, STATE, ZIP COD | DE | |
| EVERGR | REEN HEALTH AND R | EHAB | | | LWOOD AVENUE HESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 641 | make daily decision requiring assistance daily living except for could perform after section L Oral/Decoded as having not Restraints and Alar documented, "Physimethod or physical material or equipmeresident's body that easily which restrict normal access to occided as using the Review of the nursi | ns. The resident was coded as a from staff for all activities of or eating which the resident the tray was prepared. In ental status, the resident was a dental issues. In Section P ms the following was cical restraints are any manual or mechanical device, ent attached or adjacent to the attached or adjacent to the attached or movement or ne's body." The resident was bed rails daily." | F 6 | 41 | | | |
| | An interview was cop.m. with Resident use of the side rails them all the time. To move around in the interview, the reside for dentures because teeth and her gums eats, but was told it she couldn't afford thad requested the complex weeks again. | onducted on 3/27/18 at 3:23 #37. When asked about the , Resident #37 stated, "I use hey make it easier for me to bed by myself." During the ent stated that she had asked se she has many missing hurt sometimes when she would be out of pocket and them. When asked when she dentures, Resident #37 stated, io." | | | | | |
| : | documented, "1/2 s and positioning, and with stabilization wh | h 2018 physician's orders ide rails x2 to assist in turning d transfer to/from bed, and lile sitting on the side of the | | | | | |

There was no evidence of an order for the

resident to be seen by the dentist.

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | ILTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|----------------------|---|-----------------------------------|-------------------------------|--|
| | | 495142 | B. WING | 3 | 0. | C 3/30/2018 | |
| | PROVIDER OR SUPPLIEF | R | | STREET ADDRESS, CITY, STATE, Z 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 641 | Continued From p | page 115 | Ff | 641 | | | |
| | side rails x2 to ass and transfer to/from while sitting on the shift). Start Date 1 | rch 2018 TAR documented, "1/2 sist in turning and positioning, om bed, and with stabilization e side of the bed QS (every 11/28/2017." The plan did not evidence agarding the side rails. | | | | | |
| | documented "Focu | e plan initiated on 3/23/18 cus. The resident is a smoker. ks. Monitor oral hygiene." | : | | | | |
| | evaluation dated 1 Resident Evaluation representative has rails. Yes (was man physically able to upositioning or transassistance. Yes (was manassistance. | e rail and entrapment risk 11/28/17 documented, "B. on. 1. The resident/resident s requested use of the side arked). 2. The resident is use the side rails for bed asfer independently or with was marked). 3. The resident is safety hazards when using the as marked)." | : | | | | |
| ! : | for March 2018 did | sing and social services notes d not evidence documentation dent's request for dentures and dentist. | : | | | | |
| | p.m. with RN (regis coordinator. When P Resident #37's of set) assessment, v stated she did. Wh triggered for a phys "The first question | conducted on 3/29/18 at 12:48 istered nurse) #1, the MDS nasked who completed section quarterly MDS (minimum data with an ARD of 1/22/18, RN #1 hen asked why the resident vsical restraint, RN #1 stated, a under section P is for side of our residents have half side | | | | | |

| <u> </u> | INO I OIN MEDIOANE | A MEDICAID SERVICES | | | Civ | <u>/ID INU.</u> | 0930-0391 |
|--------------------------|--|---|---------------------|--|------------|-----------------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | ILTIPLE CONSTRUCTION DING | ļ | | ESURVEY PLETED |
| | | 495142 | B. WING | 3 | | | C 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | "" | · | STREET ADDRESS, CITY, STATE, ZIP C | :ODE | -00/1 | 30/2010 |
| | REEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | OBL | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX (EACH CORRECTIVE ACTION | I SHOULD E | BE ! | (X5) COMPLETION OATE |
| F 641 | policy or manual sh RN #1 stated, "The instrument)." RN #1 the RAI for section #1 returned she sta director of nursing). rails meets the defit then we count them meet those requirer restraint." When as were considered a When asked if the I #1 stated, "No." On 3/29/18 at 6:00 administrator, ASM | restraint." When asked what e used to complete Section P, RAI (resident assessment was asked to bring a copy of P to the surveyors. When RN ted, "I just talked to (name of She said if the use of the bed nition of a physical restrain as a restraint but if they don't ments we don't code it as a ked if the resident's side rails restraint, RN #1 stated, "No." MDS was coded correctly, RN | F 1 | 641 | | | |
| | An interview was co a.m. with RN (regist coordinator. When a L of the MDS, RN # how the residents w "The first thing I loo note and the admiss I do my initial intervi- about their teeth. I a own teeth or if they having any issues w their dentures are n assessment of my of Section L of the res which the resident w issues, RN #1 state answer for you on h asked if the residen | onducted on 3/30/18 at 11:31 tered nurse) #1, the MDS asked who completed Section 1 stated, "I do" When asked were assessed, RN #1 stated, k at is the nursing admission sion assessment form. When sew with the resident, I talk ask them if they have their have dentures. If they're with their teeth or gums or if ot fitting properly. I do an own." When asked to review ident's MDS assessment in was coded as having no dental d, "I don't really have an ow that happened." When t should have been coded as s, RN #1 stated, "Absolutely it | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|---|---|----------------------|-----|--|-----------|----------------------------|
| | | 495142 | B. WING | | | C | |
| | PROVIDER OR SUPPLIER | | | 380 | EET ADDRESS, CITY, STATE, ZIP COD MILLWOOD AVENUE NCHESTER, VA 22601 | | 0/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 641 | should have been of 4. The facility staff f quarterly MDS (min | _ | F 6 | 41 | | | |
| | 7/8/16 and readmitt that included but we | admitted to the facility on ed on 8/25/17 with diagnoses ere not limited to: heart failure, hypertension and difficulty | | : | | | |
| | with an ARD of 2/14 scoring 15 out of 18 was coded as need all activities of daily Restraints and Alarr documented, "Phys method or physical material or equipmeresident's body that easily which restricts | DS, a quarterly assessment, I/18 coded the resident as on the BIMS. The resident ing assistance from staff for living. In Section P ms the following was ical restraints are any manual or mechanical device, ent attached or adjacent to the the individual cannot remove a freedom of movement or ne's body." The resident was bed rails daily. | | : | | | |
| | documented, "1/2 si and or safety every Review of the March side rails to aide in p shift Start Date 09/2 | olan did not evidence | | | | | |
| | | nducted on 3/29/18 at 12:48 | | - | | : | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI | TIPLE CONSTRUCTION | OI | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|-------------------|---|-------------------------|-------------------------------|----------------------------|--|
| | | | | | ; | : | C | |
| | | 495142 | B. WING | | | 03/ | 30/2018 | |
| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | P CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | ON SHOULD HE APPROPF | BE | (X5) COMPLETION OATE | |
| F 641 | coordinator. When P of the MDS, RN # why the resident trig RN #1 stated, "The is for side rails, the half side rails it trigg asked what policy complete Section P (resident assessme asked to bring a cothe surveyors. Whe "I just talked to (nar said if the use of the of a physical restrair restraint but if they we don't code it as resident's side rails | asked who completed section asked who completed section 1/41 stated she did. When asked aggered for a physical restraint, a first question under section P majority of our residents have gers for a restraint." When ar manual she used to 1/27, RN #1 stated, "The RAI and instrument)." RN #1 was py of the RAI for section P to the RN #1 returned she stated, me of director of nursing). She are bedrails meets the definition in then we count them as a don't meet those requirements a restraint." When asked if the were considered a restraint," When asked if the MDS was | F | 641 | | | | |
| | ASM #7 the facility the findings. 5. The facility staff f significant change Massessment, with a for the use of a rest Resident #99 was a 6/9/17 and readmitt that included but we | #2, the director of nursing and owner were made aware of failed to code Resident #99's MDS (minimum data set) in ARD of 3/5/18, accurately traint. admitted to the facility on the ded on 2/26/18 with diagnoses the renot limited to: heart failure, and depression and cognitive | | | | | | |
| | | DS, a significant change n ARD of 3/5/18 coded the | | | | | | |

| CLIVIL | TO OIL WEDIONICE | = & MEDICAID SERVICES | | | <u>_</u> | VID INU. | <u>0938-0391</u> | |
|--------------------------|--|--|----------------------|--|---|------------------------------------|----------------------------|--|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED C | | |
| | | 495142 | B. WING | | | | 30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | | | STREET ADDRESS, CI 380 MILLWOOD AVE WINCHESTER, VA | NUE | - | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORF | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY) | BE | IX5) COMPLETION DATE | |
| F 641 | was not able to come was coded as understood and have memory. The residence assistance for all acceptance for ac | he BIMS indicating the resident implete the exam. The resident erstanding others and being aving intact short and long term lent was coded as requiring activities of daily living. In a sints and Alarms documented, are any manual method or nical device, material or dor adjacent to the resident's dual cannot remove easily adom of movement or normal dy." The resident was coded ails daily. The resident was coded as a side rails to assist in turning every shift Start Date the 2018 TAR documented, "1/2 in turning and repositioning | | i41 | | | | |
| | An interview was co p.m. with RN (regist coordinator. When a P of Resident #69's data set) assessme RN #1 stated she di resident triggered fo stated, "The first que side rails, the majori side rails it triggers to what policy or manu | plan did not evidence arding the use of the side rails. Onducted on 3/29/18 at 12:48 stered nurse) #1, the MDS asked who completed section of quarterly MDS (minimum ent, with an ARD of 2/14/18, lid. When asked why the or a physical restraint, RN #1 sestion under section P is for rity of our residents have half for a restraint." When asked sal she used to complete tated, "The RAI (resident) | : | | | | | |

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB N | O. 0938-0391 |
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| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) D/ | ATE SURVEY OMPLETED |
| _ | | 495142 | B. WING | | | 0. | C 3/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | 0/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED T | JLD BE | (X5) COMPLETION OATE |
| | bring a copy of the surveyors. When R just talked to (name said if the use of the of a physical restraint but if they we don't code it as resident's side rails RN #1 stated, "No." coded correctly, RN On 3/29/18 at 6:00 administrator, ASM | nent)." RN #1 was asked to RAI for section P to the N #1 returned she stated, "I e of director of nursing). She e bed rails meets the definition in then we count them as a don't meet those requirements a restraint." When asked if the were considered a restraint, "When asked if the MDS was I #1 stated, "No." | F6 | 641 | | | |
| : | The facility staff MDS assessment, a | on was provided prior to exit. failed to code Resident #90's a quarterly assessment, with erence date of 2/22/18, se of a restraint. | | | | | |
| | 5/2/12 with diagnose limited to: Huntington hereditary condition involuntary rapid, jet deterioration, leading weakness, schizophymental disorders challot distortions of reality, contacts, and disturbly perception and emodysphagia (a condition difficult or painful during limited to the second se | idmitted to the facility on es that included but were not on's chorea (abnormal characterized by progressive rky motions and mental g to dementia) (1), muscle prenia (any of a group of aracterized by gross withdrawal from social bances of thought, language, ational response.) (2), and ion in which swallowing is the to obstruction of the cular abnormalities of the | | | | | |

esophagus). (3)

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | TIPLE CONSTRUCTION PING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|----------------------|--|--|-------------------------------|--|
| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY 380 MILLWOOD AVENU WINCHESTER, VA 2 | JE | 03/30/20 18 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF: TAG | X (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| F 641 | assessment, with a of 2/22/18, coded the on the BIMS (brief is score indicating the to make cognitive of was coded as required one or more staff of daily living. In Sealarms, the resider daily. The instruction Restraints: Physical material or equipment resident's body that easily which restrict normal access to or | DS assessment, a quarterly in assessment reference date he resident as scoring a two interview for mental status) a resident is severely impaired laily decisions. The resident iring extensive assistance of hembers for all of his activities action P - Restraints and it was coded as using bed rails ans under P0100 Physical I restraints are any manual or mechanical device, ant attached or adjacent to the it the individual cannot remove its freedom of movement or ne's body." | . F6 | 541 | | | |
| | dated 2/16/18, docu "1. The resident/res requested use of th documented. 2. The resident is p rails for bed position independently or wi documented. 3. The resident is a when using the side 4. The resident doe that would place res entrapment - Yes w 5. The resident has trunk control when i bed - Yes was docu 6. The resident doe 'climbing' over or ar documented. | th assistance - Yes was ble to recognize safety hazard e rails - Yes was documented. s not demonstrate behaviors sident at risk for injury and/or as documented. difficulty with balance or poor n bed or transferring to/from mented. s not have a history of ound rails - Yes was | | | | | |
| : | | s not have an injury from use | | ; | | | |

| | VT OF OEFICIENCIES OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | (X2) MUI A. BUILO | ILTIPLE CON: OING | (X3) OAT COM | (X3) OATE SURVEY COMPLETEO | |
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| | | 495142 | B. WING | 3 | | 1 | C / 30/2018 |
| | PROVIOER OR SUPPLIER | | | STREET 380 MIL | AOORESS, CITY, STATE, ZIP COOE LWOOD AVENUE HESTER, VA 22601 | <u>l = -</u> . | 30/2010 |
| (X4) IO PREFIX TAG | (EACH OEFICIENC) | ATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION) | IO PREF TAG | -IX | PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY) |) BE | (X5) COMPLETION OATE |
| F 641 | functionally) to use assistance - Yes wa 9. The use of a side independence in be was documented. 10. The use of the staff will optimize re Yes was documented. 11. The resident is pressure mattress of documented. 12. The resident ha movements - No was 13. The resident ha unsafe behaviors the No was documented 14. The bed inspected demonstrated that the railed and mattress entrapment or restrict 15. Resident/reside consent if side rails 16. Physician order rails - Yes was documented in the resident or the r | was documented. able (cognitively and e the call bed to call for vas documented. de rail will optimize resident led mobility and transfer - Yes side rail during care provide by resident safety and security - ted. using an alternation air or overlay mattress - No was as uncontrolled body vas documented. as periods of confusions or hat may place resident at risk - ed. ction has been completed and the bed is safe functionally and s do not create a risk for raint - Yes was documented. ent representative has signed as are being used. r is complete for use of side eumented." ned and dated by the nurse | F (| 641 | | | |
| | "Padded side rails of the comprehensive documented in part impaired skin integr documented in part padded to aid in turn | | | | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | <u>O</u> | <u>MB NO. 0938-039</u> | 1 |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | C 03/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | E, ZIP CODE | | \neg |
| E1 /== == | | | | 380 MILLWOOD AVENUE | • | | |
| EVERGR | REEN HEALTH AND R | EHAB | | WINCHESTER, VA 22601 | | | |
| /V4) ID | CI IMMADV CTA | TEMENT OF DEFICIENCIES | | · · · · · · · · · · · · · · · · · · · | | | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI | ACTION SHOULD TO THE APPROPE | BE COMPLETION | |
| F 641 | Continued From pa | ge 123 | : F6 | 41 | | • | |
| | | coordinator, on 3/29/18 at | | •• | | | |
| | | sked why the resident was | | | | | |
| | coded for restraints | , RN #1 stated, "The first | : | | | • | |
| | | o bedrails. Most have one | | | | • | |
| | | ce for positioning. So the first | | | | : | |
| | | use side rails, and how often." | | | | 1 | |
| | | get the RAI (resident | | : | | • | |
| | assessment instrun | nent) manual. She returned at | | • | | | |
| | | p.m. and stated, "I spoke with | | | | | |
| | | f nursing), she (the DON) said | | | | | 1 |
| | | I rails meets the definition of a | | | | | |
| | | en we code them as a | | | | | |
| : | | don't meet the requirement | | | | | |
| | | it as a restraint." When asked | | | | 1 | |
| | | straint, RN #1 stated, "any | | | | | ١ |
| | | physical or mechanical device, | | | | : | Ì |
| | | ent attached or adjacent tot eh he individual cannot remove | | | | | |
| | | stricts freedom of movement | | | | • | |
| : | | one body. This is as per the | | | | | |
| | | I further stated, "We are | | | | | |
| | | reevaluate all of this." RN #1 | | | | |] |
| | | et the definition for a restraint, | | | | | Ì |
| | | s playing safe. Not everyone | | | | | - |
| : | | e if they met the definition of | | | | | - |
| i | | sked if side rail assessments | | : | | : | - |
| | | MDS, RN #1 stated, "Yes but | : | | | | |
| | not by me. The nurs | se's do them." | | | | | - |
| | 0-0100140 : 4 == | DATE WAR | | | | | |
| ı | On 3/29/18 at 4:09 a | a.m., RN #1 returned and | | | | ė. | |
| | | the list of residents that was | | | | i : | |
| | | f they met the criteria for a | | | | | |
| | criteria for a restrain | ot. None of them meets the | | | | | |
| : | cinena ioi a restram | и. | | | | ! | |
| | The administrator A | ASM (administrative staff | | | | : | |
| : | member) #1, the dir | ector of nursing, ASM #2 and were made aware of the | • | | | | |

above findings on 3/29/18 at 6:10 p.m.

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | 0.5 | C 3/ 30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 73072010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 641 | Continued From p | age 124 | F 6 | 41 | | : | |
| | No further informa | tion was provided prior to exit. | | | | | |
| | Non-Medical Read Chapman, page 2 (2) Barron's Diction Non-Medical Read Chapman, page 5 (3) Barron's Diction Non-Medical Read Chapman, page 1 7. The facility staff quarterly MDS asserference date of 2 of a restraint. Resident #89 was 5/4/14 with a recent diagnoses that incleft shoulder pain, | nary for Medical Terms for the der, 5th edition, Rothenberg and 22. nary for Medical Terms for the der, 5th edition, Rothenberg and | | | | | |
| : | pressure, stroke, a disorder in which to from reality and ha | nd psychosis (major mental he person is usually detached is impaired perceptions, s and interpersonal | | : | | | |
| | with an assessment coded the resident | IDS, a quarterly assessment, nt reference date of 2/22/18, as scoring a 15 on the BIMS | | | | : | |
| :: | the resident was ca cognitive decisions requiring extensive staff members for | mental status) score, indicating apable of making daily The resident was coded as assistance of one or more most of her activities of daily Restraints and Alarms, the | | | | : | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | | C | |
| | PROVIDER OR SUPPLIE | R | | STR 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | 1 0. | 3/30/2018 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 641 | The most recent 'Evaluation" dated nurse on 12/20/13 "The "Side Rail & dated 2/16/18, do "1. The resident/n requested use of documented. 2. The resident is rails for bed positi independently or documented. 3. The resident is when using the side. The resident dothat would place rentrapment - Yes 5. The resident hat trunk control when bed - Yes was doc 6. The resident do | ed as using bed rails daily. Side Rail & Entrapment Risk, 12/15/17 and signed by the 7, documented the following: Entrapment Risk Evaluation" cumented in part the following: esident representative has the side rails Yes was physically able to use the side oning or transfers with assistance - Yes was able to recognize safety hazard de rails - Yes was documented. The side of the side on the side on the side on the side on the side on the side on the side on the side on the side on the side on the side of the side | F6 | 541 | | | | |
| | documented. 7. The resident do of side rails - Yes 8. The resident is functionally) to use assistance - Yes v 9. The use of a sid independence in b was documented. 10. The use of the staff will optimize of Yes was document 11. The resident is | les not have an injury from use was documented. able (cognitively and e the call bed to call for was documented. de rail will optimize resident led mobility and transfer - Yes side rail during care provide by resident safety and security - | | | | | | |

| | FOR DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|----------------------|-----|---|-------------------------------|----------------------------|--|
| | | 495142 | B. WING | i | | 02 | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | _1 | 100/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFILIENCY) | DBE | (X5) COMPLETION OATE | |
| F 641 | movements - No will a The resident has unsafe behaviors the No was documented 14. The bed inspect demonstrated that it railed and mattress entrapment or restricts. Resident/reside consent if side rails 16. Physician order rails - Yes was documented in part impaired skin integrit documented in part impaired skin integrit documented in part impaired skin integrit documented in part to aid in turning and On 3/29/18 at 4:09 stated, "I evaluated #89 was on the list) they met the criteria None of them meet. The administrator, member) #1, the direct ASM #7, the owner above findings on 3. No further information (1) Barron's Dictional contents of the properties of the part of th | as uncontrolled body as documented. Is periods of confusions or nat may place resident at risk - id. Ition has been completed and the bed is safe functionally and do not create a risk for aint - Yes was documented. Intrepresentative has signed are being used. Is complete for use of side umented." If dated 5/26/18 documented, to aid in bed mobility every If care plan dated, 5/26/17, If "Focus: Potential for rity." The "Interventions" If "Resident has 1/2 side rails If positioning." a.m., RN #1 returned and the list of residents (Resident that was given to me to see if a for a restraint. They do not. Is the criteria for a restraint. ASM (administrative staff rector of nursing, ASM #2 and were made aware of the | | 341 | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | <u>OMB</u> | NO. 0938-0391 |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION DING | | 3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | *** | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | - |
| EVERGR | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (V4) ID | SI IAAAA DV STA | TEMENT OF DEFICIENCIES | | ** | S=0=:01: | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION E DATE |
| F 641 | : · Continued From pa | ge 127 | · F6 | 641 | | , |
| | Chapman, page 48 | - | | | | |
| | | | | | | |
| | | coded Resident #130 | | • | | |
| | | ing a physical restraint on a | | | | |
| | | imum data set) assessment | | | | |
| | 3/9/18. | ssment reference date) of | : | | | • |
| | | | | | | |
| | | admitted to the facility on | | | | |
| | | tted on 2/2/18. Resident | | | | |
| | | ncluded but were not limited to | | | | |
| | | es and urinary tract infection. ost recent MDS, a quarterly | | | | |
| | | ARD of 3/9/18, coded the | | | | |
| | | ely intact. Section G | | | | |
| | documented Reside | ent #13 0 as requiring | | | | |
| | | e of one staff with bed | | | | |
| | | 0100 Physical Restraints ical restraints are any manual | | | | |
| | | or mechanical device, | | | | |
| ! | | ent attached or adjacent to the | | | | |
| ļ | resident's body that | the individual cannot remove | | | | |
| : | | s freedom of movement or | | | | : |
| | | ne's body." A bed rail was | | | | : |
| | coded as a restrain | t used daily for Resident #130. | | | | |
| | Review of Resident | #130's clinical record | | | | |
| | revealed a physicial | n's order dated 2/2/18 for | | | | |
| | | assist in turning and | | | | ĺ |
| | | rail and entrapment risk | | | | |
| | | 2/18 documented, "The use of ize resident independence in | | : | | |
| | bed mobility and tra | | | | | ľ |
| : | • | | | | | |
| İ | | p.m., an interview was | | | | : |
| | | (registered nurse) #1 (the | | | | : |
| į | | egarding physical restraint assessment. RN #1 stated, | | | | |
| į | "The first question u | inder (section) p is bed | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED |
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| | | | | • | | С |
| | | 495142 | B. WING | ; | | 03/30/2018 |
| EVERGE | PROVIDER OR SUPPLIER REEN HEALTH AND R | | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | ON SHOULD HE APPROPE | BE COMPLETION |
| | railings. I would sar residents have bed positioning. Side ra #1 was asked to ob Medicare and Medicare and Medicare and returned stated she just spoke who said if the use definition of a physic staff has to code a rebedrails does not medicalls does not medicalls does not medicalls does not medicalls does not medicalls does not medicalls does not medicalls device rattached or adjacent the individual cannot restricts freedom of to one's body." RN obtained from the R this definition applies side rails, RN #1 state to need to reevaluate that was coded (for evaluated to see if it restraint." RN #1 we names (including Reevaluate whether the should be coded as On 3/29/18 at 4:07 pevaluated the list of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. RN #1 state of side rails for those restraints. | y a great majority of our rails in place for turning and alls trigger as restraints. RN tain the CMS (Centers for caid Services) RAI (Resident ment) manual. RN #1 left the a few moments later. RN #1 ke to the director of nursing of bedrails meets the cal restraint then the MDS restraint but if the use of leet the definition then the lot code a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint but if the use of leet the definition then the lot code a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint. RN #1 littion of a restraint. RN #1 littion of a resident who uses all manual. When asked if so every resident who uses ated, "Apparently we are going the all of this. Every resident a physical restraint) was not a met the true definition of a las provided a list of resident lesident #130) and asked to lose residents' use of side rails | F | 641 | | |
| : | On 3/29/18 at 5:48 p | om., ASM (administrative staff | | ! | | |

| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED |
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| | | 495142 | B. WING | 3 | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | . J | STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | 03/30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD | BE COMPLETION |
| F 641 | director of nursing above concern. | age 129 dministrator) and ASM #2 (the) were made aware of the tion was presented prior to exit. | | 641 | | |
| | inaccurately as has significant change | coded Resident #132 ving a physical restraint on a in status MDS (minimum data ith an ARD (assessment 3/15/18. | | : | | |
| | 2/6/18 and readmit #132's diagnoses is acute respiratory for weakness. Resides significant change ARD of 3/15/18, conserverely impaired. Resident #132 as not two or more staft P0100 Physical Represtraints are any restraints are any restraints are any restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restricts freedom of the individual cannot restrict the individual cannot r | s admitted to the facility on ted on 3/8/18. Resident included but were not limited to ailure, stroke and muscle and #132's most recent MDS, a in status assessment with an oded the resident's cognition as Section G documented requiring extensive assistance of with bed mobility. Section instraints documented, "Physical manual method or physical or in material or equipment and to the resident's body that not remove easily which of movement or normal access and rail was coded as a for Resident #132. | | | | |
| | Review of Resident revealed a physicial one-half side rails the assist the resident side rail and entrap 3/8/18 documented | t #132's clinical record in's order dated 3/8/18 for to both sides of the bed to in turning and positioning. A ment risk evaluation dated in The use of a side rail will idependence in bed mobility | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | | OATE SURVEY OMPLETED |
|--------------------------|---|---|---------------------|---|--------------------------------|----------------------------|
| | | 495142 | B. WING | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | • | STREET ADDRESS, CITY, STATE, ZII 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 7070072070 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 641 | Continued From pa | ge 130 | F6 | 41 | | |
| | conducted with RN MDS Coordinator) is coding on the MDS provided a list of re Resident #132) and | 3 p.m., an interview was (registered nurse) #1 (the regarding physical restraint assessment. RN #1 was sident names (including asked to evaluate whether e of side rails should be coded ts. | | | | |
| | evaluated the list of side rails for those restraints. RN #1 s | p.m., RN #1 stated she residents to see if the use of residents met the criteria for tated the use of side rails for s did not meet the criteria for | | | | |
| : | member) #1 (the ac | pm., ASM (administrative staff Iministrator) and ASM #2 (the were made aware of the | | | | |
| | No further informati | on was presented prior to exit. | | | | i |
| : : | inaccurately as havi admission MDS (mi | coded Resident #133 ng a physical restraint on an nimum data set) assessment sment reference date) of | | | | |
| • | 3/8/18. Resident #1 were not limited to he pressure and chroni #133's most recent assessment with an date) of 3/15/18, coas moderately impa | admitted to the facility on 33's diagnoses included but leart failure, high blood c kidney disease. Resident MDS, an admission ARD (assessment reference ded the resident's cognition fired. Section G documented equiring extensive assistance | | | | |

| CLIVIL | NO FOR WIEDICARE | & MEDICAID SERVICES | | | | OMB N | O. 0938-0391 |
|--------------------------|------------------------------------|--|-------------------------|---------|---|---------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | ISTRUCTION | (X3) D. | ATE SURVEY OMPLETED |
| | | 495142 | B. WING _ | | | | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| EVEDO | SEEN HEALTH AND D | FILAD | İ | 380 MIL | LWOOD AVENUE | | |
| EVERG | REEN HEALTH AND R | EHAB | | | HESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 641 | Continued From an | | | | | | |
| 1.041 | Continued From pa | | F 64 | 1 | | | |
| | | f with bed mobility. Section | | | | | |
| | | straints documented, "Physical | | | | | |
| | | nanual method or physical or | | | | | |
| | | material or equipment nt to the resident's body that | | * | | | |
| | | ot remove easily which | | | | | |
| | | movement or normal access | | | | | |
| | | ed rail was coded as a | | | | | |
| | restraint used daily | for Resident #133. | | | | | |
| | Dovinus of Desident | : #4.00!!!-!- 1 | i | • | | | |
| | | :#133's clinical record n's order dated 3/8/18 for | | | | | |
| | one-half side rails to | o assist the resident in turning | | | | | |
| | and positioning. As | side rail and entrapment risk | | | | | : |
| | | 8/18 documented, "The use of | | | | | |
| | a side rail will optim | ize resident independence in | | | | | |
| | bed mobility and tra | insfer" | | | | | |
| | On 3/29/18 at 12:48 | p.m., an interview was | | | | | |
| | conducted with RN | (registered nurse) #1 (the | | | | | |
| | | egarding physical restraint | | | | | |
| | | assessment. RN #1 was | | | | | |
| : | provided a list of res | sident names (including | | | | | |
| | | d asked to evaluate whether | | | | | |
| | | e of side rails should be coded | | | | | |
| : | as physical restraint | ts. | | | | | • : |
| | On 3/29/18 at 4:07 i | p.m., RN #1 stated she | | | | | |
| | evaluated the list of | residents to see if the use of | : | | | | |
| | side rails for those r | esidents met the criteria for | | | | | |
| | | tated the use of side rails for | | | | | |
| : | | s did not meet the criteria for | | | | | |
| · | a physical restraint. | | | | | | |
| : | On 3/29/18 at 5:48 r | om., ASM (administrative staff | | | | | ĺ |
| | | ministrator) and ASM #2 (the | | • | | | |
| : | director of nursing) | were made aware of the | | | | | İ |
| | above concern. | | | | | | ļ |

PRINTED: 04/13/2018 FORMAPPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-0391 |
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| STATEMEN AND PLAN (| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l · · · | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CO | |
| | SEEN HEALTH AND D | FILAB | | 380 MILLWOOD AVENUE | |
| EVERGE | REEN HEALTH AND R | EHAB | | WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION |
| F 641 | Continued From pa | nne 132 | · F6 | · ://4 | : |
| | • | ion was presented prior to exit. | | '4 | |
| | 44 7% - 4 - 00 - 1 - 77 | - 1- 145 - D111 #475- | | | i |
| | | coded the Resident #47's num data set) assessment with | | | : |
| | | ent reference date) of 1/1/18 in | | | |
| | accurately for the u | se of restraints when in fact | | | : |
| | the resident did not | have restraints. | | | ! |
| | Resident #47 was a | admitted to the facility on | | | |
| | | ses that included but were not | | | 1 |
| | | sorder, Alzheimer's disease, | | | |
| | | tia without behavioral lood pressure, muscle | | | |
| | | or depressive disorder. | | | |
| | Resident #47's mos | st recent MDS (minimum data | | | i i |
| | | as annual assessment with an | | | |
| | | reference date) of 1/1/18. coded as severely cognitively | | | · |
| | | ity to make daily decisions | | | |
| | scoring 03 out of 15 | on the BIMS (Brief Interview | | | |
| | | exam. Section P (restraints | | | |
| | rail restraints used | Resident #47 has having bed on a daily hasis | | | |
| | | on a dany bacto. | | | |
| | | :#47's most current POS | | | |
| | | mmary) documented the 2 side rails for turning and | | | ļ |
| | positioning every sh | | | | |
| | Davidson of D. 11 at | #4 - 1 | | | |
| | | :#47's side rail assessment umented the side rails as not | - : - | | |
| | being a restraint. | amortion the side rails as not | | | |
| | On 3/29/18 at 12:45 | 5 p.m., an interview was | | | |
| | | (registered nurse) #1, the | | • | |
| | | stated that the great majority | | | |
| | of residents in the b | ouilding had 1/2 side rails. RN | | | , |
| | #1 stated that all sid | de rails were considered a | | | |

restraint and therefore documented as such on

PRINTED: 04/13/2018 FORM APPROVED
OMB NO 0938-0391

| <u> </u> | TO TOT WEDIOAILE | L & MEDICAID SERVICES | | | | <u> </u> |
|--------------------------|--|---|---------------------|---------|---|-------------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | | C 03/30/2018 |
| | RGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The MDS assessment. RN #1 was asked to provide that information from the RAI (Resident Assessment Instrument) manual. On 3/29/18 at approximately 1:00 p.m., RN #1 stated that she had just spoken to the DON (Director of Nursing). RN #1 stated that if the bed rails would be coded as a restraint, then the MDS. RN #1 stated that if they don't meet the requirement of a restraint, then the MDS should code them as a restraint. When asked the definition of a physical restraint, RN #1 stated that a restraint was "any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 was reading this definition | MILLWOOD AVENUE | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREF | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PERICIENCY) | D BE COMPLÉTION |
| F 641 | the MDS assessment provide that informal Assessment Instruction of 3/29/18 at approximated that she had (Director of Nursing rails met the definition rails would be code RN #1 stated that in requirement of a recode them as a residefinition of a physical restraint was "any or mechanical deviattached or adjacenthe individual cannot restricts freedom of to one's body." RN straight from the Rula "Apparently we are this." RN #1 stated | ent. RN #1 was asked to ation from the RAI (Resident ment) manual. roximately 1:00 p.m., RN #1 to just spoken to the DON g). RN #1 stated that if the bed tion of a restraint, then the bed ed as a restraint on the MDS. If they don't meet the estraint, then the MDS should straint. When asked the sical restraint, RN #1 stated that y manual method or physical ice material or equipment nt to the resident's body that ot remove easily and which of movement or normal access | | 641 | | |
| : | staff member) #1, t DON (director of no | p.m., ASM (administrative the administrator, ASM #2, the ursing) and ASM #7, the facility aware of the above concerns. | | | | |
| | quarterly MDS (min with an ARD (asses 2/13/18, inaccurate when in fact the res | f coded Resident #66's nimum data set) assessment ssment reference date) of ely for the use of restraints, sident did not have restraints. | | Ė | | |
| | | admitted to the facility on itted on 2/11/18 with diagnoses | | | | 1 |

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

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 134 of 328

RECEIVEDW 24 2018

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PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | KS FUR MEDICARE | A MEDICAID SEKVICES | | | | OMRI | <u> 10. 0938-0391</u> |
|--------------------------|--|---|--|-------------------------|---|-----------|----------------------------|
| | FOR DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | DATE SURVEY COMPLETED |
| _ | | 495142 | B. WING | | | | C 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRES | SS, CITY, STATE, ZIP C | ODE | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD WINCHESTER | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | X (EACH | OVIDER'S PLAN OF COR CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION OATE |
| F 641 | that included but we dementia without be failure, gout, major blood pressure and #66's most recent in a quarterly assessment refere Resident #66 was dimpaired in the abiliseoring 03 out of 15 for Mental Status) of coded as requiring staff member with reliving). Section P (resident #66 has hon a daily basis. Review of Resident (physician order surfollowing order: "1/2 positioning every should be restraint. On 3/29/18 at 12:45 conducted with RN MDS nurse. RN #1 of residents in the bestraint and therefor the MDS. RN #1 we with the sident in the first the MDS. RN #1 we with the major in the major i | ere not limited to unspecified ehavioral disturbance, heart depressive disorder, high atrial fibrillation. Resident MDS (minimum data set) was nent with an ARD ence date) of 2/13/18. Coded as severely cognitively ity to make daily decisions on the BIMS (Brief Interview exam. Resident #66 was extensive assistance from one most ADLs (activities of daily restraints and alarms) coded aving bed rail restraints used aving bed rail restraints used as idea rails for turning and hift." #66's most current POS mmary) documented the side rails as not mented the side rails as not fregistered nurse) #1, the stated that the great majority building had 1/2 side rails. RN de rails were considered a pre documented as such on as asked to provide that the RAI (Resident Assessment | F | 541 | | | |
| | | oximately 1:00 p.m., RN #1 | : | | | | |

(Director of Nursing). RN #1 stated that if the bed

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION DING | (2 | X3) DATESURV COMPLETED | |
|--------------------------|--|---|----------------------|---|-----------------------------|---------------------------|---------------------|
| | | 495142 | B. WING | | | C 03/30/20 | 10 |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZII 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | P CODE | 05/30/20 | 10 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD B HE APPROPRI | E COMPI | (5) LETION TE |
| F 641 | rails met the defining rails would be cook RN #1 stated that requirement of a recode them as a redefinition of a phy a restraint was "all or mechanical devattached or adjace the individual cannestricts freedom to one's body." RN straight from the F "Apparently we are this." RN #1 state rail assessments: On 3/29/18 at 5:45 staff member) #1, DON (director of redefinition of restricts freedom to one's body." RN straight from the F "Apparently we are this." RN #1 state rail assessments: | page 135 nition of a restraint, then the bed ded as a restraint on the MDS. If they don't meet the restraint, then the MDS should estraint. When asked the resical restraint, RN #1 stated that my manual method or physical vice material or equipment ent to the resident's body that not remove easily and which of movement or normal access N #1 was reading this definition RAI manual. RN #1 stated, e going to re-evaluate all of ed that the nurses did the side for residents with side rails. 7 p.m., ASM (administrative the administrator, ASM #2, the nursing) and ASM #7, the facility aware of the above concerns. | F6 | 341 | | | |
| | quarterly MDS (mi with an ARD (asse 2/8/18, inaccurate when in fact the reaction of the reacti | aff coded Resident #57's inimum data set) assessment reference date) of ally for the use of a restraint, esident did not have restraints. admitted to the facility on inited on 1/22/18 with cluded but were not limited to navioral disturbance, muscle mer's disease and mood at #57's most recent MDS at assessment was a quarterly an ARD (assessment reference esident #57 was coded as paired in cognitive function | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | | E SURVEY MPLETED |
|--------------------------|--|---|----------------------|---|-------------------------|-------|----------------------------|
| | | 495142 | B. WING | | | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | , CODE | 1 03/ | 30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD HE APPROPF | BE | (X5) COMPLETION DATE |
| F 641 | Interview for Menta was coded as required from two staff mem (activities of daily linalarms) coded Resident (activities of daily linalarms) coded Resident (activities of Resi | Dessible 15 on the BIMS (Brief II Status) exam. Resident #57 iring extensive assistance abers with most ADLS ving). Section P (restraints and ident #57 has having bed rail a daily basis. It #57's most current POS mmary) documented the 2 side rails for turning and hift." It #57's side rail assessment mented the side rails as not 5 p.m., an interview was (registered nurse) #1, the I stated that the great majority building had 1/2 side rails. RN de rails were considered a ore documented as such on ras asked to provide that e RAI (Resident Assessment | F | i41 | | | |
| | stated that she had (Director of Nursing rails met the definit rails would be code RN #1 stated that if requirement of a recode them as a rest definition of a physical restraint was "any or mechanical device." | oximately 1:00 p.m., RN #1 just spoken to the DON j). RN #1 stated that if the bed ion of a restraint, then the bed id as a restraint on the MDS. If they don't meet the straint, then the MDS should traint. When asked the cal restraint, RN #1 stated that y manual method or physical be material or equipment int to the resident's body that | | • | | | |

| | | | | (3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|--------------------|---|---------------------------------|----------------------------|
| | | | | | | С |
| | | 495142 | B. WING | | | 03/30/2018 |
| | PROVIDER OR SUPPLIEF | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION OATE |
| F 641 | ˈ └ _i Continued From p | page 137 | F (| 541 | | |
| | the individual cannestricts freedom of to one's body." RN straight from the F "Apparently we are this." RN #1 state rail assessments from 3/29/18 at 5:47 staff member) #1, DON (director of nowner were made 14. The facility state quarterly MDS (Mi with an ARD (Asse 3/14/18, in accurate | not remove easily and which of movement or normal access N #1 was reading this definition RAI manual. RN #1 stated, re going to re-evaluate all of ed that the nurses did the side for residents with side rails. 7 p.m., ASM (administrative, the administrator, ASM #2, the nursing) and ASM #7, the facility e aware of the above concerns. aff coded Resident #3's linimum Data Set) assessment essment Reference Date) of tely for the use of restraints, esident did not have restraints. | | | | |
| | 9/10/16 with the di atrial fibrillation, m disease, systemic syndrome, bladder heart disease, sch disease, diabetes, bipolar disorder. The most recent M quarterly assessm Reference Date) of coded as being codaily life decisions care for bathing; e dressing, toileting, | admitted to the facility on liagnoses of but not limited to norbid obesity, chronic kidney inflammatory response or obstruction, chronic ischemic hizophrenia, Parkinson's, high blood pressure, and MDS (Minimum Data Set) was a ment with an ARD (Assessment of 3/14/18. The resident was ognitively intact in ability to make a the resident required total extensive care for transfers, and hygiene; was independent | | | | |
| | for eating; and was an indwelling cathe "Restraints and Ala | is incontinent of bowel and had leter for bladder. Section P larms" documented, "Physical manual method or physical or | : : | | | · |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' | TIPLE CONSTRUCTION ING | | | E SURVEY IPLETED |
|--------------------------|--|--|---------------------|---|--------|----------|----------------------------|
| | | 495142 | B. WING | | | | C 30/2018 : |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 |)DE | <u> </u> | 30/20 10 |
| (X4) ID PREFIX TAG | ! (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD | BE | (X5) COMPLETION OATE |
| F 641 | attached or adjace the individual cannorestricts freedom or to one's body." The used, 1. Used less Next to "Bed rail", to "Used daily." No or coded. A review of the cliniphysician's order dato assist times 2 will evidence the side restraint. A review of the care evidence of the res Observations made 3/28/18 at 8:13 a.m. | material or equipment of the resident's body that of remove easily which of movement or normal access ecoding options were "0. Not than daily, 2. Used daily." The resident was coded "2" for ther restraint devices were call record revealed a sted 3/21/18 for "1/2 side rails the bed mobility." There was not ails were ordered to be a explain failed to reveal any ident requiring restraints. The con 3/17/18 at 3:29 p.m.,, 3/29/18 at 8:16 a.m., ant in bed asleep, and | F 6 | 41 | | | |
| | #1 (Registered Nur stated, "a great maj side rails for turning triggers it for a restr room to obtain her l Assessment Instrur On 3/29/18 at 1:00 stated she had spol Nursing (DON). RI that if the use of be a physical restraint | S p.m., in an interview with RN se, the MDS nurse) she ority of residents have 1/2 and positioning, which aint. At this time, she left the RAI manual (Resident nent). p.m., RN #1 returned and ken with the Director of N #1 stated the DON stated drails meets the definition of then we have to count them they don't meet the definition | | | | | |

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| OPI I P | TO T OIT MILDIOMITE | - WINIEDIONID OF MICEO | | | OND NO. 0930-039 I |
|--------------------------|---|---|-------------------------|---|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING_ | | 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | |
| EVERGR | REEN HEALTH AND RI | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE |
| F 641 | stated the definition method or physical or equipment attach resident's body that easily and which resor normal access to stated, "Apparently reevaluate all of this coding this, did she if they met this defir stated, "I was playir not evaluated to see restraint. If residen considered a restra | code them as a restraint. She of a restraint is "Any manual or mechanical device material hed or adjacent to the the individual cannot remove estricts freedom of movement of one's body." RN #1 then we are going to need to s." When asked if, when evaluate the residents to see nition for a restraint. She ng it safe, every resident was the if they met the definition of a net wants it, it would not be aint." | F 64 | 11 | |
| : | stated she had eval list (including Resid criteria for side rails that none of them m restraint; therefore, been coded as havi On 3/29/18 at 6:05 | luated all the residents on the dent #3) to see if they met s as a restraint. RN #1 stated meets the criteria for a none of them should have | | | |
| | Staff Member) #1, I and the facility owne of the findings. No provided by the end 15. The facility staff quarterly MDS (Mini with an ARD (Asses 2/16/18, inaccuratel | Director of Nursing (ASM #2), er (ASM #7) were made aware further information was | | | |
| | | | | | |

Resident #74 was admitted to the facility on

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI | | CONSTRUCTION | | ESURVEY MPLETED |
|---|--|---|-------------------|-----|--|------|----------------------------|
| | | 495142 | B. WING | | | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE) MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | ΊX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| F 641 | 8/26/13 with the dia stroke, intestinal dis encephalopathy, de disorder, dysphagia cataracts, presbyop schizophrenia, bipo high blood pressure obstructive pulmona. The most recent MI quarterly assessme Reference Date) of coded as severely omake daily life decistotal care for transfe extensive care for extensive care | agnoses of but not limited to isease, depression, metabolic ementia, schizoaffective a, gastrostomy feeding tube, pia, Parkinson's disease, olar disorder, angina, diabetes, e, hypothyroidism, and chronic hary disease. IDS (Minimum Data Set) was a ent with an ARD (Assessment f 2/16/18. The resident was cognitively impaired in ability to isions. The resident required fers, dressing, and hygiene; eating; and was incontinent of . Section P "Restraints and ed, "Physical restraints are any physical or mechanical device, ent attached or adjacent to the att the individual cannot remove the freedom of movement or one's body." The coding out used, 1. Used less than at "." Next to "Bed rail", the di "2" for "Used daily." No other | | 641 | | | |
| : : : : : : : : : | | e plan failed to reveal any sident requiring restraints. | i | : | | | : |
| ; | | e on 3/17/18 at 3:29 p.m., 1., and 3/29/18 at 8:16 a.m., | | : | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | KO FOR MEDICARE | A MEDICALD SERVICES | | | | <u> </u> | <i>).</i> 0930-0391 | |
|--------------------------|--|---|--------------------|-----------------------------------|---|----------|----------------------------|--|
| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | e) MULTIPLE CONSTRUCTION BUILDING | | | TE SURVEY MPLETED | |
| | | 495142 | B. WING | | | 0: | C 3/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGE | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF T | D BE | (X5) COMPLETION DATE | |
| F 641 | Continued From parevealed the reside side rails up. | nge 141 ent in bed asleep, half-length | F | 641 | | | | |
| | #1 (Registered Nur stated, "a great ma side rails for turning triggers it for a rest | 6 p.m., in an interview with RN se, the MDS nurse) she jority of residents have 1/2 g and positioning, which raint. At this time, she left the RAI manual (Resident ment). | | | | | | |
| | stated she had spo Nursing (DON). Re that if the use of be a physical restraint as a restraint, but in then we should not stated the definition method or physical or equipment attact resident's body that easily and which re or normal access to stated, "Apparently reevaluate all of this coding this, did she if they met this defi- stated, "I was playinot evaluated to se | p.m., RN #1 returned and ken with the Director of N #1 stated the DON stated of rails meets the definition of then we have to count them they don't meet the definition code them as a restraint. She not a restraint is "Any manual or mechanical device material hed or adjacent to the the individual cannot remove stricts freedom of movement one's body." RN #1 then we are going to need to s." When asked if, when a evaluate the residents to see nition for a restraint. She ng it safe, every resident was the if they met the definition of a new ants it, it would not be aint." | | | | | | |
| | stated she had eva list (including Resident criteria for side rails | p.m., RN #1 returned and luated all the residents on the lent #3) to see if they met as a restraint. RN #1 stated meets the criteria for a | | : | | | | |

restraint; therefore, none of them should have

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|---|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | 0: | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CI 380 MILLWOOD AVE WINCHESTER, VA | ENUE | | <u>)/30/20 10</u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | K (EACH CORI | R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPR DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 641 | been coded as have | | F 6 | 41 | | | |
| | meeting, the Admi Staff Member) #1, and the facility own | inistrator, ASM (Administrative, Director of Nursing (ASM #2), rner (ASM #7) were made aware o further information was | | | | | |
| | quarterly MDS (Mill (Assessment Refe | aff coded Resident #114's inimum Data Set) with an ARD erence Date) of 3/6/18, e use of restraints, when in fact of have restraints. | | · · · | | | : : |
| | 4/7/17 with the diag deep vein thrombo pneumonia, shortn insomnia, dementi anxiety disorder, h emphysema, chror | s admitted to the facility on agnoses of but not limited to osis, ankle fracture, aspiration ness of breath, edema, ia, schizophrenia, depression, nigh blood pressure, inic obstructive pulmonary nritis, fibromyalgia, and chronic | | | | | |
| | quarterly assessmined restraints and Alar restraints are any rechanged as to a serious and transmit of the serious and transmit of the serious and Alar restraints are any restraints and device | MDS (Minimum Data Set) was a ment with an ARD (Assessment of 3/6/18. The resident was everely impaired in ability to cisions. The resident requireding; extensive care for hygiene, sfers; limited assistance for lent for eating; and was and bladder. Section Parms" documented, "Physical manual method or physical or e, material or equipment ent to the resident's body that | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------|--|--------------------------------|-------------------------------|--|
| | | 495142 | B. WING | | 0: | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 641 | restricts freedom of to one's body." The used, 1. Used less Next to "Bed rail", to "Used daily." No occoded. A review of the cliniphysician's order dix2 to assist with t/p There was no evide ordered to be a result of the care evidence of the result of t | ot remove easily which of movement or normal access e coding options were "0. Not than daily, 2. Used daily." the resident was coded "2" for ther restraint devices were lical record revealed a ated 6//3/17 for "1/2 side rails to (turning and positioning)." ence the side rails were straint. e plan failed to reveal any sident requiring restraints. e on 3/17/18 at 3:28 p.m., ent to be out of the room; n., revealed the resident up in the ching television and on 3/29/18 alled the resident in bed asleep, e rails up. 6 p.m., in an interview with RN rese, the MDS nurse) she ajority of residents have 1/2 g and positioning, which traint. At this time, she left the RAI manual (Resident ment). p.m., RN #1 returned and | : F6 | | ') | | |
| | Nursing (DON). R that if the use of be a physical restraint as a restraint, but if | oken with the Director of the Mark the DON stated and rails meets the definition of then we have to count them they don't meet the definition of the code them as a restraint. She | | · · · · · · · | | : | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | | |
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| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CI 380 MILLWOOD AVE WINCHESTER, VA | NUE | 03/30 | 72016 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX (EACH CORF | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY) | BE c | (X5) OMPLETION DATE | |
| F 641 | method or physical or equipment attack resident's body that easily and which re or normal access to stated, "Apparently reevaluate all of this coding this, did she if they met this defir stated, "I was playir not evaluated to see restraint. If residen considered a restra On 3/29/18 at 4:09 stated she had eval list (including Resid criteria for side rails that none of them mare traint; therefore, been coded as having the facility owned the findings. No provided by the end 17. The facility staff quarterly MDS (Mini with an ARD (Asses 3/12/18, inaccuratel) | of a restraint is "Any manual or mechanical device material ned or adjacent to the the individual cannot remove stricts freedom of movement o one's body." RN #1 then we are going to need to s." When asked if, when evaluate the residents to see nition for a restraint. She ng it safe, every resident was a if they met the definition of a training wants it, it would not be int." p.m., RN #1 returned and uated all the residents on the ent #3) to see if they met as a restraint. RN #1 stated neets the criteria for a none of them should have ng a restraint. p.m., at the end of day istrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware further information was | F | 641 | | | | |
| | | dmitted to the facility on gnoses of but not limited to | | | • | i | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILC | LTIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | 4 | C 03/30/20 18 | | |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 5/30/20 10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 641 | pneumonia, osteo hypothyroidism, d depression, Parki blood pressure, is pulmonary emboli disease, chronic orespiratory failure, shortness of breath The most recent of quarterly assessme Reference Date) of coded as being coded as being coded as being coded as being coded as being coded as being coded as being coded as being coded as being coded as being coded as being coded and bladded Alarms" document manual method or material or equipmore resident's body the easily which restrinormal access to options were "0. Notaily, 2. Used daily resident was coded restraint devices were restraint devic | porosis, bronchitis, iabetes, morbid obesity, nson's disease, epilepsy, high chemic heart disease, sm, stroke, peripheral vascular obstructive pulmonary disease, spinal stenosis, fibromyalgia, th, dysphagia, and ataxia. MDS (Minimum Data Set) was a nent with an ARD (Assessment of 3/12/18. The resident was ognitively intact in ability to make attensive assistance for g, toileting, and hygiene; ating; and was incontinent of the coding of the individual cannot remove the individual cannot remove the freedom of movement or one's body." The coding tot used, 1. Used less than y." Next to "Bed rail", the di "2" for "Used daily." No other | | 641 | | | |
| : | evidence of the re- | re plan failed to reveal any sident requiring restraints. | | ; ; | | | |

| AND PLAN OF CORRECTION I IDENTIFICATION NUMBER. I | | (X2) MU A. BUILI | LTIPLE C | (X3) DATE SURVEY COMPLETED | | | | |
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| | PROVIDER OR SUPPLIE | | • | 380 1 | EET ADDRESS, CITY, STATE, ZIP COI MILLWOOD AVENUE CHESTER, VA 22601 | DE | | 50.2510 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD | BE | (X5) COMPLETION OATE |
| F 641 | revealed the reside half-length side rath half-length side rath of the half-length side rath of the half-length side rath of the stated, "a great mister side rails for turning triggers it for a restroom to obtain he Assessment Instruction of the half of the | m., and 3/29/18 at 8:12 a.m., dent to be in bed asleep, ails up. 46 p.m., in an interview with RN urse, the MDS nurse) she rajority of residents have 1/2 ng and positioning, which straint. At this time, she left the r RAI manual (Resident | F (| 541 | DEFICIENCY) | | | |
| | if they met this de stated, "I was play not evaluated to s | finition for a restraint. She ving it safe, every resident was ee if they met the definition of a ent wants it, it would not be | | : | | | | |
| | stated she had ev list (including Res criteria for side rai | 9 p.m., RN #1 returned and aluated all the residents on the ident #3) to see if they met ls as a restraint. RN #1 stated meets the criteria for a | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (X3) D | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION DATE | |
| F 641 | On 3/29/18 at 6:05 meeting, the Admin Staff Member) #1, I and the facility own of the findings. No provided by the end 18. The facility staff assessment correct when in fact the reservable. Resident #83 was a 4/11/17 with the dia acute kidney failure | none of them should have ing a restraint. p.m., at the end of day istrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware further information was I of the survey. If coded Resident #83's MDS the for the use of restraints, ident did not have restraints. Indmitted to the facility on gnoses of but not limited to aspiration pneumonia, with hypoxia, dysphagia, pulmonary disease, | F | 541 | | | |
| | quarterly assessment Reference Date) of coded as being cogodaily life decisions. care for bathing; expressing, toileting, a eating; and was incompleted by a section P "Restraint physical or mechan equipment attached body that the individual which restricts freed access to one's bodo". Not used, 1. Use | OS (Minimum Data Set) was a nt with an ARD (Assessment 2/19/18. The resident was nitively intact in ability to make The resident required total tensive care for transfers, and hygiene; independent for ontinent of bowel and bladder. Its and Alarms' documented, are any manual method or ical device, material or or adjacent to the resident's lual cannot remove easily from of movement or normal ly." The coding options were ed less than daily, 2. Used rail", the resident was coded | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | I | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE |
| F 641 | were coded. A review of the clin physician's order do to aid in independence the siderestraint. A review of the care evidence of the result | ical record revealed a ated 12/14/17 for "1/2 side rails at bed mobility." There was e rails were ordered to be a e plan failed to reveal any ident requiring restraints. e on 3/17/18 at 3:20PM, and revealed the resident to be in e rails up. 6 p.m., in an interview with RN rese, the MDS nurse) she jority of residents have 1/2 g and positioning, which raint. At this time, she left the RAI manual (Resident | F 6 | 341 | | |
| | stated she had spo Nursing (DON). R that if the use of be a physical restraint, as a restraint, but if then we should not stated the definition method or physical or equipment attact resident's body that easily and which re or normal access to stated, "Apparently | p.m., RN #1 returned and sken with the Director of the N #1 stated the DON stated of rails meets the definition of then we have to count them they don't meet the definition code them as a restraint. She of a restraint is "Any manual or mechanical device material hed or adjacent to the the individual cannot remove stricts freedom of movement to one's body." RN #1 then we are going to need to s." When asked if when | : | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 330 MILLWOOD AVENUE WINCHESTER, VA 2204) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SWOULD BE CROSS-REFERENCE) TO THE APPROPRIATE COMING THE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SWOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 641 Continued From page 149 coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, 1 was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint. The stated at the resident and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for a restraint, therefore, none of them should have been coded as having a restraint. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey. 19. The facility staff coded Resident #55's quarterly MIDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. Resident #55's was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, | | OF DEFICIENCIES OF CORRECTION | (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | | |
|--|------------|--|--|----------|---|---------|----------------------------|--|--|
| MAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR COMMINISTRY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 149 coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint." On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met orfteria for side rails as a restraint. Rh #1 stated that none of them meets the criteria for a restraint, therefore, none of them should have been coded as having a restraint. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey. 19. The facility staff coded Resident #55's quarterly MIDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. Resident #55's was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, | 78101 1541 | OUTRED TON | IDENTIFICATION NUMBER. | A. BUILD | DING | | | | |
| EVERGREEN HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 (X4)ID | | | 495142 | B. WING | <u> </u> | I | | | |
| FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 149 coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint." If resident wants it, it would not be considered a restraint. She list (including Resident #3) to see if they met criteria for side rails as a restraint. RM #1 stated that none of them meets the criteria for a restraint, therefore, none of them should have been coded as having a restraint. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey. 19. The facility staff coded Resident #55's quarterly MIDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, | | | ЕНАВ | | 380 MILLWOOD AVENUE | | | | |
| coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint." On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have been coded as having a restraint. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey. 19. The facility staff coded Resident #55's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREF | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP | OULD BE | (X5) COMPLETION OATE | | |
| quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints. Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, | F 641 | coding this, did she if they met this defir stated, "I was playir not evaluated to serestraint. If residen considered a restra On 3/29/18 at 4:09 stated she had evallist (including Resid criteria for side rails that none of them not restraint; therefore, been coded as having the Admin Staff Member) #1, I and the facility owned the findings. No | evaluate the residents to see nition for a restraint. She ng it safe, every resident was e if they met the definition of a t wants it, it would not be int." p.m., RN #1 returned and luated all the residents on the ent #3) to see if they met as a restraint. RN #1 stated neets the criteria for a none of them should have ing a restraint. p.m., at the end of day istrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware further information was | F | 341 | | | | |
| depression, mood disorder, anxiety disorder, pseudobul bar affect, high blood pressure, and dysphagia. The most recent MDS (Minimum Data Set) was a | | quarterly MDS (Min with an ARD (Asses 2/7/18, inaccurately when in fact the reseased of the re | imum Data Set) assessment ssment Reference Date) of for the use of restraints, ident did not have restraints. Identified to the facility on agnoses of but not limited to e, benign prostatic es, dementia, psychosis, lisorder, anxiety disorder, t, high blood pressure, and | | | | | | |

quarterly assessment with an ARD (Assessment

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| NAME OF | PROVIOER OR SUPPLIER | 493142 | D. WING | | | <u>03/30/2018</u> | |
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| F 641 | coded as severely of make daily life decilextensive care for the dressing, and transformand was incontinent. Section P "Restraint" "Physical restraints physical or mechant equipment attached body that the individual which restricts freed access to one's body "O. Not used, 1. Used daily." Next to "Bed | ge 150 2/7/18. The resident was cognitively impaired in ability to sions. The resident required bathing, hygiene, toileting, fers; supervision for eating; t of bowel and bladder. Its and Alarms' documented, are any manual method or ical device, material or d or adjacent to the resident's dual cannot remove easily dom of movement or normal dy." The coding options were ed less than daily, 2. Used it rail", the resident was coded No other restraint devices | F6 | 641 | | | |
| | hysician's order da to aid in independe | cal record revealed a atted 12/14/17 for "1/2 side rails at bed mobility." There was no ails were ordered to be a | | | | | |
| | | plan failed to reveal any dent requiring restraints. | | | | | |
| | 3/28/18 at 9:12AM, | on 3/17/18 at 3:16PM, and 3/29/18 at 8:14AM nt to be in bed asleep, s up. | | | | : | |
| | A review of the abo | ve MDS, | | | | | |
| | #1 (Registered Nurs stated, "a great maj side rails for turning | i p.m., in an interview with RN se, the MDS nurse) she ority of residents have 1/2 and positioning, which aint. At this time, she left the | | | | : | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 03/30/2018 | |
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| | | 495142 | B. WING | | | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 5/30/20 18 |
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| F 641 | Assessment Instru | RAI manual (Resident | F 64 | 41 | | |
| | stated she had spon Nursing (DON). Fithat if the use of bear a physical restraint as a restraint, but if then we should not stated the definition method or physical or equipment attactive and which resident's body that easily and which resor normal access that stated, "Apparently reevaluate all of the coding this, did she if they met this definition of evaluated to see | oken with the Director of RN #1 stated the DON stated ed rails meets the definition of them we have to count them if they don't meet the definition to code them as a restraint. She in of a restraint is "Any manual I or mechanical device material shed or adjacent to the at the individual cannot remove estricts freedom of movement to one's body." RN #1 then we are going to need to is." When asked if, when a evaluate the residents to see inition for a restraint. She ing it safe, every resident was see if they met the definition of a not wants it, it would not be | | | | |
| | stated she had evaluate (including Residual criteria for side rails that none of them r | p.m., RN #1 returned and aluated all the residents on the dent #3) to see if they met as as a restraint. RN #1 stated meets the criteria for a none of them should have ring a restraint. | | : | | |
| | meeting, the Admir Staff Member) #1, I and the facility own | p.m., at the end of day nistrator, ASM (Administrative Director of Nursing (ASM #2), er (ASM #7) were made aware further information was d of the survey. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/13/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING __ COMPLETED C 495142 B. WING 03/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **ID** (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 645 PASARR Screening for MD & ID F 645 F645 $SS=E \mid CFR(s): 483.20(k)(1)-(3)$ PASARR's have been completed for Residents #89, #90, #74, #114, #55, and #98. §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals Current facility residents have the potential to be affected by the alleged deficient practice. 100% with intellectual disability. audit will be completed to ensure residents have had a Preadmission Screening and Resident §483.20(k)(1) A nursing facility must not admit, on Review (PASARR). The screening will be done or after January 1, 1989, any new residents with: for those residents identified as not having one. (i) Mental disorder as defined in paragraph (k)(3) Measures put into place to assure alleged (i) of this section, unless the State mental health deficient practice does not recur include: authority has determined, based on an Admissions and Social Service staff will be independent physical and mental evaluation reeducated on PASARR and ensuring the resident performed by a person or entity other than the has one at the time of admission. State mental health authority, prior to admission, The Director of Nursing and/or designee will (A) That, because of the physical and mental analyze/review for patterns/trends and report in condition of the individual, the individual requires the Quality Assurance committee meeting the level of services provided by a nursing facility, quarterly for a minimum of six months to evaluate the effectiveness of the plan and will (B) If the individual requires such level of adjust the plan as the committee may services, whether the individual requires recommend, based on outcomes/trends identified specialized services; or from date. (ii) Intellectual disability, as defined in paragraph Completion Date: May 11, 2018 (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires

section-

specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after

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| | REEN HEALTH AND R | ЕНАВ | | 38 | MILLWOOD AVENUE MINCHESTER, VA 22601 | | |
| /// 10 | CUMMADVICTA | TEMENT OF OFFICIENCIES | | l | - | ON | |
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| F 645 | Continued From pa | ge 153 | F | 345 | | | |
| | i | ne nursing facility, was | | | | | |
| | transferred for care | | | | | | |
| | I . | choose not to apply the | | | | | |
| | | ening program under | | | | | |
| | | this section to the admission | | | | | |
| | to a nursing facility | | | | | | |
| | | d to the facility directly from a | | | | | : |
| | | ring acute inpatient care at the | | | | | |
| | hospital, | | | | | | : |
| | | ursing facility services for the | | | | | I |
| | | the individual received care in | | | | | i |
| | the hospital, and | | | | | | |
| | | ng physician has certified, | | | | | • |
| | | the facility that the individual | | | | | 1 |
| | facility services. | ess than 30 days of nursing | | | | | į |
| | lacility sel vices. | | | | | | |
| | §483.20(k)(3) Defin | ition. For purposes of this | | | | | |
| | | onsidered to have a mental | | | | | |
| | | dual has a serious mental | | | | | |
| | disorder defined in | | | | | | |
| | | considered to have an | | | | | |
| | intellectual disability | / if the individual has an | | | | | į |
| | | y as defined in §483.102(b)(3) | | | | | i |
| | | a related condition as | | | | | 1 |
| | described in 435.10 | · | | | | | |
| | | NT is not met as evidenced | | | | | • |
| | by: | rview and clinical record | | | | | |
| | | mined the facility staff failed to | | | | | : |
| | | rission Screening and | : | | | | · |
| | • | ASARR) for six of 31 | | | | | |
| | | vey sample, Residents #89, | : | : | | | |
| | #90, #74, #114, #55 | | ; | | | | |
| | 1. The facility staff f | ailed to complete a Level I | | | | | : |
| | | ent # 89, to ensure each | | | | | |
| | | g facility, is screened for a | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | (X3 | 3) DATE SURVEY COMPLETED |
|---------------------------------------|---|---|----------------------|---|----------|-------------------------------|
| | | 495142 | B. WING | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP COI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | 00/00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | (X5) CDMPLETIDN TE DATE |
| F 645 | mental disorder (Mi prior to admission, evaluated, and rece most integrated set 2. The facility staff f PASARR for Reside resident in a nursing mental disorder (Mi prior to admission a and receive care ar | age 154 D) or intellectual disability (ID) and that individuals are eive care and services in the ting appropriate to their needs. failed to complete a Level I ent #90, to ensure each ag facility, is screened for a D) or intellectual disability (ID) and individuals are evaluated and services in the most appropriate to their needs. | | 645 | | |
| · · · · · · · · · · · · · · · · · · · | #74's PASARR was resident was evaluated services in the most appropriate for the services. 4. The facility staff #114's PASARR was resident was evaluated as a services in the most appropriate for the services. | resident's needs. failed to ensure Resident as complete to ensure the ated and receiving care and at integrated setting | | | | |
| | #55's PASARR was | | | · · · · · · · · · · · · · · · · · · · | | |
| | PASAAR for Reside resident in a nursing mental disorder (MI prior to admission a evaluated and recei | failed to complete a Level I ent #98, to ensure each g facility, is screened for a D) or intellectual disability (ID) and that individuals are ive care and services in the ting appropriate to their needs. | | · : : : | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| OFILIFI | TO I OK WILDICAKE | A MILDICAID SERVICES | | | OIVIB NO. 0938-03 |
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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING_ | | 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE | E |
| | <u> </u> | | | WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE COMPLÉTI |
| F 645 | Continued From pa | ge 155 | F 64 | 45 | |
| | The findings include | e: | | ÷ | |
| | PASARR for Resider resident in a nursing mental disorder (MI prior to admission a evaluated and recemost integrated set Resident #89 was a 5/4/14 with a recent diagnoses that includeft shoulder pain, up of her leg, diabetes pressure, stroke, ar disorder in which the | railed to complete a Level I ent # 89, to ensure each g facility, is screened for a D) or intellectual disability (ID) and that individuals are ive care and services in the ting appropriate to their needs. Individuals are it readmission of 3/18/18, with under the ting appropriate to their needs. In the treatmission of 3/18/18, with under the ting appropriate to the facility on the treatmission of 3/18/18, with under the ting appropriate to their needs. In the treatmission of 3/18/18, with under the ting appropriate to their needs. In the treatmission of 3/18/18, with under the ting appropriate to their needs. In the treatmission of 3/18/18, with under the ting appropriate to their needs. | | | |
| | with an assessment coded the resident a (brief interview for n | OS, a quarterly assessment, treference date of 2/22/18, as scoring a 15 on the BIMS nental status) score, indicating pable of making daily | | | |
| : | | al record failed to evidence a ening and Resident Review | | | |
| | | nd of the day meeting, a for Resident #89's PASARR. | | | |
| : | An interview was co | nducted with other staff | | | |

member (OSM) #3, the social worker, on 3/30/18

| | . to / Olt III.EDIO/ IIIL | G MILDIO/ND OLIVIOLO | | | | <u>UNI GINU</u> | <u>. บองด-บงษา</u> |
|--------------------------|---|--|----------------------|-------|--|-------------------------------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | ; | 495142 | B. WING | | | | C /20/2040 |
| NAME OF | PROVIDER OR SUPPLIER | | | | DEET ADDRESS OFFICE TO SEE | 1 03/ | <u>/30/2018</u> |
| | REEN HEALTH AND R | EHAB | | 386 | REET ADDRESS, CITY, STATE, ZIP CODE O MILLWOOD AVENUE INCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | knowledge of the PAOSM #3 stated, "I e manager, I was not I should be doing. I yesterday. The other this morning about we don't have any casked what the PAS some type of evalua asked what the pury OSM #3 stated she An interview was conther social worker, When asked what a "My understanding and to determine if or mental disability to come to the facility apsychologist or doctor of them." When asked PASARR, OSM #4 sthe facility. If one do hospital the admission where I worked, but social worker to comis more to the PASA to the facility, OSM issue so we can me typically get a notice sometimes has to do come here." OSM # not communicated to do it." When asked job description, OSM in my file but it's presented. | ASARR for the residents, explained to the business office told that it was something that it came to our attention er social worker spoke with me PASARR. To my knowledge, of the PASARRs." When SARR is, OSM #3 stated, "It's ation of that person." When cose of the PASARR was, did not know. Inducted with OSM #4, the on 3/30/18 at 9:45 a.m. a PASARR is, OSM #4 stated, is that it starts at the hospital a resident has a mental illness to make sure they are safe to and if they need a tor so we can safely take care sed the purpose of the stated it's so they can come to one not come from the ion did it in West Virginia, in Virginia it's referred to the nplete." When asked if there are their needs. Level 2 with yes or no. The doctor ecide if a resident is going to 4 stated, "Unfortunately it was one that social services was ed if she was provided with a M #4 stated, "Yes, there is one tty basic." | F | , 645 | | | |
| ļ | The Job Description | for the Social Worker | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 4054.40 | | | С | | | |
| NAME OF | DDOLUDED OD OLIDBUIED | 495142 | B. WING | | | /30/2018 | | |
| NAME OF | PROVIDER OR SUPPLIER | (| | STREET ADDRESS, CITY, STATE, ZIF | CODE | | | |
| EVERGE | REEN HEALTH AND F | REHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) | | | | |
| F 645 | Continued From p | age 157 | F | 645 | - | | | |
| | | rt, "Clinical - 4. Ensure or | , , | | | 1 | | |
| | | nd education to resident/family | | | | | | |
| | | nt others to assist in their | | | | | | |
| | | placement and facility issues in | | | | 1 | | |
| | | g them to the appropriate social | l. | | | | | |
| | | when the facility does not | | | | | | |
| | provide the neede | | | • | | · | | |
| | | | | | | | | |
| | | 30 a.m. the director of nursing, | | | | | | |
| | | ve staff member) #2, informed | | | | | | |
| | | e facility did not have any | | * | | | | |
| | policy on PASARR | | : | | | 1 | | |
| | The administrator, | ASM #1 was made aware of | | | | ; ; | | |
| ! | the above findings | on 3/30/18 at 12:57 p.m. | | | | | | |
| | No further informa | tion was provided prior to exit. | | | | : : | | |
| : | (1) Barron's Diction | nary for Medical Terms for the | • | | | | | |
| | | er, 5th edition, Rothenberg and | | | | | | |
| | Chapman, page 48 | | | · : | | | | |
| : | | | | | | | | |
| | | failed to complete a Level I | | | | : | | |
| | | lent #90, to ensure each | | | | | | |
| | resident in a nursir | ng facility, is screened for a | | | | | | |
| | | ID) or intellectual disability (ID) | | | | | | |
| : | | and that individuals are | | | | | | |
| | | eive care and services in the | • | | | | | |
| | most integrated se | tting appropriate to their needs. | | | | | | |
| ļ | Resident #90 was | admitted to the facility on | 1 | ! ! | | : | | |
| | | ses that included but were not | : | 1 1 1 | | | | |
| i | | on's chorea (abnormal | | : | | | | |
| | | n characterized by progressive | | | | ' | | |
| | | erky motions and mental | | | | | | |
| | | ng to dementia) (1), muscle | : | 1 | | ļ . | | |
| | | hrenia (any of a group of | | | | 1 | | |
| | | haracterized by gross | | | | İ | | |
| İ | distortions of reality | y, withdrawal from social | | | | : | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | LTIPLE CONSTRUCTION DING | 0 | (3) DATE SURVEY COMPLETED |
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| | | 495142 | B. WING | i | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | E, ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | ACTION SHOULD B O THE APPROPRI | |
| F 645 | contacts, and dist perception and endysphagia (a condifficult or painful esophagus or mulesophagus.) (3) The most recent nassessment, with of 2/22/18, coded on the BIMS (briescore indicating the to make cognitive was coded as require one or more staff of daily living. Review of the clin Preadmission Scribad been completed on 3/29/18 at the request was made. An interview was member (OSM) # | page 158 urbances of thought, language, notional response.) (2), and dition in which swallowing is due to obstruction of the scular abnormalities of the MDS assessment, a quarterly an assessment reference date the resident as scoring a two finterview for mental status) are resident is severely impaired daily decisions. The resident uiring extensive assistance of members for all of his activities ical record failed to evidence a eening and Resident Review red for Resident #90. end of the day meeting, a refor Resident #90's PASARR. conducted with other staff 3, the social worker, on 3/30/18 in asked if she had any | F 6 | 645 | | |
| | knowledge of the OSM #3 stated, "I manager, I was not I should be doing yesterday. The other this morning about we don't have any asked what the Pasome type of eval | PASARR for the residents, explained to the business office of told that it was something that It came to our attention her social worker spoke with me t PASARR. To my knowledge, of the PASARRs." When ASARR is, OSM #3 stated, "It's uation of that person." When irpose of the PASARR was, | : : : | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION DING | | TE SURVEY |
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| NAME OF F | PROVIDER OR SUPPLIER | | ' | STREET ADDRESS, CITY, STATE, ZIP CODE | | 0,00,2010 |
| 10.400 | THO FIDER OF TELET | | | | | |
| EVERGR | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE | | |
| | | | | WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ULD BE | (X5) COMPLETION OATE |
| F 645 | other social worker When asked what "My understanding and to determine if or mental disability come to the facility psychologist or doc of them." When ask PASARR, OSM #4 the facility. If one determine the society of the society. | onducted with OSM #4, the on 3/30/18 at 9:45 a.m. a PASARR is, OSM #4 stated, is that it starts at the hospital a resident has a mental illness to make sure they are safe to and if they need a tor so we can safely take care sed the purpose of the stated it's so they can come to oes not come from the | | 645 | | |
| | where I worked, bu social worker to cor is more to the PASA to the facility, OSM issue so we can me typically get a notice sometimes has to come here." OSM # not communicated to do it." When ask | ion did it in West Virginia, in Virginia it's referred to the implete." When asked if there ARR then being safe to come #4 stated, "If they have an eet their needs. Level 2 e with yes or no. The doctor decide if a resident is going to #4 stated, "Unfortunately it was to me that social services was ed if she was provided with a M #4 stated, "Yes, there is one etty basic." | | | | |
| | ASM (administrative | a.m. the director of nursing, e staff member) #2, informed a facility did not have any | | | | |
| | | ASM #1 was made aware of on 3/30/18 at 12:57 p.m. | | | | |
| : | No further informati | on was provided prior to exit. | | : | | |
|) | (1) Barron's Diction | on was provided prior to exit. ary for Medical Terms for the | : : | | | : |

Chapman, page 246.

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | LTIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING |) | | 03 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY 380 MILLWOOD AVENU WINCHESTER, VA 2 | UE | 1 00 | 10012010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | XX (EACH CORREC CROSS-REFEREN | S PLAN OF CORRECTIO CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | Non-Medical Read-Chapman, page 52 (3) Barron's Diction Non-Medical Read-Chapman, page 17 3. The facility staff #74's PASARR was resident was evaluated as evices in the most services. | parry for Medical Terms for the er, 5th edition, Rothenberg and e2. parry for Medical Terms for the er, 5th edition, Rothenberg and e8. failed to ensure Resident as complete to ensure the eated and receiving care and est integrated setting | F (| 645 | | | |
| | 8/26/13 with the dia stroke, intestinal discrephalopathy, de disorder, dysphagia cataracts, presbyop schizophrenia, bipolicity blood pressure obstructive pulmon MDS (Minimum Da assessment with al Reference Date) of coded as severely make daily life deci | admitted to the facility on agnoses of but not limited to sease, depression, metabolic ementia, schizoaffective a, gastrostomy feeding tube, bia, Parkinson's disease, blar disorder, angina, diabetes, e, hypothyroidism, and chronic ary disease. The most recent at Set) was a quarterly a ARD (Assessment 2/16/18. The resident was cognitively impaired in ability to sions. The resident was | | | | | |
| | dressing, and hygicand as incontinent Review of Resident reveal the resident comprehensive car documentation regardon 3/29/18 at 6:05 meeting, the Admin | total care for transfers, ene; extensive care for eating; of bowel and bladder. It #74's clinical record failed to see PASARR. Resident #74's en plan failed to reveal arding the PASARR. p.m., at the end of day histrator ASM (Administrative Director of Nursing (ASM #2), | | : - | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | |
|---|--|---|------------------------|---|-------------------|
| | | 495142 | B. WING | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER EEN HEALTH AND R | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE COMPLÉTION |
| F 645 | of the findings. A re of the PASARR. On 3/30/18 at 9:33 (Other Staff Member stated she "was not had to do" (obtaining She further stated them for Resident # purpose of a PASAR type of evaluation. of it is for." On 3/30/18 at 9:44 #4, another social was regarding a PASAR hospital. They review resident doesn't have mental disability to screening that need psychologist, in ord residents) are safe deemed that we can when asked if a PA the hospital, is the sone, OSM #4 states communicated to make sure that if the able to handle their meet their needs. | er (ASM #7) were made aware equest was made for evidence a.m., in an interview with OSM er, the social worker) #3, she told it was something that I g, performing PASARR's). hat the facility did not have f74. When asked what is the RR, OSM #3 stated, "some I don't know what the purpose a.m., in an interview with OSM worker, she stated, that R, that "It is done at the ew the chart to make sure the eve any mental illness or a determine if there is a level 2 list to be processed by a er to make sure they (the to come to a facility, and are in take care of them safely." ASARR does not come from social worker responsible to do d, "That was not the here." When asked what is PASARR, OSM #4 stated, "To ere is an issue, that we are needs and how we can best | F | 345 | |
| : | | ASM #1 was made aware of on 3/30/18 at 12:57 p.m. | | : | ; |
| ! | No further informati | on was provided prior to exit. | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | E & MEDICAID SERVICES | | | OMB NO | <u> 0938-0391)</u> |
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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2 MUL A. BUILD | TIPLE CONSTRUCTION | | TE SURVEY |
| | | 495142 | B. WING | | 03 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII | | · |
| EVERGR | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 645 | Continued From pa | age 162 | Ff | 645 | | |
| ! | 4. The facility staff #114's PASARR waresident was evaluated services in the most appropriate for the | failed to ensure Resident as complete to ensure the ated and receiving care and st integrated setting resident's needs. | | 7 70 | | |
| | 4/7/17 with the diag deep vein thrombos pneumonia, shortne insomnia, dementia anxiety disorder, hig emphysema, chron disease, osteoarthr kidney disease. The Data Set) was a que ARD (Assessment The resident was cability to make daily was coded as requiextensive care for his preumonia, shortness and the distribution of the control of th | s admitted to the facility on gnoses of but not limited to sis, ankle fracture, aspiration ess of breath, edema, a, schizophrenia, depression, igh blood pressure, nic obstructive pulmonary ritis, fibromyalgia, and chronic ne most recent MDS (Minimum varterly assessment with an Reference Date) of 3/6/18. coded as severely impaired in y life decisions. The resident iring total care for bathing; hygiene, dressing, and ssistance for toileting; | | | | |
| | independent for eat and bladder. Review of Resident | ting; and as continent of bowel t #114's clinical record failed to | | | | : |
| ! | comprehensive cardocumentation rega | e plan failed to reveal arding the PASARR. | | | | |
| | meeting, the Admin Staff Member) #1, I and the facility own | p.m, at the end of day nistrator, ASM (Administrative Director of Nursing (ASM #2), ner (ASM #6) were made aware equest was made for evidence | | | | |
| | | a.m., in an interview with OSM er, the social worker) #3, she | | | was to all the | |

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

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 163 of 32B



PRINTED: 04/13/2018 FORMAPPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | ILTIPLE CONSTRUCTION | | (X3) DATE SURVE | Y |
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| AND PLAN U | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | DING | | COMPLETED | |
| | I | 495142 | B. WING | 3 | | 03/30/201 | 8 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | EX (EACH CORRECTIVE AC | THE APPROPE | DBE COMPLE | ETION |
| | had to do" (obtaining She further stated to them for Resident # purpose of a PASAI type of evaluation. of it is for." On 3/30/18 at 9:44 #4, another social was regarding a PASAR hospital. They review resident doesn't have mental disability to excreening that need psychologist, in orderesidents) are safe deemed that we can When asked if a PA the hospital, is the sone, OSM #4 stated communicated to make sure that if the able to handle their meet their needs. No further information the survey. 5. The facility staff #55's PASARR was resident was evaluated services in the most | of told it was something that I had, performing PASARR's), that the facility did not have #74. When asked what is the IRR, OSM #3 stated, "some I don't know what the purpose a.m., in an interview with OSM worker, she stated, that IRR, that "It is done at the ew the chart to make sure the ew the chart to make sure the ve any mental illness or a determine if there is a level 2 ds to be processed by a ler to make sure they (the to come to a facility, and are in take care of them safely." ASARR does not come from social worker responsible to do d, "That was not ne here." When asked what is PASARR, OSM #4 stated, "To here is an issue, that we are needs and how we can best ion was provided by the end of failed to ensure Resident accomplete to ensure the ated and receiving care and strintegrated setting | Fe | 645 | | | |
| | appropriate for the r | admitted to the facility on | | | | | |

10/25/04 with the diagnoses of but not limited to

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|---|-----------------------------|-------------------------------|----------------------------|
| | | 405440 | <u>.</u> | | | | С |
| ***** | == <u>=</u> | 495142 | B. WING | | | 03/ | <u>30/201</u> 8 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | STREET ADDRESS, CITY, STATE, 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | CTION SHOULD THE APPROPE | BE | 1X5) COMPLETION DATE |
| F 645 | Parkinson's disease hyperplasia, diabete depression, mood of pseudobulbar affect dysphagia. The moderate Data Set) was a quark ARD (Assessment The resident was occognitively impaired decisions. The resident for bathing, hygiene transfers; supervision incontinent of bower Review of Resident reveal the resident's comprehensive can documentation regardocumentation regardocumentation regardocumentation regardocumentation strative Staff (ASM #2), and the for evidence of the On 3/30/18 at 9:33 #3 (Other Staff Mer stated that she "was that I had to do" (other Staff Mer stated that she "was that I had to do" (other Staff Mer stated that she "was that I had to do" (other Staff Mer stated that she purpose of evaluation purpose of it is for." | e, benign prostatic es, dementia, psychosis, disorder, anxiety disorder, et, high blood pressure, and est recent MDS (Minimum earterly assessment with an Reference Date) of 2/7/18. oded as being severely d in ability to make daily life ident required extensive care e, toileting, dressing, and on for eating; and was el and bladder. It #55's clinical record failed to s PASARR. Resident #55's re plan failed to reveal earding the PASARR. p.m., at the end of day enistrator (ASM #1 - f Member), Director of Nursing facility owner (ASM #6) were findings. A request was made PASARR. a.m., in an interview with OSM ember, the social worker) she is not told it was something obtaining, performing earther stated that the facility for Resident #55. When asked e of a PASARR, she stated, eation. I don't know what the | F € | 645 | | | |
| | #4, another social v | a.m., in an interview with OSM worker, she stated, that that "It is done at the | - | | | | |

PRINTED: 04/13/2018 FORMAPPROVED OMB NO. 0938-0391

| CENT | TO FOR MEDICARE | E & MEDICAID SERVICES | | | | <u>OMB NO. 0</u> | <u> 1938-0391</u> |
|--------------------------|-------------------------------------|--|----------------------|------|--|----------------------|----------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE S COMPL | SURVEY LETED |
| | | 495142 | B. WING | 3 | | 03/30 | 0/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | 00,00 | J/20 10 |
| := 501 | | | ŗ | | MILLWOOD AVENUE | | |
| EVERGE | REEN HEALTH AND R | KEHAB | | i . | NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | IX : | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | IX5) COMPLETION OATE |
| F 645 | Continued From pa | | | 745 | | | |
| | | _ | | 645 | | | |
| | nospital. They revi | riew the chart to make sure the ave any mental illness or a | | | | | |
| | | ave any mental illness or a determine if there is a level 2 | | | | | |
| | | eds to be processed by a | | | | : | |
| | | der to make sure they (the | | | | : | |
| | | to come to a facility, and are | | | | ! | |
| | | an take care of them safely." | | | | | |
| | When asked if one | e does not come from the | | | | | |
| , | hospital, is the soci | cial worker responsible to do | | | | | |
| , | | hat was not communicated to | | | | | |
| : | | asked what is the purpose of | | | | | |
| | one, she stated, "It | o make sure that if there is an | | | | | |
| | | able to handle their needs and | | | | · | |
| - | how we can best m | reet their needs. | | | | • | |
| ļ | | ASM #1 was made aware of on 3/30/18 at 12:57 p.m. | : | | | | |
| | No further informat | tion was provided prior to exit. | : | | | | |
| | | failed to complete a Level I | | | | | |
| - | | lent #98, to ensure each | | | | | |
| | | ng facility, is screened for a | | i | | | |
| | mental disorder (MI | ID) or intellectual disability (ID) | | | | | |
| r | prior to admission a | and that individuals are | | | | | |
| | | eive care and services in the | : | | | | |
| ! | most integrated set | tting appropriate to their needs. | | | | | |
| į | Resident #98 was a | admitted to the facility on | | | | | |
| : | 4/21/15 with diagno | oses that included but not | | | | • | |
| ! | limited muscle weal | akness, diabetes mellitus, chest | t · | | | | |
| : | pain, paranoid schiz | izophrenia, chronic kidney | | | | 1 | |
| | | blood pressure. Resident | : | | | | |
| : | | MDS (minimum data set) | | : | | 1 | |
| ļ | assessment was a | quarterly assessment with an | : | | | | |
| ļ | ARD (assessment r | reference date) of 2/28/18. | • | | | | |
| | | coded as being moderately | | | | : | |
| 1 | | /e function scoring 10 out of | | ; | | | |
| 1 | possible 15 on the r | BIMS (Brief Interview for | | | | | |

Mental Status) exam. Resident #98 was coded as

| OLIVIL | TO T OIL MILDIONICE | A MEDICAID SERVICES | | | | NO. 0930-039 | ı |
|--------------------------|-----------------------------------|--|-------------------|----------|---|-------------------------------|---|
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | . | | C | |
| NAME OF 1 | PROVIDER OR SUPPLIER | | L | | EET ADDRESS, CITY, STATE, ZIP CODE | 03/30/2018 | 4 |
| | REEN HEALTH AND R | ЕНАВ | | 380 | MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION | |
| F 645 | Continued From pa | age 166 | . E | 345 | · · | | |
| | | | . ' ' | J-J | | | |
| | | assistance from one staff ADLs (activities of daily living). | | | | | |
| | The most recent co | omprehensive MDS (minimum | | ï | | 1 | |
| | | ent, an annual assessment, | | : | | : | ١ |
| | | t reference date of 11/1/18, | | | | | - |
| : | | 1500 - Preadmission | | | | : | - |
| | | ident Review, the resident as | | | | | |
| | not being currently | considered by the state level II | | | | ! | |
| | PASAAR process to | o have a serious mental illness | | | | | İ |
| | and/or intellectual d | lisability or a related condition. | : | | | | |
| | _ | | | | | • | |
| • | | al record failed to evidence a | | | | | |
| | | ening and Resident Review | | : | | ! | |
| | was completed for l | Resident #98. | | ٠ | | • | |
| | On 3/30/18 at 9:23 | a.m., an interview was | | | | | |
| | | M (other staff member) #3, the | | İ | | | |
| - ' | | A #3 stated that she was not | | | | | |
| | | ervices was responsible for | | : | | | |
| | | SAAR. OSM #3 stated it was | | | | | |
| | | ition that she had to complete | | | | | Ì |
| ŀ | PASAARS. When a | asked how long she had been | | | | | |
| | | OSM #3 stated since April of | | | | | |
| | | ed the purpose of the | | | | | |
| | | stated she was not sure of the | | | | | 1 |
| | (of the PASARR) pu | urpose or what it was used for. | : | | | | |
| i | On 3/30/18 at 9:32 | a.m., an interview was | - | | | | |
| | | M #4, another social worker | | | | | |
| : | | red at the facility. When | | | | | |
| 1 | | AR was, OSM #4 stated that | | , | | : | |
| į | | y happens at the hospital and | | | | | ļ |
| ! | | dent's chart to see if a | | | | 1 | |
| | | tal illness or disability and then | | | | ! | |
| : | | evel two PASAAR needs to be | | | | | |
| | | ed that it ensures residents | | : | | | |
| į | | the facility and that the facility | | | | | |
| | can meet the reside | ent's needs. OSM #4 stated | | | | : | 1 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A, DOILD | | | | c | |
| | | 495142 | B. WING | | | 03/ | 30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 M | T ADDRESS, CITY, STATE, ZIP COI ILLWOOD AVENUE CHESTER, VA 22601 | DE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION OATE | |
| F 645 | services was to co hospital did not do another state wher another departmen completing PASAA | mmunicated to her that social mplete the PASAAR if the one. OSM #4 stated that in e she had worked previously, at was responsible for | F | 645 | | | | |
| | staff member) #1, DON (director of n owner were made On 3/30/18 at 10:3 | | · F | 655 | D655 | | | |
| | Planning §483.21(a) Baselir §483.21(a)(1) The implement a basel that includes the ir effective and perse that meet professi The baseline care (i) Be developed wadmission. (ii) Include the mir necessary to prop- including, but not I | facility must develop and ine care plan for each resident astructions needed to provide on-centered care of the resident onal standards of quality care. plan must-vithin 48 hours of a resident's simum healthcare information erly care for a resident imited to-sed on admission orders. | | 2. | be affected by the alleged def 100% audit of admissions sin will be done to assure an appr care plan has been completed admission will be audited by Coordinator or designee x 3 n compliance. | in regards to are plan has been for an indwelling a developed for the end of the potential to ficient practice. In the end of the en | ; | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | II TIPI F | CONSTRUCTION | | (X3) DATE SURVEY | | | |
|---|---|--|--------------------|---------------|---|--|-------------------|----------------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | CONSTRUCTION | | СОМ | IPLETED |
| 0- | - | 4 95142 | B. WING | | | | 1 | C 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ŀ | REET ADDRESS, CITY, STATE, ZI | P CODE | | |
| EVERGF | REEN HEALTH AND R | ЕНАВ | | 1 | MILLWOOD AVENUE NCHESTER, VA 22601 | | _ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD HE APPROPI | BE | (X5) COMPLETION DATE |
| F 655 | Continued From pa | age 168 | - - F: | 655 <i>-</i> | 4. The Director of Nursing a | and/or desig | nee will | - |
| | | nmendation, if applicable. | - | | analyze/review for patters the Quality Assurance co | ns/trends an | d report in | 1 |
| | comprehensive care care plan if the com (i) Is developed with admission. (ii) Meets the require | facility may develop a re plan in place of the baseline aprehensive care planthin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of | : | | quarterty for a minimum evaluate the effectiveness adjust the plan as the correcommend, based on out identified from date. 5. Completion Date: May 1 | of six month s of the plan nmittee may tcomes/trend | hs to and will | |
| | resident and their re of the baseline care limited to: (i) The initial goals | he resident's medications and | | | | | ; | |
| | (iii) Any services an administered by the on behalf of the faci | nd treatments to be e facility and personnel acting illity. | | i | | | | |
| : | of the comprehensive | formation based on the details ve care plan, as necessary. NT is not met as evidenced | | : | | | | |
| | Based on observati document review an was determined that develop a complete | tion, staff interview, facility and clinical record review, it at the facility staff failed to baseline care plan for two of survey sample, Residents | | | | | : | ; |
| : | 1. The facility staff facare plan for Reside | ailed to develop a baseline ent #132's indwelling catheter. | | : | | | | |
| ! | 2. The facility staff facility staff facility staff facility staff facility staff. | ailed to address the use of line care plan for Resident | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | С |
| | | 495142 | B. WING _ | | 03/ | 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND F | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| F 655 | The findings included 1. The facility staff care plan for Resident #132 was 2/6/18 and readmined #132's diagnoses in acute respiratory facute resp | - | F 65 | 55 | | |
| | Review of Residen revealed a physicial catheter due to a value Resident #132's country and handwritten badated 3/8/18 failed | at #132's clinical record an's order dated 3/9/18 for a | | | | |
| | observed lying in a catheter bag was of fall mat lying on the On 3/30/18 at 8:25 conducted with LPI LPN #3 was asked baseline care plan. handwritten care p admission and a coand family along w stated the initial ca | a.m., Resident #132 was low bed. The resident's observed on the floor and on a e floor. a.m., an interview was N (licensed practical nurse) #3. I the purpose of the initial LPN #3 stated the lan is done on the day of opy is provided to the resident ith a medication list. LPN #3 re plan is completed in the handwritten care plan is | | | | |

| <u> </u> | NO I ON MEDIOANE | A MEDICAID SERVICES | | | | IVID IVO. | . 0330- 039 i |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI | | E CONSTRUCTION | | E SURVEY IPLETED |
| | | 4054.40 | D WING | | · · · · · · · · · · · · · · · · · · · | | С |
| | | 495142 | B. WING | | | 03/ | 30/ 2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 38 | FREET ADDRESS, CITY, STATE, ZIP CODE BO MILLWOOD AVENUE FINCHESTER, VA 22601 | | |
| (VA) ID | SLIMMADV STA | TEMENT OF DEFICIENCIES | | | PROVIDERIS DI ANI CE CORRECTIO | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 655 | Continued From pa | ae 170 | F | 655 | | | |
| | i i | | , , | 000 | | | İ |
| | | sked what information should | | : | | | |
| | | baseline care plan, LPN #3 | | : | | | : |
| | | re here, what they are going | | : | • | | |
| | | e: oxygen therapy, blood | | | | | |
| | | mptoms of infection. It | | | | | |
| | | agnosis." When asked if an | | | | | |
| | | should be included on the | | | | | |
| | | LPN #3 stated, "Yes." When | | | | | : |
| | | stated, "To make sure we are | | : | | | |
| | providing care for it | ." LPN #3 was asked to | | | | | |
| | review Resident #1 | 32's initial care plan and | | | | | 1 |
| | baseline care plan: | summary. LPN #3 confirmed | | | | | |
| | documentation rega | arding a catheter was not on | | | | | : |
| | either form. | J | | | | | |
| | | a.m., ASM (administrative | | | | | |
| | | he administrator) was made | | | | | |
| | | concern. On 3/30/18 at 9:55 | | | | | |
| | a.m., ASM #2 (the caware of the above | director of nursing) was made concern. | | | | | |
| | | nt titled, "Comprehensive | | | | | |
| | | are Planning" documented, | | | | | |
| | <u> </u> | ne resident's immediate care | | | | | |
| , | : | maintained, an interim care | | | | | |
| | plan will be develop | ed within 48 hours of the | | | | | |
| | | n. a) The Interdisciplinary | | | | | |
| | | e following to assist in | | | | | |
| | | rim care plan: i) Orders | | | | | |
| | | e of admission. ii) IDT | | | | | |
| | | am) initial evaluation and | | | | | |
| • | assessment" | , | | | | | |
| | No further informati | on was presented prior to exit. | : | | | | |
| | : ! | , | | | | | : |
| | | dwelling catheter (tube) in your | | | | | |
| , | | ' means inside your body. | | | | | |
| | This catheter drains | urine from your bladder into | | | | | |
| : | | body." This information was | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | 1 | 495142 | B. WING | | | 03 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | <u> </u> | 700.20 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 655 | Continued From pa obtained from the w https://medlineplus. 00140.htm | - | F 6 | 355 | | | : |
| | | failed to address the use of eline care plan for Resident | : | | | | · · · · · |
| | 3/22/18 with diagno limited to: fracture of (a slowly progressive characterized by restooped posture, rodrooling, and muscle chronic obstructive (COPD - a general non-reversible lung | s admitted to the facility on oses that included but were not of her leg, Parkinson's disease we neurological disorder esting tremor, shuffling gait, olling motions of the fingers, cle weakness) (1), falls, and pulmonary disease (COPD) term for chronic, g disease that is usually a physema and chronic | | | | | |
| | | pleted MDS (minimum data ompleted at the time of survey. | : | | | | · · · · |
| | | ssion Assessment" dated, ed the resident was alert and ace and person. | : | | | | |
| : | p.m. with oxygen in with two prongs that nostrils) connected that was set at 2 L/r | bserved on 3/27/18 at 2:47 a use via nasal cannula (a tube at are inserted in the resident's to an oxygen concentrator min (liters per minute). The ved on 3/29/18 at 8:39 a.m. use. | | : | | | |
| | documented in part, | plan dated, 3/23/18, t, "Focus: The resident has status/difficulty breathing r/t | : | | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL [*] A. BUILDI | TIPLE CONSTRUCTION NG | | ` СОМ | E SURVEY PLETED |
|--------------------------|---|---|------------------------------------|---|------------------|-------|----------------------------|
| | | 495142 | B. WING | | | | C 30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE _. | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD | BE | (X5) COMPLETION DATE |
| F 655 | The "Interventions" documentation of the documentation of the Review of the treatre (TAR) documented, (liters) via n/c (nasa every shift." The ox being administered 3/22/18. An interview was conurse) #1 on 3/29/1 who develops the care plan coordinate care plan." An interview was conurse plan at 3:11 p.m. should be on the bastated, "Yes, it should be on the bastated, "Yes, it should be on the plan of care for the how to obtain them accurate, LPN #5 si uses the care plan, staff, the doctors, at The administrator, of | and chronic respiratory failure." failed to evidence he administration of oxygen. ment administration record "O2 (oxygen) @ (at) 2 L al cannula), titrate as needed ygen was documented as every shift since admission on an onducted with RN (registered 8 at 1:09 p.m. When asked are plan, RN #1 stated, "The for develops and revises the anducted with LPN (licensed the care plan coordinator, on when asked if oxygen aseline care plan, LPN #5 ald be." When asked the plan, LPN #5 stated, "It's the patient and it has goals and "When asked if it should be tated, "Yes." When asked who LPN #5 stated, "The nursing and activities." | F 6 | 55 | | | |
| | No further informati | on was provided prior to exit. | | | | | : - ! |
| : : : | | ary for Medical Terms for the er, 5th edition, Rothenberg and 7. | | | | | |

| AND DIAN OF CODDECTION IDENTIFICATION NUMBER. | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-------------------|-------|--|--|--|
| | | 495142 | B. WING | | | 0: | C 3/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND I | | | 380 M | ET ADDRESS, CITY, STATE, ZIP CODE IILLWOOD AVENUE CHESTER, VA 22601 | | <u> </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 656 | Non-Medical Read Chapman, page 1 Develop/Implement CFR(s): 483.21(b) §483.21(b) Compressed Season S | nary for Medical Terms for the der, 5th edition, Rothenberg and 24. Int Comprehensive Care Plans facility must develop and brehensive person-centered resident, consistent with the forth at §483.10(c)(2) and tincludes measurable eframes to meet a resident's and mental and psychosocial ntified in the comprehensive comprehensive care plan must ring - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 33.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not be resident's exercise of rights sluding the right to refuse 483.10(c)(6). If services or specialized the servic | F | 3. 4. | F656 Corrective action has been accomalleged deficient practice in regar #95, 99, 57, 234, 97 has been revirevised as applicable. The care planestriction has been discontinued a care plan has been developed for oxygen use, a care plan has been #57 antipsychotic mediation, for thas been developed for heparin use care plan was developed for a psymedication. Current facility residents have the affected by the alleged deficient paudit of care plans has been compall areas have been care planned. Coordinator and IDT team will reresidents monthly for 4 weeks, the monthly for 3 months to validate care plans have been initiated for Results will be submitted to QAP ensure compliance. Measures put into place to assure deficient practice does not recur in Reeducation will be given to Care Coordinator to ensure all areas had planned. The Director of Nursing and/or deanalyze/review for patterns/trends the Quality Assurance committee quarterly for a minimum of six mevaluate the effectiveness of the province of the process o | ds to reside ewed and an for a flui for resident r #99 for developed f #234 a care se, and #97 chotropic potential to ractice. 100 leted to ens The Care P view 10 curen 15 resident and report the resident function we been caresignee will and report meeting onths to lan and will | ents id #95, for plan a o be 0% sure lan rrent ents riate t. to |
| : | desired outcomes. (B) The resident's | | | 5. | adjust the plan as the committee necommend, based on outcomes/t from date. Completion Date: May 11, 2018 | | fied |

| <u> </u> | CO I OIL WILD ON THE | . WILDIONID OLIVNOLO | | | O, | | . บองด-บงอ เ |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | FIPLE CONSTRUCTION NG | | | E SURVEY IPLETED |
| | | 495142 | B. WING | | | ł | C 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | 'IP CODE | | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 0052 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD THE APPROPE | BE | (X5) COMPLETION OATE |
| F 656 | community was ass local contact agence entities, for this pury (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on staff inter clinical record revies staff failed to develo comprehensive carrier the survey sample and 97. 1. The facility staff of the staff failed to develop the survey sample and 97. | nt's desire to return to the sessed and any referrals to ies and/or other appropriate | F 6 | 56 | | | |
| | was not on a fluid re 2. The facility staff f comprehensive care administration for R 3. The facility staff f anti-psychotic medic #57. 4. The facility staff f comprehensive care for Resident #234. 5. The facility staff f comprehensive care | estriction. ailed to develop a e plan for oxygen esident #99. ailed to develop an cation care plan for Resident ailed to develop a e plan for the use of heparin | | | | | |
| | The findings include | e: | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DA | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | 0, | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 5/3U/ZU IG | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION OATE | |
| F 656 | 2/17/16 and readmithat included but we bleeding, schizophr diabetes. The most recent co set), a quarterly ass (assessment refere the resident as have BIMS (brief interviethe resident was condecisions. The resident was condecisions. The resident was condecisions. The resident was condecisions. The resident was condecisions. The resident was condecisions. The resident was condecisions. Intervent cardiovascular state Hyperlipidemia (1), pressure). Intervent centimeter) fluid resonance documentation. Review of the March not evidence document for fluid restriction. Review of the March administration regard An interview was condecisions. When asked plans, RN #3 stated plans for some basis anything that might resident." When asked plans. | as admitted to the facility on nitted on 3/3/18 with diagnoses were not limited to: intestinal arenia, heart failure and complete MDS (minimum data assessment, with an ARD ence date) of 2/23/18 coded wing scored 15 out of 15 on the ew for mental status) indicating ognitively intact to make daily ident was coded as requiring ivities of daily living. In plan initiated on 3/5/18 resident has altered tus r/t (related to), Hypertension (high blood ations. 1500cc (cubic estriction, resident is mes." | F 6 | 656 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | | C 30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP | CODE | 03/ | 30/2016 |
| EVERGR | REEN HEALTH AND F | REHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 3322 | | |
| (X4) ID PREFIX TAG | | | | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 656 | Continued From pa | age 176 | · F6 | 56 | | | ! |
| | have much to do w anything." When a | ith that as far as putting it in or sked if Resident #95 was on a #3 stated she was not. | | | | | |
| : | member) #1, the a | p.m. ASM (administrative staff dministrator, ASM #2, the and ASM #7 the facility owner of the findings. | | | | | |
| | approximately 1:00 practical nurse) #3 When asked who of #3 stated she did behired. When asked LPN #3 stated, to presidents. When as | onducted on 3/30/18 at p.m. with LPN (licensed the care plan coordinator. completed the care plans, LPN but she had just been recently liwhy residents had care plans, provide the care for the sked if a resident was care striction but was not ordered to | | | | | |
| | have a fluid restrict #3 stated, no. | tion if that was accurate, LPN | | i : | | | : |
| : | part the following: 'ensure interdiscipli and reflective of the medical needs. Ca | tled, "Care Plan" documents in The company's guideline is to nary care plans are accurate e patient/residents current re plans are to be periodically acy and updated as needed. | | | | | |
| | No further informat | ion was provided prior to exit. | | | | | |
| | substance that's fo body. Your body ne hormones, vitamin you digest foods. Y cholesterol it needs foods from animals meat, and cheese. | - Cholesterol is a waxy, fat-like und in all the cells in your eds some cholesterol to make D, and substances that help our body makes all the s. Cholesterol is also found in sources, such as egg yolks, If you have too much blood, it can combine with | | | | | |

| | | WINDOWN OF COLUMN | | | <u> </u> | VIAID LAC | J. 0330-039 I |
|-----------|-------------------------------|--|---------------------|-----|---|-----------|--------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | E CONSTRUCTION | | ATE SURVEY MPLETED |
| | | 495142 | B. WING | | • | | C |
| | | 495142 | D. 11110 | | | 03 | 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVEROR | | | | 3 | 80 MILLWOOD AVENUE | | |
| EVERGR | EEN HEALTH AND R | EHAB | | 14 | VINCUESTED VA 20604 | | |
| - | | | | V | VINCHESTER, VA 22601 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ĮD | | PROVIDER'S PLAN OF CORRECTION | N | (X5) |
| PREFIX | | MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOUL | | COMPLETION |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | i | CROSS-REFERENCED TO THE APPROP | RIATE | DATE |
| | | | | | DEFICIENCY) | | |
| | | | | | ! | | |
| F 656 | Continued From pa | an 177 | _ سم | 250 | | | |
| 1 000 | • | • | F 1 | 656 | | | |
| | other substances in | the blood to form plaque. | | | | | |
| | Plaque sticks to the | walls of your arteries. This | | | | | |
| | | known as atherosclerosis. It | | | | | |
| | | y artery disease, where your | | | | | i . |
| | | | | | | | |
| | | ecome narrow or even | | | | | |
| | | nation was obtained from: | | | | | |
| | https://medlineplus. | gov/cholesterol.html | | | | | |
| | | | | | | | |
| | 2. The facility staff f | ailed to develop a care plan | | | | | |
| | | tration for Resident #99. | | | | | i |
| | io. oxygon adminio | ration for itesident #55. | | | | | |
| : | Donidont #00 | admatte ad to the facility and | | | | | : |
| | | admitted to the facility on | | | | | |
| | | ed on 2/26/18 with diagnoses | | | | | |
| İ | that included but we | ere not limited to: heart failure, | | | | | |
| | pneumonia, anemia | a, depression and cognitive | | | | | |
| | communication defi | | | | | | |
| | | | | | | | |
| | The most recent MI | OS, a significant change | | | | | |
| | | | | | | | |
| | | n ARD of 3/5/18 coded the | | | | | |
| | | ne BIMS indicating the resident | | | | | |
| | was not able to com | plete the exam. The resident | | | | | |
| | was coded as as ur | nderstanding others and being | | | | | |
| | | ing intact short and long term | | | | | |
| | | #99 was coded as requiring | | | | | |
| : | | | | | | | |
| | | ctivities of daily living. The | | | | | |
| | resident was coded | as receiving oxygen. | | | | | |
| | | | | | | | , j |
| | | h 2018 physician orders | | | | | |
| | documented, "O2 (d | oxygen) @4L (liters) n/c (nasal | | | | | - i |
| | | c prongs that fit in the nose to | | | | | |
| | | / titrate as needed every shift." | | | | | |
| : | ==: s.r.y gon, may | , and do nooded every stillt. | | | | | 4 |
| ; | Review of the Marel | h 2019 TAP documented "OO | | | | | * |
| i | | h 2018 TAR documented, "O2 | | | | | :] |
| ! | @4∟ n/c may titrate | as needed every shift." | | i | | | † |
| | | | | | | | |
| | Review of the reside | ent's care plan did not | | | | | ļ |
| | | ation of an oxygen plan of | | | | | İ |
| ! | care. | | | | | | ļ l |
| | ~ . | : | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|--|--|----------------------|-------------|---|----|----------------------------|
| | | 495 14 2 | B. WING | | | 03 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | ЕНАВ | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | Terme . |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 656 | p.m. with RN (regist nurse. When asked plans, RN #3 stated plans for some basianything that might resident." When asl RN #3 stated, "Well have much to do with anything." When as oxygen, RN #3 state would be care plant it should be. On 3/29/18 at 6:00 | onducted on 3/29/18 at 2:25 stered nurse) #3, the resident's d why residents had care d, "Well, we have to have care ic things first of all and then be a specific thing to that ked who used the care plan, II, I'm assuming we do. I don't ith that as far as putting it in or sked if Resident #99 was on ed he was. When asked if that ned, RN #3 stated she thought | F | 656 | | | |
| | | owner were made aware of | | | | | |
| | approximately 1:00 practical nurse) #3, When asked who co #3 stated she did bu hired. When asked LPN #3 stated, to puresidents. When as | pnducted on 3/30/18 at p.m. with LPN (licensed the care plan coordinator. ompleted the care plans, LPN ut she had just been recently why residents had care plans, rovide the care for the ked if a care plan would be ident on oxygen, LPN #3 | | : : : | | | |
| ı | No further information | on was provided prior to exit. | | | | | |
| | 3. The facility staff | ailed to develop an cation care plan for Resident | | | | | : |
| : | 5/24/14 and readmit | admitted to the facility on tted on 1/22/18 with uded but were not limited to | | : | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | (X: | (X3) DATE SURVEY COMPLETED | |
|--|---|--|----------------------|--|-------------------------------------|-------------------------------|--|
| | | 495142 | B. WING | 3 | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | , ZIP CODE | 00/00/20 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | IX (EACH CORRECTIVE A | CTIDN SHOULD BE O THE APPROPRIAT | | |
| F 656 | weakness, Alzheim disorder. Resident (minimum data set) assessment with ar date) of 2/8/18. Re severely impaired in out of possible 15 of Mental Status) example as requiring extens members with most living). | navioral disturbance, muscle ner's disease and mood t #57's most recent MDS t) assessment was a quarterly an ARD (assessment reference esident #57 was coded as in cognitive function scoring 06 on the BIMS (Brief Interview for am. Resident #57 was coded sive assistance from two staff at ADLS (activities of daily | | 656 | | | |
| | order summary revo on Zyprexa (1) 5 mg related to behaviora | at #57's most recent physician vealed that Resident #57 was and (milligrams) two times a day ral disturbance. Resident #57 and the hospital with this order | | | | | |
| | Resident #57 on 2/2 Zyprexa as is until r documented, "Plan medications as abo | /chiatric physician evaluated /2/18 and decided to keep the next visit. The following was n - continue current ove No medication changes consider decreasing Zyprexa | | | | | |
| | plan dated 1/24/18 t | t #57's comprehensive care failed to evidence an ication care plan to address a. | | | | | |
| | conducted with LPN the care plan coord important that the ca #5 stated that it was | p.m., an interview was N (licensed practical nurse) #5, dinator. When asked if it was care plan was accurate, LPN s. LPN #5 stated that she was reloping care plans. When | : | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | , | 495142 | B. WING | 3 | | l | C / 30/20 18 |
| | PROVIDER OR SUPPLIER | ЕНАВ | 1 | STREET ADDRESS, CITY, STATE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | E, ZIP CODE | <u> </u> | /30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ACTION SHOULD O THE APPR O PF | BE | (X5) COMPLETION DATE |
| | anti-psychotic medi place, LPN #5 state developed. When a care plan, LPN #5 s (interdisciplinary tea #5 confirmed that the care plan for Reside On 3/30/18, LPN #5 updated care plan for was documented: "I Zyprexa r/t (relate disorder. Goal: The psychotropic drug romovement disorder disturbancecognit through next review psychotropic medical physician. Monitor for effectiveness q (ever Monitor/D ocument/r adverse side effects medicationsMonitotarget behavior symfacility protocol." | portant for a resident on an ication to have a care plan in led that a care plan should be asked who has access to the stated that the IDT am) uses the care plan. LPN here was not an anti-psychotic ent #57. To presented this writer with an for Resident #57. The following Focus: The Resident uses led to) Behavior and mood resident will be/remain free of lelated complications, including the dateAdminister lations as ordered by for side effects and lery shift). | | 656 | | | |
| | staff member) #1, the DON (director of nu | p.m., ASM (administrative he administrator, ASM #2, the irsing) and ASM #7, the facility aware of the above concerns. | | : | | | |
| | nervous, emotional also be used to trea information was obtainstitutes of Health. | ntipsychotic used to treat and mental conditions. Can at bipolar disorder. This ained from The National n.nih.gov/pubmedhealth/PMH | : | | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CLIVIE | V2 LOK MEDICAKE | A MEDICAID SEKVICES | | | | <u> YAIR IAC</u> | <u>J. 0938-0391</u> |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | | ATE SURVEY OMPLETED |
| | | 495142 | B. WING | | | 03 | C 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | TEN UEALTH AND D | | | 380 | MILLWOOD AVENUE | | |
| EVERGA | REEN HEALTH AND RI | | | Wi | NCHESTER, VA 22601 | | |
| (X4) 1D PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY) | DBE | (X5) COMPLETION DATE |
| F 656 | Continued From pa T0011473/?report= 4. The facility staff f comprehensive care for Resident #234. | details. | F6 | i56 | | | |
| | 3/13/18 with diagno limited to: fracture of chronic obstructive (COPD - a general non-reversible lung | s admitted to the facility on oses that included but were not of her left femur, pain and pulmonary disease (COPD) term for chronic, g disease that is usually a physema and chronic | | | | | |
| | assessment, an adrassessment references resident as scoring interview for mental was capable of make The resident was capable of one of most of her activitie in which she was in Medications, Residereceiving seven day | IDS (minimum data set) Imission assessment, with an ince date of 3/20/18, coded the a 14 on the BIMS (brief al status) score, indicating she king daily cognitive decisions. Toded as requiring extensive or more staff members for es of daily living except eating independent. In Section N - lent #234 was coded as ys of an anticoagulant during the look back period. | | | | | |
| | "Heparin Sodium*, inject 1 ML subcuta | er dated, 3/27/18, documented, 5000 Units/ML (milliliters); aneously every 12 hours ed intracapsular fracture of left | | : | | | |
| | | n an anticoagulant. It is used to ng ability of the blood and help its from forming. (2) | | İ | | | |

The comprehensive care plan dated, 3/13/18,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|-------------------------|-------------------------------|----------------------------|
| | | 495142 | B. WING | | ļ | l | C / 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | 700/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD IE APPROPF | BE | (X5) COMPLETION DATE |
| | The mediation adm documented, "Hepa inject 1 ML subcuta related to unspecific femur until 4/3/18." resident received he as prescribed. An interview was conurse) #1 on 3/29/1 who develops the core plan coordinate care plan." An interview was conurse plan coordinate care plan. "An interview was conurse plan coordinate care plan." An interview was conurse plan coordinate care plan. "An interview was conurse plan." An interview was conurse plan coordinate care plan. "An interview was conurse plan of care plan and revise the care plan and revise the care plan of care for the how to obtain them. accurate, LPN #5 stuses the care plan, staff, the doctors, and the CNAs (certified access to the care plan don't have actual access to the care plan't have access to the care plan't have access to the care plan't have access to t | inistration record (MAR) arin Sodium 5000 Units/ML; neously every 12 hours ad intracapsular fracture of left It was documented the ar heparin every twelve hours anducted with RN (registered at 1:09 p.m. When asked are plan, RN #1 stated, "The ar develops and revises the anducted with LPN (licensed the care plan coordinator, on . When asked what is your as, LPN #5 stated, "I review plans." When asked if an the care plan, LPN #5 and be." When asked the plan, LPN #5 stated, "It's the patient and it has goals and "When asked if it should be eated, "Yes." When asked who LPN #5 stated, "The nursing and activities." When asked if nursing assistants) have plan, LPN #5 stated, "They access to the care plans." director of nursing and owner hade aware of the above | F6 | 56 | | | |
| | No further information | on was provided prior to exit. | | | | | : |

| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB STREET ADDRESS, CITY, STATE, Z 380 MILLWOOD AVENUE WINCHESTER, VA 22601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 183 F 656 (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: | (X3) DATE SUR' COMPLETE | | | | |
|---|--|-------------------------|--|--|--|
| EVERGREEN HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 183 (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | C 03/30/20 | พด | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 183 F 656 (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | | <u></u> | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 183 F 656 (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | | | | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 183 (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | WINCHESTER, VA 22601 | | | | |
| (1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | TION SHOULD BE COMP THE APPROPRIATE D | (X5) PLETION PATE | | | |
| Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the | | | | | |
| https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH T0010545/?report=details. 5. The facility staff failed to develop o comprehensive care plan for the use of psychotropic medications for Resident #97. Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions. The resident was coded requiring limited to extensive assistance for her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antipsychotic medication during the look back period. | | | | | |
| The physician order dated, 3/15/18, documented, "Quetiapine Fumarate * Tablet 100 mg (milligrams); give 1 tablet by mouth at bedtime related to other specified anxiety disorders." | i | ļ | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|---|-------------------------|-------------------------------|----------------------------|--|
| | | 495142 | B. WING | B. WING | | | C 30/2018 | |
| | PROVIDER OR SUPPLIER | | ···· | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | 50,2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD E E APPROPR | BE | (X5) COMPLETION DATE | |
| | medication used to bipolar disorders. (Review of the com 3/15/18, failed to ethe use of an antip Resident #97. An interview was course) #1 on 3/29/18 who develops the coare plan coordinate care plan coordinate care plan." An interview was coursely #5 3/29/18 at 3:11 p.m role in the care plan and revise the care resident is receiving should it be on the "Yes, it should be." the care plan, LPN for the patient and them." When asked #5 stated, "Yes." Wellan, LPN #5 stated doctors, and activity The administrator, of the facility were a findings on 3/29/18 | rate is an antipsychotic treat schizophrenia and 1) prehensive care plan dated, vidence a care plan to address sychotic medication for onducted with RN (registered 18 at 1:09 p.m. When asked care plan, RN #1 stated, "The tor develops and revises the onducted with LPN (licensed the care plan coordinator, on a When asked what is your ns, LPN #5 stated, "I review plans." When asked if a g an anti-psychotic medication care plan, LPN #5 stated, When asked the purpose of #5 stated, "It's the plan of care it has goals and how to obtain dif it should be accurate, LPN then asked who uses the care d, "The nursing staff, the ies." director of nursing and owner made aware of the above | | 556 | | | | |
| | following website: | n was obtained from the | | : | | ; | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | | DNSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|----------|--|--|----------------------------|--|
| | | | | | | | С | |
| | | 495142 | B. WING _ | | | 03/ | 30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 M | ET ADDRESS, CITY, STATE, ZIP CODE IILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | : | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 657 | 0. Care Plan Timing a | -bc3c-48fe-1a90-79608f78e8a nd Revision | F 656 | ÷ | F657 | | | |
| SS=E | S483.21(b) Compres \$483.21(b)(2) A compres \$483.21(b)(| chensive Care Plans in 7 days after completion of assessment. interdisciplinary team, that imited to hysician. is with responsibility for the ind and nutrition services staff. acticable, the participation of aresident's representative(s). is be included in a resident's acticipation of the resident are participation of the resident are development of the | | 1. 2. | Corrective action has been accomplisite alleged deficient practice in regard residents #66, 98, 47, 384, and 130 has reviewed and revised as applicable. A comprehensive care plan has been desfor resident #66 for a head laceration secondary to fall. Resident's #66 and had their fall care plan reviewed and resident #98's comprehensive care plan been updated to reflect his use of chectobacco. Current facility residents have the pottobacco. Current facility residents have the pottobactory and the alleged deficient properties 100% audit of care plans has been contourned and areas have been care plan care Plan Coordinator and IDT team review 10 current residents monthly for to validate the appropriate care plans been initiated for the resident. Results submitted to QAPI quarterly to ensure compliance. Measures put into place to assure allegements. | ds to s been weloped #47 have revised. an has wing ential to actice. npleted and. The will or 4 3 months have will be | | |
| i ! | disciplines as detent or as requested by the second requested and rester and rester and rester and assessments. This REQUIREMENT by: Based on observation record review, and the second review, and the second review is the second review. | nined by the resident's needs the resident. vised by the interdisciplinary essment, including both the | | 4. | deficient practice does not recur inclu Reeducation will be given to Care Pla Coordinator to ensure all areas have b planned. The Director of Nursing and/or design analyze/review for patterns/trends and the Quality Assurance committee mee quarterly for a minimum of six month evaluate the effectiveness of the plan a adjust the plan as the committee may recommend, based on outcomes/trend identified from date. Completion Date: May 11, 2018 | de: n een care nee will report in ting s to and will | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | TIPLE CONSTRUCTION ING | (X: | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | C 03/30/2 018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 03/30/2018 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIA | | |
| ·F 657 | Continued From pa | age 186 | F6 | 357 | | | |
| | of 31 residents in t 66, 98, 47, 384, 13 | he survey sample, Resident # 0. | | | | | |
| | #66's comprehens | ff failed to revise Resident ive care plan after she ceration secondary to a fall on | | : | | ! ! | |
| | | f failed to revise Resident ve care plan after a fall on | · : | : | | İ | |
| : | | failed to revise Resident #98's re plan to reflect that he chews | | | | : | |
| | | failed to revise Resident #47's re plan after a fall on 5/20/17 | | | | | |
| | | failed to revise Resident sive care plan to reflect a ained on 3/25/18. | | · · | | | |
| : | | failed to revise Resident include the resident's refusal | | | | : | |
| | The findings include | e: | | | | | |
| : | 4/19/17 and readm that included but we dementia without be failure, gout, major blood pressure and | was admitted to the facility on itted on 2/11/18 with diagnoses ere not limited to unspecified ehavioral disturbance, heart depressive disorder, high atrial fibrillation. Resident MDS (minimum data set) was gent with an ARD | | | | | |
| | | nce date) of 2/13/18. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|---|---|---|--------------------|--|--|-------|----------------------------|
| | | 495142 | B. WING | | | i | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY 380 MILLWOOD AVENU WINCHESTER, VA 2 | UE | 1 00. | 30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | IX (EACH CORREC CROSS-REFEREN | S PLAN OF CORRECTION CCTIVE ACTION SHOULD INCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 657 | impaired in the abi scoring 03 out of 1 for Mental Status) coded as requiring | page 187 coded as severely cognitively partially to make daily decisions 15 on the BIMS (Brief Interview exam. Resident #66 was greatensive assistance from one a most ADLs (activities of daily | F | 657 | | | |
| | made of Resident: | 5 p.m., an observation was #66. Resident #66 was sitting om with a bandage to the left ad. | | | | | I |
| | made of Resident and her bed was a | 2 a.m., an observation was #66. She was sleeping in bed at the lowest position. The in place to left side of her | | · · | | | |
| | | nt #66's current POS (physician evealed a daily treatment order ion. | | : | | | |
| | that she went to the following note was a.m.) resident sittin resident (sic) leaning up. staff (sic) direct started going to resident forward and forward and forward and to speak (Name of CNA) to and able to speak (Pupils Equal, Roul accommodation). | nt #66's clinical record reveled ne hospital on 2/27/18. The solution does not common area. In the solution of the following in chair in common area. In the solution of the forward to pick something cotted resident to sit back and esident. resident (continued) to rell face first onto floor. this (sic) entified nursing assistant) resident. resident (sic) alert clearly. follow (sic) instructions stions appropriately. PERRLA and, Reactive to light), and denied dizziness. resident (sic) | | | | | |
| | | n face at time of fall, residents | | | | | ļ |

| <u> </u> | 101 Orthic Diorace | L & MEDICAID SERVICES | | | Ulvid i | NO. 0938-039 I |
|--------------------------|--|--|---------------------|---|---------------------------------|----------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | IPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED |
| | | 495142 | B. WING _ | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | | | STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 657 | large (sic) laceration (sic) amounts of bloomotion) performed (sic) denied that new Tylenol (1). resider current position. sitt (sic) and kling (sic) (Name of NP (nurse above information. (Name of ED (emer (evaluation) and trees.) | o onto forehead during fall. on noted to forehead. copious ood noted. ROM (range of with minimal difficulty. resident eed for PRN (as needed) nt (sic) refusing to lay in tting (sic) up on floor. gauze wrap applied to forehead. ee practitioner)) notified of order (sic) obtained to send to ergency department)) for eval eat. resident (sic) husband and onsible party) to be contacted. |) | | | |
| | revealed that she re 2/27/18 at 11:00 a.m documented: "Residual with paramedics from a fall side of forehead me (by) 1 cm pen area. measuring 3 cms are the laceration with the re-dressed it due to bright red blood. Ne 4x4's and cling wrap | Resident #66's clinical record eturned to the facility on m. The following was ident returned via stretcher om (Name of hospital) for headshe has a laceration to left easuring 2 cm (centimeters) X Laceration with 6 sutures and another laceration under the sutures measuring 3 cms. I o dressing being saturated with ew dressing is non-adherent, ip. She has scabbed areas on | I | | | |
| : | and pointer fingerl elbow and right hip | ger, area between right thumb bruising to left wrist, shoulder, and bruise to center of chest. eek and left eye is black" | ! | | | i : : : : |
| | 10/9/17 and updated following interventio | t #66's fall care plan dated ed 2/27/18 revealed the on after her 2/27/18 fall: te for reacher (2/27/18)." | | · | | |
| : | Further review of he | er current care plan failed to | | | | : |

| STATEMEN | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X3) MIII | TIDLE C | ONSTRUCTION | · T | E SUBVEY |
|---------------|----------------------|---|-------------|---------|---|-----|----------------------|
| | OF CORRECTION | IDENTIFICATION NUMBER: | 1 ' ' | | ONSTRUCTION | | TE SURVEY MPLETED |
| | | | , Baile | | | | С |
| | | 495142 | B. WING | i | | 1 | /30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | • | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | , | |
| EVERGE | REEN HEALTH AND R | FHAR | | 380 N | MILLWOOD AVENUE | | |
| | | | | WIN | CHESTER, VA 22601 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | | COMPLETION DATE |
| | | | | | DEFICIENCY) | | |
| E 657 | i : | | : | | | | |
| F 007 | Continued From pa | _ | : F(| 657 | | | |
| | evidence her head | laceration. | | | | | İ |
| | On 3/20/18 at 3:11 | p.m., an interview was | | | | | |
| | | V (licensed practical nurse) #5, | | | | | |
| | | inator, regarding the purpose | | | | | |
| | of the care plan. LP | 'N #5 stated that the purpose | | | | | |
| | | s to plan the care of the | | | | | |
| | | goals and how the resident will | | | | | |
| | | When asked if it was are plan was accurate, LPN | | | | | |
| | | s. When asked when the care | | | | | |
| | | ited, LPN #5 stated that the | | | | | |
| | | updated for any changes in | | • | | | |
| | | new orders, any monitoring | | | | | |
| | | care plans should be updated | | | | | |
| • | | stated yes. When asked if a nead laceration, if that | | | | | |
| | | be on the care plan, LPN #5 | | | | | |
| | | LPN #5 stated that the floor | | | | | |
| | | ate the care plan that it was | | | | | |
| , | | ated the quality assurance | | | | | |
| | | puts interventions in place | | | | | • |
| | | a fall on the care plan. When ess to the care plan, LPN #5 | | | | | |
| | | (interdisciplinary team) uses | | | | | : |
| | | #5 confirmed that Resident | | | | | |
| | | on was not on the care plan. | | | | | |
| | 0.00040 | | | | | | |
| | | p.m., ASM (administrative | | : | | | |
| | | ne administrator, ASM #2, the rsing) and ASM #7, the facility | | | | | |
| | | ware of the above concerns. | | : | | | |
| : | | | | | | | |
| | | led, "Care Plan" documents in | | | | | |
| ļ | | The company's guideline is to | | | | | 1 |
| | | ary care plans are accurate | | | | | i 1 |
| : | | patient/residents current e plans are to be periodically | | · | | | · |
| | | cy and updated as needed. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | I ` ′ | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-----------------------|--|------------------------------|----------------------------|
| | | 495142 | B. WING | | 1 | C /3 0/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 2072310 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | IX5) COMPLETION DATE |
| F 657 | Continued From pa | ge 190 | F 6 | 57 | | |
| | Williams and Wilkin documented, "A write communication too members that helps careThe nursing information about the and goals. It contates achieving the goals and is used to direct revise and update there are changes in with new orders" (1) Tylenol Tablet 3: minor aches and partition was linstitutes of Health. | amentals of Nursing Lippincott as 2007 pages 65-77 atten care plan serves as a lamong health care team as ensure continuity of care plan is a vital source of the patient's problems, needs, ins detailed instructions for established for the patient of careexpect to review, the care plan regularly, when in condition, treatments, and also reduces fever. The sobtained from The National m.nih.gov/pubmedhealth/PMH | | | | |
| | T0008785/?report= 1b. The facility staff | | | | | : |
| | Review of Resident the following note d out for help and upon (sic) was sitting on wheelchair legs she she was able to mo was assisted to cha (sic) she denies hav (sic) Resident has so | #66's clinical record revealed ated 4/27/17: "Resident yelled on entering the room Resident the floor in between the e (sic) had stool all over (sic) we all extremities (sic) she had taken to the shower wing any pain or discomfort some indentations on her back is leaning against the elements of the shower wing any same the second of the shower of the second of the shower of the second of the shower of the second of the shower of the second of the shower of the second of the shower of the second of the | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | 1 | 03 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 2 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 110012010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION OATE |
| F 657 | Continued From pa | age 191 | F6 | 557 | | |
| | failed to evidence the | nt #66's fall report dated 4/27/17 the care plan was updated or on intervention was put into | | | | |
| | plan with resolved i | nt #66's comprehensive care items and revisions, failed to plan was updated after the | | : | | |
| | revealed she had a | Resident #66's clinical record a second fall on 2/8/18. Her ated after that fall and she had | | | | |
| | conducted with LPN the care plan coord of the care plan. LP of the care plan was | p.m., an interview was N (licensed practical nurse) #5, dinator, regarding the purpose PN #5 stated that the purpose as to plan the care of the goals and how the resident will | | | | |
| | obtain these goals. important that the c #5 stated that it was plan would be upda care plan would be | When asked if it was care plan was accurate, LPN is. When asked when the care ated, LPN #5 stated that the updated for any changes in | : | | | |
| : | etc. When asked if after falls, LPN #5 s the floor nurses did it was just her. LPN | new orders, any monitoring care plans should be updated stated yes. LPN #5 stated that I not update the care plan that N #5 stated that the quality | | | | |
| | in place after a residual. When asked w | pdates and puts interventions ident has a fall on the care who has access to the care d that the IDT (interdisciplinary e plan. | | | | |
| į | On 3/29/18 at 4:11 | p.m., an interview was | : | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|---|---|-------------------------|-------------------------------|----------------------------|--|
| | | | A. Buile | MVG | | | С | |
| | | 495142 | B. WING | i | | | /30/2018 | |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | , | 00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | ON SHOULD HE APPROPF | BE | (X5) COMPLETION DATE | |
| F 657 | conducted with LF nurse. When asked updating the care that she was. LPI the IDT team wou interventions to pr When asked if sh was updated after LPN #8 stated she Con 3/29/18 at 4:3 not find where the Resident #66's fai she was not responsible to May of 20 On 3/29/18 at 5:4 staff member) #1, DON (director of rowner were made 2. The facility staff | PN #8, the quality assurance ed who was responsible for plans after falls, LPN #8 stated N #8 stated after a fall, she and ld try to come up with revent the resident from falling. e could find out if the care plan Resident #66's fall on 4/27/17, e would go check. 8 p.m., LPN #8 stated she could a care plan was updated after I on 4/27/17. LPN #8 stated that possible for updating care plans | F 6 | 357 | | | | |
| | 4/21/15 with diagral limited muscle we pain, paranoid schadisease, and high #98's most recent assessment was a ARD (assessment Resident #98 was in cognitive function the BIMS (Brief exam. Resident #8 | admitted to the facility on loses that included but not akness, diabetes mellitus, chest nizophrenia, chronic kidney blood pressure. Resident MDS (minimum data set) a quarterly assessment with an a reference date) of 2/28/18. coded as moderately impaired on scoring 10 out of possible 15 finterview for Mental Status) 98 was coded as requiring ace from one staff member with lies of daily living) | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MUI A. BUILD | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|----------------------|------|--|-------------------------------|----------------------------|--|
| | | 495142 | B. WING | | | | C | |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | 1 | STRI | EET ADDRESS, CITY, STATE, ZIP CODI | | 03/30/2018 | |
| EVERGR | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE ICHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 657 | Continued From pa | age 193 | . F6 | 857 | | | | |
| | LPN (licensed prac LPN #1 and this wr room. Four chewin his bed. LPN #1 st chewing tobacco si #1 stated Resident his tobacco. | ervation was conducted with tical nurse) #1. At 9:44 a.m., iter entered Resident #98's ag tobacco cans were noted on ated Resident #98 had been nce he has been here. LPN #98 was very protective over | : | | | • | | |
| | 11/1/16 and revised care plan reflecting Resident #98's care revealed that Resid | t #98's current care plan I 2/1/18 failed to evidence a his tobacco use. Review of e plan with resolved items, lent #98 had a tobacco care ved in December of 2017. | | | | | | |
| · · · · · · · · · · · · · · · · · · · | interview was cond asked the purpose stated that the purp set fourth their direc important that the o stated that it was. V should be monitoring chewing tobacco, L monitor the residen | | | : | | | | |
| | When asked how o nurse, who has nev would know to mon | y changes in oral health. ther nurses such as a new er worked with the resident, itor Resident #98 for those use was not on the care l, "They wouldn't." | | i | | | | |
| : | conducted with LPN the care plan coord | o.m., an interview was I (licensed practical nurse) #5, inator, regarding the purpose N #5 stated that the purpose | | | | | : | |

| | | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | | | | (X3) OATE SURVEY COMPLETEO | | |
|--------------------------|--|--|--------------------|---|--|-------------------------------|--|--|
| | | 495142 | B. WING | i | | C 3/30/2018 | | |
| | PROVIOER OR SUPPLIER | ЕНАВ | , | STREET AOORESS, CITY, STAT 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | STREET AOORESS, CITY, STATE, ZIP COOE 380 MILLWOOD AVENUE | | | |
| (X4) IO PREFIX TAG | (EACH OEFICIENC) | ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION) | IO PREFI TAG | X (EACH CORRECTIVE | OF CORRECTION ACTION SHOULO BE TO THE APPROPRIATE ENCY) | (X5) COMPLETION DATE | | |
| F 657 | of the care plan wa patient, determine will obtain these go important that the care plan would be upda care plan would be treatment such as etc. On 3/29/18 at 5:05 conducted with LPN while back she was who smoked. LPN Resident #98 on the she didn't realize the chewing the tobacc anything in his char she saw the tobacc in December, but set to be saw the should he double check to see using tobacco. Whe would be in place for the sill obtain the saw the should he check to see using tobacco. | s to plan the care of the goals, and how the resident als. When asked if it was are plan was accurate, LPN s. When asked when the care ated, LPN #5 stated that the updated for any changes in new orders, any monitoring p.m., further interview as N #5. LPN #5 stated that a presented a list of residents #5 stated she did not see at list. LPN #5 also stated that at Resident #98 was still to because she did not see at about it. LPN #5 stated that to care plan had been resolved the did not reinstate it. LPN #5 have called the unit manager to be if Resident #98 was still en asked what interventions or a resident who chews atted that she would add the | F 6 | 657 | | | | |
| | on 3/29/18 at 5:47 staff member) #1, the DON (director of null owner were made at 3. The facility staff for the staff of t | p.m., ASM (administrative ne administrator, ASM #2, the rsing) and ASM #7, the facility ware of the above concerns. ailed to revise Resident #47's a plan after a fall on 5/20/17 | | ! : | | | | |
| į | Resident #47 was a | dmitted to the facility on | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|---|-----------------------|---|----------------------------|
| | | 495142 | B. WING | | | | C / 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | , <u>, , , , , , , , , , , , , , , , , , </u> | 00.2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD E APPROPF | BE | (X5) COMPLETION DATE |
| | limited to anxiety di unspecified demendisturbance, high be weakness, and maj Resident #47's mosset) assessment wat ARD (assessment in Resident #47 was dimpaired in the abilistoring 03 out of 18 for Mental Status) ecoded as requiring or more persons will daily living). Review of Resident that she had a fall of documented in a nureceiving report from CNA (certified nursistation and reported Resident #47) on the room 401 near her | ge 195 ses that included but were not sorder, Alzheimer's disease, tia without behavioral lood pressure, muscle or depressive disorder. It recent MDS (minimum data as annual assessment with an reference date) of 1/1/18. Soded as severely cognitively ty to make daily decision on the BIMS (Brief Interview exam. Resident #47 was extensive assistance from two th most ADLS (activities of #47's clinical record revealed on 5/20/17. The following was prising note: "This nurse was in day shift nurse and day shift nurse and day shift nurse and day shift nurse and the following was assistant) came to nurses if she observed (Name of the floor on her buttocks in stall dresser. Resident so No apparent injuries at this | F 6 | 557 | | | |
| | 12/1/16 with revision | #47's current care plan dated ns and resolved items failed to are plan was updated after her | | | | | |
| | | #47's incident report dated dence that an intervention fter her 5/20/17 fall. | | | | | |
| : : | revealed that she ha | esident #47's clinical record ad another fall on 6/13/17. ocumented: "Dietary manager | | : | | | |

| I AND DIAN DE CODDECTION I IDENTIFICATION NUMBER | | | (X2) MUI A. BUILD | JLTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|----------------------|---|---|-------------------------------|----------------------------|
| | | 495142 | B. WING | G | | 03 | C 8/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | IP CODE | | 100/20 10 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | FIX (EACH CORRECTIVE ACT | T <mark>ION SHO</mark> ULD THE APPROPE | BE | (X5) COMPLETION OATE |
| F 657 | floor, upon entering floor sitting on butto was doing she repli w/c (wheelchair)," n denies any pain or follows; BP (blood p (pulse) 73, R (respi 97.6, 02 (oxygen) s | e resident was observed on the g the room resident was on the ocks, when asked what she lied, "I was trying to get into my no injury, denies hitting head, discomfort, VS (vital signs) as pressure) 1327/72 (sic), P irations) 18, T (temperature) sat (saturation) 95 percent on wer of attorney) and NP (nurse | | 657 | | | |
| : | 6/13/17 failed to evi was put into place a On 3/29/18 at 3:11 conducted with LPN the care plan coord | t #47's incident report dated vidence that an intervention after her 6/13/17 fall. p.m., an interview was N (licensed practical nurse) #5, dinator, regarding the purpose | | | | | |
| | of the care plan. LF of the care plan was patient, determine gobtain these goals. important that the care plan would be upda care plan would be treatment such as netc. When asked if after falls, LPN #5 sthe floor nurses did it was just her. LPN assurance nurse up in place after a resignan. When asked was plan. When asked was patient of the care plan would be treatment such as netcomment. | PN #5 stated that the purpose is to plan the care of the goals and how the resident will. When asked if it was care plan was accurate, LPN is. When asked when the care ated, LPN #5 stated that the updated for any changes in new orders, any monitoring care plans should be updated stated yes. LPN #5 stated that it not updated the care plan that N #5 stated that the quality odates and puts interventions ident has a fall on the care who has access to the care it that the IDT (interdisciplinary | | | | | |
| | On 3/29/18 at 4:11 | p.m., an interview was | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | C | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | | C 30/2018 |
| | DER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | P CODE | | 30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | • | ON SHOULD B HE APPROPRIA | | (X5) COMPLETION DATE |
| con nurs upd that and inte Who was and che On not Res #8 s upd On staff DOI own 4. T #38/bruis Res 3/13 limit distupers diso mus MDS assedate sever | se. When asked ating the care parshe was. LPN the IDT team was the IDT team was remarked if she asked if she asked if she asked after in 6/13/17, LPN # ck. 3/29/18 at 4:38 find where the condition in the ident #47's falls at a the ident #47's falls at a the ident #47's falls at a the ident #47's falls at a the ident #47's falls at a the ident #47's falls at a the ident #384 was a the facility staff of a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the ident #384 was a the identification in the i | Age 197 N #8, the quality assurance of who was responsible for plans after falls, LPN #8 stated #8 stated that after a fall, she would try to come up with event the resident from falling could find out if the care plan Resident #47's fall on 5/20/17 8 stated that she would go p.m., LPN #8 stated she could care plan was updated after to on 5/20/17 and 6/13/17. LPN was not responsible for the administrator, ASM #2, the administrator, ASM #2, the arsing) and ASM #7, the facility aware of the above concerns. Failed to revise Resident sive care plan to reflect a plan to reflect a plan admitted to the facility on ses that included but were not addementia with behavioral and dementia with behavioral and dementia with behavioral and Alzheimer's Disease and Resident #384's most recent as each was admission and ARD (assessment reference the sident #384 was coded as impaired in the ability to make a simpaired in the ability to make a sing 03 out of possible 15 on | | 657 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION | () | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 2CODE | 00/00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD B HE APPROPRIA | | 1 |
| F 657 | exam. Resident #3 supervision only wi daily living). Review of Residen revealed the follow | erview for Mental Status) 84 was coded as requiring th most ADLs (activities of t #384's clinical record ing nursing note dated 3/24/18: | F6 | 557 | | | |
| | "Resident up walking on her shoulder. I rassessing her I fou lateral side of right hurts and she can | ng throughout unit with purse noticed she had a limp, when nd a knot with swelling on foot. She is complaining it barely walk on it. I had her sit it up for as long as she would | | | | | |
| | documented: "Resibruising to lateral sasked how this hap unable to explain dwas called and ord (three views). POA POA) was called ar Imaging was called X-ray was just obta Resident is current station with right for | d 3/24/18 at 6:32 p.m., and dent noted with swelling and ide of right foot. Resident was pened and Resident was ue to dementia. (Name of NP) er for x-ray of right foot 3V (power of attorney) (Name of nd notified. Dynamic Mobile and order placed for x-ray. ined. Awaiting results. ly sitting up at nurses (sic) of propped up and ice pack couraging Resident to sit and is possible" | | | | | |
| | following: "X-ray re: | ed 3/25/18 documented the sult stated soft-tissue swelling and otherwise negative | ! | : | | : : | |
| | | #384's care plan dated idence the bruise to her right | | | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | 03/ | /30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | D BE | IX5) COMPLETION DATE |
| F 657 | (physician order shactive order: "eleval active order: "eleval active order: "eleval or 3/29/18 at 3:11 conducted with LPN the care plan coord of the care plan coord of the care plan was patient, determine gobtain these goals. important that the care plan would be updated in would be updated are plan would be treatment such as retc. LPN #5 stated updated immediate On 3/30/18 at 10:30 Resident #384's bruste was dark purthe top of her entired On 3/30/18 at 12:15 conducted with RN on the unit where R stated that she had a few months. When a bruise to her right did. RN #2 stated the bruise because she as soon as the nurs discovered the bruis should monitor the I sensitivity, and color | t #384's current POS eet) revealed the following te right foot as tolerated." p.m., an interview was N (licensed practical nurse) #5, inator, regarding the purpose PN #5 stated that the purpose is to plan the care of the goals and how the resident will When asked if it was eare plan was accurate, LPN is. When asked when the care ited, LPN #5 stated that the updated for any changes in new orders, any monitoring the care plan would be ly following a change. D a.m., observation of uise was conducted. Her replish blue that spread across is right foot. D p.m., an interview was (registered nurse) #2, a nurse esident #384 resides. RN #2 in the been on the name of unit in the asked if Resident #384 had foot, RN #2 stated that she that she only knew about the that s | F 6 | 57 | | |
| : | | know to monitor the bruise, e plan should be in place for | | 1 | | : |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|-------------|--|-------------|----------------------------|
| | | 495142 | B. WING | | | 0 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 380 MILLWOO | ESS, CITY, STATE, ZIP C DD AVENUE ER, VA 22601 | | <u> </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | (EACI | OVIDER'S PLAN OF COP H CORRECTIVE ACTION -REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 657 | Continued From pa | ge 200 | : : F6 | 57 | ** | | |
| | the bruise. When R plan for the bruise v 3/29/18, RN #2 stat | N #2 was informed the care was not put into place until ed that a care plan should place before 3/29/18. | | | | | |
| | staff member) #1, t DON (director of nu owner were made a 5. The facility staff f #130's care plan to | p.m., ASM (administrative he administrator, ASM #2, the rsing) and ASM #7, the facility ware of the above concerns. ailed to revise Resident include the resident's refusal | | | | | |
| | 1/11/18 and readmi #130's diagnoses ir pneumonia, diabete Resident #130's mo data set), a quarterl | admitted to the facility on ted on 2/2/18. Resident included but were not limited to its and urinary tract infection. The strecent MDS (minimum of the same of 3/9/18, coded the ely intact. | ï | | | | |
| | revealed a physicial documented, "O2 (0 | #130's clinical record n's order dated 2/2/18 that Dxygen) @ (at) 2L (Liters) via may titrate as needed." | | | | | |
| | | a.m., Resident #130 was Ichair in the bedroom. The ceiving oxygen. | | | | | : |
| | | a.m., Resident #130 was chair in the dining room. The eiving oxygen. | : | i | | | |
| | conducted with ASM member) #5 (the nu | o.m., an interview was I (administrative staff rse practitioner), regarding gen therapy. ASM #5 stated | : | : | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | | CONSTRUCTION | | DATE SURVEY COMPLETED |
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| | | 495142 | B. WING | | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE ICHESTER, VA 22601 | | 03/30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 657 | | age 201 ses oxygen when she is up | F | 357 | | | : |
| | conducted with LPI regarding Resident #6 stated Resident | p.m., an interview was N (licensed practical nurse) #6, #130's oxygen therapy. LPN #130 does not like to use goes off the unit and the xygen at night. | | : | | | |
| | plan initiated on 1/1 | t #130's comprehensive care 1/18 failed to reveal arding Resident #130's refusal | | | | | |
| | conducted with LPN coordinator). LPN | p.m., an interview was N #5 (the care plan #5 confirmed a resident's care sed to include a resident's | | : | | | |
| | | pm., ASM #1 (the ASM #2 (the director of e aware of the above concern. | | · | | | : |
| , | documented, "11. T for review for all sta care delivery. Reco and updates can be | ont titled, "Care Plan" The Care Plan will be available off to consult for accuracy of commendations for changes of made by staff to the Director hee with review by the m" | | | | | |
| | No further informati Services Provided M CFR(s): 483.21(b)(3 | on was presented prior to exit. Meet Professional Standards 3)(i) | : . F6 | : 58 | | | : |
| : | §483.21(b)(3) Comp | orehensive Care Plans | | : | | | : |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | DNSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING_ | | | | C 30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 M | ET ADDRESS, CITY, STATE, ZIP CODE ILLWOOD AVENUE CHESTER, VA 22601 | <u> </u> | 30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION OATE |
| | as outlined by the omust- (i) Meet professional This REQUIREMENT by: Based on observated document review, as was determined that follow professional of 31 residents in the #83, #236, #69, and 1. The facility staff orders regarding the Synthroid as related an iron tablet, per a recommendations of medications by at lead an iron tablet, per a recommendations of medications by at lead administered the Sylater than the sched same time as the incommendation of the facility staff of #236's physician or citrate with Vitamin the dose dispensed match. 3. The facility staff of 69's oxygen flow rational oxygen saturation and 4. The facility staff of facility staf | ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to standards of practice for four he survey sample; Residents d #99. failed to clarify Resident #8's the timing of administration for d to the timing of administration for separating the two the east 4 hours. The staff ynthroid an hour and a half duled time, giving it at the fon. failed to clarify Resident der for Calcitrate (calcium D). The dose prescribed and if by the pharmacy did not failed to document Resident # te of two to five to maintain the | F 65 | 2. 3. 4. | the alleged deficient practice in regard residents #83, 236, 69, and 99. The or synthroid for # 83 was clarified by the be given 4 hours apart from iron. The Calcitrate for resident #236 was clarified the NP and the pharmacy to be given correct dosage. The order for #69 and oxygen nasal cannula was clarified by and corrected per order. Current facility residents have the potobe affected by the alleged deficient proposed for accuracy has been completed of oxygen orders have been reviewed corrected. Orders will be reviewed damorning meeting to assure continued compliance. Measures put into place to assure alledeficient practice does not recur inclust Reeducation will be given to nursing medication administration and oxygen administration per policy, with a foculor order clarification. The Director of Nursing and/or design analyze/review for patterns/trends and the Quality Assurance committee medical quarterly for a minimum of six month evaluate the effectiveness of the plan adjust the plan as the committee may recommend, based on outcomes/trendidentified from date. | ds to rder for re NP to rorder for re NP to rorder for rified by in the 199 for the NP tential to ractice. the last 30 the last 30 the last 30 the low and the follow to follow to follow to follow to follow to follow to follow and the report in the fing to and will | |
| | The findings include | i 3: | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (2 | (X3) DATE SURVEY COMPLETED | |
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| | | 405440 | | | | С |
| NAMEOF | DECLIPE OF CUENCY | 495142 | B. WING | | | 03/30/2018 |
| | PROVIDER OR SUPPLIEI REEN HEALTH AND | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD B | |
| F 658 | Continued From p | page 203 | F 6 | 58 | | į |
| | orders regarding to Synthroid as relations an iron tablet, per recommendations medications by at administered the State than the schesame time as the *According to Synthroid and the synthroid and the synthroid and antacids can absorb levothyroxidan. | for separating the two least 4 hours. The staff Synthroid an hour and a half eduled time, giving it at the iron. throid.com, DID only as ordered by your THROID as a single dose, empty stomach, one-half to one | | | | |
| | 4/11/17 with the di acute kidney failure respiratory failure chronic obstructive depression, shortr hypothyroidism, hy diabetes, dementic syndrome, sleep a peripheral vascula osteoporosis, chrobenign prostatic hy coded as cognitive life decisions. The bathing; extensive toileting, and hygie | admitted to the facility on agnoses of but not limited to e, aspiration pneumonia, with hypoxia, dysphagia, e pulmonary disease, less of breath, heart failure, perparathyroidism, insomnia, a, anxiety disorder, restless legipnea, high blood pressure, r disease, spinal stenosis, inic kidney disease, and perplasia. The resident was ely intact in ability to make daily e resident required total care for care for transfers, dressing, ene; independent for eating; and of bowel and bladder. | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | C | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF | | 03/30/2018 | |
| | | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION OATE | |
| F 658 | ### A95142 ### A95142 ### AP | ge 204 | F 65 | 8 | | | |
| | Practical Nurse) wa administering the fo Resident #83: Synthroid [1] 25 mo | s observed preparing and illowing medications to | · ! : | · : : : : : : | | | |
| | Allocution [2] 100 m Bro [3] 200-25 mcg Iron [4] 325 mg Neuron [5] 300 mg Hydrastine [6] 50 m Motorola [7] 100 mg Miramax [8] 17 gm Zoo [9] 100 mg Sportive [10] 18 mc Solace [11] 100 mg On 3/28/18 at 8:58 medications to Resi them, including adm Iron together. The Shour and a half later after the resident has | g (grams) (resident refused) g (resident refused) a.m., LP #2 took the above dent #83 and administered hinistering the Synthroid and synthroid was administered an than the scheduled time, and eaten breakfast and did not | | | | | |
| | On 3/29/18 at 9:24 a nurses should have synthroid are being together. LPN #2 si When asked why th administered at the and was given an he stated there was no On 3/29/18 at 9:50 at | a.m., LPN #2 was asked if identified the iron and administered too close tated that they should have. e Synthroid was not scheduled time of 7:30 a.m., our and a half late, LPN #2 | | | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|----------------------|--|----------|-------------------------------|----------------------------|
| | | 405440 | | | | | С |
| NAME OF | DDO//DED 00 01/00/150 | 495142 | B. WING | | | 03/ | 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD B | 3E | (X5) COMPLETION DATE |
| | absorption of synth be separated by 4 han empty stomach. recognized this irre. On 3/29/18 at 1:40 Staff Member) #5, at that Synthroid shoul hour before a reside should be given so iron. I don't remem. On 3/29/18 at 6:05 meeting, the Admin Nursing (ASM #2), #7) were made awainformation was prosurvey. Fundamentals of New Wilkins, fifth edition are expected to pramanner. Each nurse knowledgeable aboindications, contrain | cations) interfere with the roid. OSM #7 stated it should hours from iron, and taken on He stated he should have gularity. p.m., ASM (Administrative a Nurse Practitioner) stated ld be given a half-hour to an ent eats breakfast; and that "It many hours before or after ber why." p.m., at the end of day istrator (ASM) #1, Director of and the facility owner (ASM are of the findings. No further evided by the end of the lursing, Lippincott Williams & 2007. Page 557, "Nurses ctice in a safe and prudent e is responsible for being ut the medication's actions, adications, and any adverse | F | 658 | | | |
| | dosage schedules, administration, and | of appropriate dosages and routes and methods of actions to take if the client ction is also important" | | | | | |
| | Information obtained | d to treat thyroid deficiency. d from gov/druginfo/meds/a682461.h | | | | : | |
| | [2] Allopurinol is use | | | | | | |

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| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, 380 MILLWOOD AVENU WINCHESTER, VA 2 | , STATE, ZIP CODE JE | 00/00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION OATE | |
| F 658 | Continued From pa https://medlineplus tml | ge 206 gov/druginfo/meds/a682673.h | F 6 | 58 | | | |
| | pulmonary disease Information obtaine | | | | | : | |
| | meta?v%3Aproject medlineplus-bundle | | | | | · · | |
| | syndrome. Information obtaine | gia, and restless leg | | · | | | |
| | pressure. Information obtaine | sed to treat high blood d from gov/druginfo/meds/a682246.h | | | | | |
| | pressure. Information obtaine | ed to treat high blood d from gov/druginfo/meds/a682864.h | | | | | |
| : | [8] Miralax is used to Information obtained https://medlineplus. | | | | | | |

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | | C / 30/2018 |
| | PRDVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | 30/2010 |
| (X4) ID PREFIX TAG | : (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | · | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 658 | Continued From pa | ge 207 | F6 | 58 | | | |
| | [9] Zoloft is used to Information obtaine https://medlineplus. tml | treat depression. d from gov/druginfo/meds/a697048.h | | | | | |
| | pulmonary disease. Information obtained | to treat chronic obstructive d from gov/druginfo/meds/a604018.h | | | | | |
| : | [11] Colace is used Information obtained https://medlineplus.gml | | | ; | | | |
| ! | #236's physician ord citrate with Vitamin | ailed to clarify Resident der for Calcitrate (calcium D). The dose prescribed and by the pharmacy did not | | | | | |
| : | 3/19/18 with diagnost limited to: diabetes, blood pressure, low | admitted to the facility on ses that included but were not cancer of the colon, high back pain, heart attack, of bone density and structure, | | | | | |
| | There was not comp set) assessment con | leted MDS (minimum data npleted at the time of survey. | | : | | į | ı |
| | 3/19/18, documente | sion Assessment" dated d the resident was oriented to bt to time and situation. | | • | | : | |
| | | inistration observation was 8 at 8:27 a.m. with LPN | | i | | : | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | 0 | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | C 03/30/3049 | | |
| | PROVIDER OR SUPPLIER | ЕНАВ | I | STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | P CODE | 03/30/2018 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ION SHOULD B HE APPROPRIA | (X5) E COMPLETION ATE DATE | | |
| F 658 | Continued From pa | nge 208 | Fé | 658 | | | | |
| | (licensed practical Resident #236's medication card wi with Vitamin D) 315 can't give that, it do says. I won't give i LPN #4 proceeded medications excep The physician orde "Calcium citrate + (milligram); Give 1 for supplement." (Calcium. An nerve, muscle, and the citrate salt helps | nurse) #4. LPN #4 prepared edications. LPN #4 pulled a th Calcitrate (calcium citrate 5/250 tablet. LPN #4 stated, "I sesn't match what the order to until I've checked the orders." to administer all other to the Calcitrate. If dated, 3/19/18, documented, plus) Tablet 315 - 200 MG tablet by mouth in the morning falcium Citrate is the citrate element necessary for normal cardiac function, calcium as so to maintain calcium balance | | | | | | |
| | An interview was comember (OSM) #7, 2:45 p.m. OSM #7, #236's order for Ca #7 was asked if the order says and what pharmacy, OSM #7 should have clarifie | onducted with other staff the pharmacist; on 3/28/18 at was asked to review Resident lcitrate. Once reviewed, OSM re is a discrepancy in what the t is dispensed by the stated, "Yes the pharmacy d that order. There should incation between the pharmacy | | | | | | |
| | 3/28/18 at 2:50 p.m when she finds a di doctor's order and v #4 stated, "First, I d the nurse practitione and how many time pharmacy and tell thand they sent some | onducted with LPN #4 on. When asked what happens screpancy between the what the pharmacy sent, LPN on't give the medication. I tell er. I see when it was started is it was given. I call the nem the order says one thing thing else. I called the if they told me they didn't carry | | | | | | |

| | . 19 / GITTINE BIO/ III L | A WILDION OF OFTANOED | | | | OIVID IV | <u>J. 0936-039 î</u> | |
|-------------------|------------------------------------|---|----------------------|------|--|----------|-------------------------------|--|
| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | ONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | 03 | C 3/ 30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | İD | | PROVIDER'S PLAN OF CORREC | | (X5) | |
| TAG | | SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | | COMPLETION DATE | |
| F 658 | Continued From pa | ge 209 | · F 6 | 858 | | | | |
| | | only carry the 315/250 strength | , (| ,,,, | | | : | |
| | of the medication. | asked if they had called the | | | | | • | |
| | facility to get the ord | der changed to the 315/250 | | | | | | |
| | | e pharmacist told me there | : | | | | | |
| | were no records reg | garding this indicating the | | 1 | | | ÷ | |
| | pharmacy had spok | en to the facility. I then went | | | | | | |
| | | ractitioner and she changed | | | | | : | |
| | tne order to match t drawer." | what we had in the medication | | | | | : | |
| | drawer. | | | | | | | |
| : | An interview was co | enducted with OSM #8, the | | | | | : | |
| | | harmacy on 3/27/18 at 4:34 | | | | | | |
| | | bout the process followed if | | | | | | |
| | there is an order that | at doesn't match what you | | | | | | |
| | | #8 stated, "We should call | | | | | | |
| | the facility and tell th | nem that what the doctor | | | | | ı | |
| | | r stock and this is the dose we | | : | | | | |
| ; | | what happened with lcitrate, OSM #8 stated, "I | | • | | | | |
| | don't see a note on | her profile that we called the | | | | | | |
| | facility." | nor prome that we called the | | | | | | |
| | The feetlers are 10 | For a control of the second | | | | | | |
| ! | Orders" decumente | Franscribing Physician | | | | | i | |
| | | d in part, "1. Review the order leteness. If the order is not | | | | | | |
| | | ontact the physician giving | | | | | | |
| | | clarification. Discontinue the | | | | | | |
| | | rite a new order that is clear | | | | | : | |
| i | and complete 3. Ve | | | | | | | |
| | | ght Resident, b. Right Time, | | | | | | |
| ļ | c. Right Route, d. Ri | ight dose." | | | | | 1 | |
| : | The administrator, A | SM (administrative staff | | i | | | | |
| | member) #1, directo | or of nursing, ASM #2, and | | | | | | |
| i i | ASM #7, owner of th | ne facility were made aware of | | | | | I | |
| | | n 3/29/18 at 6:10 p.m. | | | | | ĺ | |
| | No further information | on woo provided arise to asit | | | | | | |
| į | TAO IOLUBEL HIBOHIIISUU | on was provided prior to exit. | | | | | . [| |

| STATEMENT AND PLAN (| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION DING | (x 3) | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|----------------------|--|--------------------------------------|-------------------------------|--|--|
| | | 495142 | B. WING | | | C 03/30/2018 | | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CITY, STATE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | , ZIP CODE | 03/30/2018 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION E OATE | | |
| | following website: https://pubchem.no ium_citrate#section stry 3. The facility staff if 69's oxygen flow ra oxygen to maintain 92% as ordered. Resident #69 was a 7/8/16 and readmitt that included but we diabetes, demential sleeping. The most recent MI quarterly assessme reference date) of 2 scoring a 15 out of interview for mental coded as needing a activities of daily livi as receiving oxygen An observation was of Resident #69. Th side of the bed with liters/minute via the resident was awake An observation was | bi.nlm.nih.gov/compound/Calca=Pharmacology-and-Biochemicalled to document Resident # te when titrating the resident's oxygen saturations above admitted to the facility on ed on 8/25/17 with diagnoses are not limited to: heart failure, hypertension and difficulty DS (minimum data set), a nt, with an ARD (assessment 1/14/18 coded the resident as 15 on the BIMS (brief status). The resident was ssistance from staff for all ng. The resident was coded | F6 | 558 | | | | |
| | in the chair next to he turned off. An observation was Resident #69. The | made on 3/29/18 7:50 a.m. of resident was sitting on the oxygen via nasal cannula at | | · : | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-------------------|---|--------------------------------|----------|------------------------------|
| | | 495142 | B. WING | 3 | | | C 3 0/ 2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 2 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ZIP CODE | <u> </u> | 30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | TION SHOULD B THE APPROPRIA | | (X5) COMPLETION DATE |
| F 658 | one and a half liters Review of the Marc documented, "O2 ((soft plastic prongs oxygen). May titrate minute)-5 LPM to n >90% every shift." Review of the Marc administration reco nasal cannula. May maintain O2 sat >9 was documented every shift. | ch 2018 physician's orders oxygen) via nasal cannula that fit in the nose to deliver e from 2LPM (liters per naintain O2 SAT (saturation) ch 2018 treatment rd (TAR) documented, O2 via vitrate from 2LPM-5LPM to 0%." The oxygen saturation very shift but the oxygen rate | F | 358 | | | |
| : | for March 2018 doo saturations but not Review of the nurse | the oxygen flow rate. e's notes documented the evel and the oxygen flow rate. | : | | | : | İ |
| | p.m. with ASM (adn the nurse practition were supposed to do oxygen to be titrated. "I don't normally wri- because we want to we can to keep ther | onducted on 3/29/18 at 1:15 ninistrative staff member) #5, er. When asked what staff to if the physician ordered the d as needed, ASM #5 stated, ite to titrate as needed b keep them at the lowest liter m comfortable. It really needs | | | | | |
| : | would write two liter saturation above 90 the 02 they need to asked if it was impo know how much oxy | to be specific for example I is to keep their oxygen b. If they are going to increase call for an order." When ortant for the practitioner to bygen a resident needed to aturation levels above 90%, | | i | | | · |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|-------------------------------|---------------|
| | | 495142 | B. WING | | | C |
| | PROVIDER OR SUPPLIER | 3 | | STREET ADDRESS, CITY, STATE, Z 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | IP CODE | 03/30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | · | TION SHOULD THE APPROPI | BE COMPLETION |
| F 658 | ASM #5 stated, "Y many liters they're An interview was on p.m. with LPN (lice #9 was asked to let the oxygen. When what oxygen flow #9 stated, "It shou LPN #9 reviewed and stated, "It shou and it's not here." resident's notes are lit's a hit and miss was important for oxygen rate was, I know what her sat asked why staff neoxygen being admitted much oxygen can nurses think it's or rate) when it's real Nursing Interventice edition, Elkin, Perri "Oxygen is a drug" | res. It's important to know how on." conducted on 3/29/18 at 2:23 ensed practical nurse) #9. LPN bok at the March 2018 TAR for asked how staff would know rate Resident #69 was on, LPN ld be in (name of software)." Resident #69's nursing notes, uld say here under the notes LPN #9 further reviewed the not stated, "There's one here. kinda thing." When asked if it staff to know what a resident's LPN #9 stated, "We need to s (saturations) are." When seeded to know the amount of inistered, LPN #9 stated, "Too be dangerous, I think some ally for them (the oxygen flow ly not." ons and Clinical Skills, 2nd y and Potter 2000, page 936, and is administered and | F | 658 | | |
| | medication." On 3/29/18 at 6:00 member) #1, (the adirector of nursing) | p.m. ASM (administrative staff administrator), ASM #2, (the) and ASM# 7, (the owner of ade aware of the findings. | | | | : |
| | 4. The facility staff | tion was provided prior to exit. failed to clarify a physician's pen as needed for Resident | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------------|--|-----------------------------------|----------------------------|
| | | 495142 | B. WING_ | | 0, | C 3/30/2018 |
| | PROVIDER OR SUPPLIEF | R | | STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 3/30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 658 | Continued From p | page 213 | F 6 | 58 | | |
| | 6/9/17 and readmi that included but w | s admitted to the facility on nitted on 2/26/18 with diagnoses were not limited to: heart failure, nia, depression and cognitive eficit. | | | | |
| | assessment, with a resident as 99 on the was not able to compare to compare the was coded as undunderstood and has memory. The resident | MDS, a significant change an ARD of 3/5/18 coded the the BIMS indicating the resident complete the exam. The resident derstanding others and being laving intact short and long ident was coded as requiring activities of daily living. | | | | |
| | documented, "O2 | rch 2018 physician's order @4L (oxygen at four liters) via needed every shift." | | | | |
| : | @4L via n/c may ti The oxygen was d | rch 2018 TAR documented, "O2 titrate as needed every shift." documented as being each shift during March. | | | | |
| | p.m. with ASM (ad the nurse practition were supposed to oxygen to be titrate "I don't normally will because we want to we can to keep the to be specific. I like would write two lite saturation above 9 | conducted on 3/29/18 at 1:15 dministrative staff member) #5, oner. When asked what staff o do if the physician ordered the ted as needed, ASM #5 stated, write to titrate as needed to keep them at the lowest liter em comfortable. It really needs to be specific for example I ers to keep their oxygen 90. If they are going to increase to call for an order." When | | | | |
| | asked if it was imp | portant for the practitioner to | | • | | ; |

| CENTE | KS FOR MEDICARE | A MEDICAID SERVICES | | | | <u> </u> | <u>, 0938-0391</u> |
|--------------------------|--|--|----------------------|---------|---|----------------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ONSTRUCTION | | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 03 | C / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | | ET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | | MILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 658 | Continued From pa | ge 214 | . F6 | ! 58 | | | |
| | know how much ox to keep their oxyge | ygen a resident was needing n saturation levels above 90%, ss. It's important to know how | | | | | |
| | p.m. with LPN (licel #9 was asked to loo oxygen. LPN #9 sta clarified." When as | onducted on 3/29/18 at 2:23 nsed practical nurse) #9. LPN ok at Resident #99's order for ated, "That needs to be ked why, LPN #9 stated, "Too be dangerous. Oxygen is a | | | | | |
| | edition, Elkin, Perry "Oxygen is a drug a | ns and Clinical Skills, 2nd and Potter 2000, page 936, and is administered and same care as any other | | | | | |
| | | p.m. ASM #1, the #2, the director of nursing and owner were made aware of | | | | | |
| | No further informati | on was provide prior to exit. | | | | | |
| | member) #1, (the a director of nursing) the facility) were ma | p.m. ASM (administrative staff dministrator), ASM #2, (the and ASM# 7, (the owner of ade aware of the findings. for Dependent Residents 2) | F 6 | 77 | | | |
| : | out activities of daily services to maintain personal and oral h | ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced | | . 1. | F677 Corrective action has been accomplied the alleged deficient practice in regarment residents #49 by assuring resident has shower on his scheduled shower day | rds to ad a | 1 |

| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLE C | CONSTRUCTION | (X3) DATE | |
|--------------------------|--|--|-------------------|----------|--|--|----------------------------|
| AND LEAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILI | DING | | COMP | LETED |
| | _ | 495142 | B. WING | ÷ | | 03/3 | |
| NAME OF | PROVIDER OR SUPPLIER | | <u> </u> | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | 03/3 | 0/2018 |
| EVERGI | REEN HEALTH AND R | REHAB | | Į. | MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE : | (X5) COMPLETION DATE |
| | facility document review, it was deterprovide activities of resident of 31 reside (Resident # 49) whextensive assistance. The facility staff fail week to Resident # The findings included Resident # 49 was a 5/10/14 and readmithat included but we depression, diabete anemia. The most recent min assessment, with an of 2/2/18 coded the 15 on the brief interindicating the resident make daily decision requiring assistance daily living. In section hygiene the resider extensive assistance bathing. On 3/29/18 at approached this with me. The resider Resident # 49 stated two weeks stating, asked if he had asked if he had asked in the stated two weeks stating, asked if he had asked in the stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating, asked if he had asked in the sident # 49 stated two weeks stating # 49 stated two w | interview, staff interview, eview and clinical record rmined the facility staff failed to daily living care for one lents in the survey sample, no was coded as requiring be from staff for bathing. ed to provide a shower for one 49. | F | 3. | be affected by the alleged deficient 100% audit was completed of show to assure all residents due a shower received one. An audit of shower received one. An audit of shower received one. An audit of shower received one. An audit of shower received one. An audit of shower received one. An audit of shower received one. An audit of shower received one assure and then 40 residents a month x 2 more assure continued compliance. Measures put into place to assure all deficient practice does not recur incompliance and give showers per facility policy accurately. The Director of Nursing and/or designallyze/review for patterns/trends at the Quality Assurance committee materially for a minimum of six mone evaluate the effectiveness of the plate adjust the plan as the committee material recommend, based on outcomes/trendentified from date. | practice. er records has ecords for 4 weeks months to leged lude: g to offer and chart gnee will nd report in eeting ths to n and will y | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILE | | CONSTRUCTION | (X3) DA | ATE SURVEY DMPLETED |
|--------------------------|--|---|----------------------|-----|--|---------|----------------------------|
| | | 495142 | B. WING | ; | | 0 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | 3 | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | 1 0. | 3/30/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 677 | Continued From pa | age 216 eel not to have a shower, | . F6 | 677 | | | |
| | Resident #49 state A review of the sho unit did not evidence | ed, "It makes me feel bad." ower sheets on the resident's ce documentation that the a shower on 3/16/18, 3/20/18, | | : | | | |
| ļ | report for March 20 | dent's documentation survey 018 did not evidence It the resident received a For 3/23/18. | | | | | ł |
| : | | se's notes did not evidence parding the resident not | | · | | | |
| : : | p.m. with LPN (licer When asked the private was not bathed, LP the next shift to do had received his batto 11:00 p.m. shift, documentation that after the staff lately | conducted on 3/29/18 at 3:15 ensed practical nurse) #9. rocess staff follow if a resident PN #9 stated they would ask it. When asked if Resident #49 ath on 3/20/18 on the 3:00 p.m. LPN #9 stated, "There is no tit was done. I've had to get to get the baths done lot of blank spaces on the | | | | | |
| | 4:30 p.m. of ASM (a #2, the director of n | de on 3/29/18 at approximately administrative staff member) nursing of evidence that the yed a bath/shower on 3/20/18 | | ï | | | |
| - | bathing documental stated there was no | p.m. a copy of the resident's ation was received. ASM #2 o documentation that the bathed on those days. | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|-----|---|--------------|-------------------------------|--|
| | | 495142 | B. WING | l | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 | REET ADDRESS, CITY, STATE, ZIP COD MILLWOOD AVENUE NCHESTER, VA 22601 | I | 03/30/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION E OATE | |
| F 677 | Continued From pa | | F | 677 | | _ | | |
| | a.m. with CNA #4, t asked how often re | onducted on 3/30/18 at 8:55 he resident's aide. When sidents were to have a shower stated, twice a week. When | | | | | : | |
| | asked what process not get a shower or | s staff followed if they could bath completed, CNA #4 e you can't get everything | | : | | | | |
| | done if there's only have three, usually the option to take the | three aides, it's very rare to have four to five. I give them leir showers. We have to have hey have to refuse to the | | | | | | |
| | When asked why R shower on 3/20/18, to his shower becau | we are not doing it (shower). esident #49 did not get a CNA #4 stated, "I couldn't get use one of the aides had to | | | | | | |
| | they'd have three to asked about 3/23/18 CNA) isn't here toda | manager know and they said in eleven (shift) do it." When so can be stated, "(Name of the she put 'NA' that means in the said in the she put 'NA' that means in the said in th | | | | | | |
| : | it." | didn't get a chance to get to | | | | | | |
| | was not available fo | for the resident on 3/23/18 r interview. | | | | | | |
| : ! ! | member) #1, the ad | o.m. ASM (administrative staff ministrator, ASM #2, the nd ASM #7, the facility owner f the findings. | | | | | : | |
| | POLICY" document | s policy titled, "BATH" od 1. Residents will be offered nowers on their assigned | | : | | | | |
| | No further information | on was provided prior to exit. | F6 | 84 | | | : | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (2) MULTIPLE CONSTRUCTION BUILDING | | | E SURVEY PLETED |
|--------------------------|--|--|---------------------|------------------------------------|---|---|----------------------------|
| · · · | | 495142 | B. WING_ | | | 1 | C 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | 1 | <u> </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | : | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| SS=D | applies to all treatm facility residents. Ba assessment of a rethat residents received accordance with propractice, the comprocare plan, and the rathes This REQUIREMENT by: Based on observated document review are determined the facility accordance with propractice, the comprocare plan, and the rathes and the rathes and the rathes for administer medication for Calcitation for Cal | care fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, staff interview, facility and clinical record review it was failty staff failed to ensure that reatment and care in rofessional standards of rehensive person-centered residents' choices, for two of survey sample, Resident's failed to follow the physician's reing the prescribed clium citrate to Resident #236. failed to weigh Resident #37 the physician. e: failed to follow the physician's | F 68 | 3. | the alleged deficient practice in regaresidents #236 and 37. For resident # nurse clarified the order for Calcium with the NP and pharmacy and obtain proper medication in the proper dose resident. For resident #37 the nursing reeducated to follow MD/NP orders weighing the resident daily as ordered. Current facility residents have the post be affected by the alleged deficient put The Unit Managers or designee will an audit of 10 residents per week for and 15 residents per month for the numonths to ensure physician's orders followed. A random sample of reside be audited quarterly thereafter for 6 the ensure continued compliance. Measures put into place to assure alledeficient practice does not recur included Reeducation given to nursing staff to MD/NP orders with a focus on medion orders and weight orders per policy. | rds to #236 the citrate ned the e for the g staff was for ed. otential to oractice. conduct 4 weeks ext 2 are being ents will months to eged ude: o follow cation gnee will d report in eeting hs to and will | |

limited to: diabetes, cancer of the colon, high

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|--|--|----------------------|-----|--|----|----------------------------|
| | | 495142 | B. WING | | | | C |
| NAME OF | PROVIDER OR SUPPLIER | 155112 | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 03 | /30/2018 |
| EVERGR | REEN HEALTH AND R | EHAB | | 31 | 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 684 | specified disorders and heart failure. There was not comset) assessment conset assessment conset. The "Nursing Admis 3/19/18, documents person and place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand place, resonand resona | r dated, 3/19/18, documented, plus) Tablet 315 - 200 MG tablet by mouth in the ment." (Calcium Citrate is the m. An element necessary for cie, and cardiac function, at each tablet by to maintain ad prevent bone loss when | F 6 | 684 | | | |
| | on 3/28/18 at 8:27 a practical nurse) #4, prescribed medicat label on the medica physician's order. The medication car 315/250 mg." Therefrom the card indicate medication had been the medication addocumented, Calcid | ministration record (MAR) um citrate + (plus) Tablet 315 - let by mouth in the morning | | | | | |
| : | documented as have nine days. | ving been administered for | | | | | : |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|----------------------|--|--------------------------------|----------------------------|--|
| | | 495142 | B. WING | | 0 | C 3/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | L | | STREET ADDRESS, CITY, STATE, ZIF | | 3/30/2010 | |
| EVERGR | REEN HEALTH AND R | EHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 684 | Continued From pa | age 220 | F6 | 84 | | | |
| | part, "Focus: The r musculoskeletal sta (a generalized term amount of bone tis | d, 3/22/18, documented in esident has an alteration in atus r/t (related to) Osteopenia of for any decrease in the sue). (2) The "Interventions" any documentation related to ments. | | | | | |
| | 3/28/18 at 2:50 p.m when she finds a d doctor's order and #4 stated, "First, I of the nurse practition and how many time pharmacy and tell thank they sent some pharmacy today and that strength, they of the medication. I facility to get the orm g strength, and they sent some pharmacy had spol back to the nurse put the order to match drawer." When as documented the accorder and the strength or the pharmacy had spol back to the nurse put the order to match drawer." When as documented the accorder and the strength or the pharmacy had spol back to the nurse put the order to match drawer." | onducted with LPN #4 on a. When asked what happens iscrepancy between the what the pharmacy sent, LPN don't give the medication. I tell her. I see when it was started as it was given. I call the chem the order says one thing ething else. I called the dot they told me they didn't carry only carry the 315/250 strength asked if they had called the der changed to the 315/250 he pharmacist told me there garding this indicating the ken to the facility. I then went oractitioner and she changed what we had in the medication ked if the other nurses who diministration of the medication physician's order, LPN #4 ere not." | | | | | |
| | documented in par medication, facility required by facility pincluding but not lin Verify each time an | Medication Administration" t, "4. Prior to administration of staff should take all measures policy and applicable law, nited to the following: 4.1.1. medication is administered that | | | | | |

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| CLIVIL | NO FOR WILDICANE | A MEDICAID SERVICES | | | | <u>OM DIME</u> | <u>. 0930-039 I</u> |
|--------------------------|--|--|---------------------------------------|-----|--|----------------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | COV | TE SURVEY MPLETED |
| | | 495142 | B. WING | · | | 1 | C / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | <u></u> | <u> </u> | ST | REET ADDRESS, CITY, STATE, ZIP CODE | - | |
| | REEN HEALTH AND R | | | 380 | 0 MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| | . | | | 771 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| F 684 | Continued From pa | | . : F(| 684 | | | |
| | | at the correct rate, at the | | | | | |
| | Edition, 2009: by Po "Medication Admini (page) 707 read: "F as the American Nu Scope and Standar apply to the activity To prevent medicat medication adminis you administer medication adminis inconsistency in admedication administed medication administed medication administed the right medication | damentals of Nursing", Seventh Perry and Potter Chapter 35 istration" Chapter 35, pg Professional standards, such urses Association's Nursing: rds of Nursing Practice (2004) of medication administration. Ition errors, follow the six rights stration consistently every time dications. Many medication d, in some way, to an althering to the six rights of stration. The six rights of stration include the following: 1. on, 2. The right dose, 3. The right route, 5. The right time, ocumentation." | | | | | |
| | | director of nursing and owner made aware of the above at 6:10 p.m. | | | | | |
| | No further informat | tion was provided prior to exit. | | | | | • |
| | following website: https://pubchem.nc | n was obtained from the cbi.nlm.nih.gov/compound/Calc n=Pharmacology-and-Biochemi | | | | | |
| | (2) Barron's Diction Non-Medical Reade Chapman, page 42 | failed to weigh Resident #37 | · · · · · · · · · · · · · · · · · · · | : | | | : |
| | | | | | | | 1 |

Resident #37 was admitted to the facility on

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| CENTE | 48 FUR MEDICARE | & MEDICAID SERVICES | | | | <u>OWR NO</u> | <u>). 0938-0391</u> |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) Mul A. Build | | E CONSTRUCTION | COV | TE SURVEY MPLETED |
| | | 495142 | B. WING | · | | | C / 3 0/ 20 1 8 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | | 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECT | ION | (VE) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | LDBE | (X5) COMPLETION OATE |
| F 684 | Continued From pa | ge 222 | F (| 684 | | | |
| | · · · · · · · · · · · · · · · · · · · | itted on 12/11/17 with | | | | | |
| | | uded but were not limited to: | | | | | |
| | heart failure, shortn | ess of breath, diabetes, stroke | | | | | |
| | and kidney disease | • | | | | | 1 |
| , | The most recent Mi | DS (minimum data set), a | | | | | ; |
| | | ent, with an ARD (assessment | | | | | • |
| | | 1/22/18 coded the resident as | : | | | | |
| | | ut of 15 on the BIMS (brief I status), indicating the | : | | | | : |
| | | r status), mulcating the tively intact to make daily | | | | | |
| | | dent was coded as requiring | | | | | · |
| | | aff for all activities of daily living | - | | | | |
| | | hich the resident could | | | | | ı |
| | | ay was prepared. In section L s documented the resident | | | | | : |
| | | ng no dental issues. | | | | | |
| | Review of the care | plan initiated on 10/31/17 and | | | | | |
| : | | documented "Focus. Resident | | | | | |
| | | fluctuation of sign (significant) | | | | | |
| : | | gain due to resident history of | | | | | |
| | | eart failure)Interventions. | | | | | |
| | gain." | d daily to monitor wt loss or | | | | | • |
| | | | | | | | |
| į | | th 2018 physician's orders | | | | | |
| | Date 2/16/2018." | weight every night shift. Start | | | | | |
| | | | | | | | |
| | Review of the Marc | | | | | | |
| | | rd (TAR) documented, "Daily shift. Start Date 2/16/2018" | | | | | • |
| | | e TAR did not evidence | | | | | |
| ! | | the weight had been obtained | | | | | |
| | on 3/4/18, 3/5/18, 3 | /12/18, 3/17/18, 3/18/18 and | | | | | |
| : | 3/24/18. | : | | | | | İ |
| | | | | | | | |

Review of the March 2018 weights and summary

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CON | NSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-------------------|-----------|---|--|--------------------------------|--|
| | | 495142 | B. WING | | | | C / 3 0/ 2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | LLWOOD AVENUE HESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | IX5) COMPLETION DATE | |
| F 684 | Continued From pa | age 223 | Fé | 684 | | | | |
| | report documented on 3/5/18, 3/12/18 were not obtained | the weight had been obtained and 3/24/18. Three weights on 3/4/18, 3/17/18, and nth of March as ordered. | | | | | | |
| | p.m. with RN (regis nurse and LPN (lic When asked if staf physician's order, It asked who docume stated, "The aides they don't put it in the Resident #37 had a "Because fluid ove She carries a lot of On 3/29/18 at 6:00 member), the adm | onducted pn 3/29/18 at 2:14 stered nurse) #4, the resident's ensed practical nurse) #9. If were expected to follow the RN #4 stated "Yes." When ented daily weights, RN #4 put it in." LPN #9 stated, "No we do." When asked why daily weights, RN #4 stated, rload is the major issue for her. If fluid and edema in her leg." p.m. ASM (administrative staff inistrator, ASM #2, the director M #3, the facility owner were findings. | | | | | | |
| | Free of Accident H CFR(s): 483.25(d) (S483.25(d)) Accident The facility must et §483.25(d)(1) The as free of accident S483.25(d)(2) Each supervision and as accidents. This REQUIREME by: Based on staff into | nts. | F (| 1. 2. | F689 Corrective action has been according the alleged deficient practice in residents #66 and 47 regarding for interventions. The resident's cordinate plan has been reviewed and interventions have been put into pertaining to falls. Current facility residents have the affected by the alleged deficition 100% of fall reports have been a beginning on Feb. 1, 2018. Fall audited daily during morning meinterventions. | regards to fall inprehensive I revised and place ne potential to ent practice. A audited reports will be | 4 | |

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUC | CTION | | E SURVEY IPLETED |
|--------------------------|---|---|-----------------------------|--|---|---|----------------------------|
| | ! | 107110 | | | | 1 | С |
| | <u> </u> | 495142 | B. WING | | | 03/ | 30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRE | ESS, CITY, STATE, ZIP CODE | | |
| EVERGE | REEN HEALTH AND RI | FHAR | 1 | 380 MILLWOO | | | |
| | | | ' | WINCHESTE | ER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EAC | ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROFILE DEFICIENCY | DBE | (X5) COMPLETION DATE |
| | free from accidents residents in the sum #47. 1. The facility staff frimplement fall preverse Resident #66 sustain 2. The facility staff frimplement fall preverse Resident #47 fell on The findings include 1. Resident #66 was 4/19/17 and readmit that included but we dementia without be failure, gout, major of blood pressure and #66's most recent Ma quarterly assessment reference Resident #66 was compaired in the ability scoring 03 out of 15 for Mental Status) ecoded as requiring experience. | led to ensure residents were sor hazards for two of 31 reey sample, Resident #66 and failed to develop and rentive interventions after ained a fall on 4/27/17. failed to develop and rentive interventions after in 5/20/17 and 6/13/17. e: Is admitted to the facility on receive interventions after in 5/20/17 and 6/13/17. e: Is admitted to the facility on receive in the facility on receive in the facility on receive in the facility on receive in the facility on receive in the facility on receive depressive disorder, high receive disorder, high received at a fibrillation. Resident received as severely cognitively received as severely cognitively received as severely cognitively received as resident #66 was extensive assistance from one | F 689 | deficie Nursin interve Coord be reed assurir 4. The D analyz the Qu quarter evalua adjust recomi | ures put into place to assure allent practice does not recur incling staff will be educated on initention following a fall. The Calinator and Quality Assurance Inducated to audit the 24 hour reing continued compliance. Director of Nursing and/or designated the effectiveness of the plantate the effectiveness of the plantate the plan as the committee may amend, based on outcomes/trends field from date. Seletion Date: May 11, 2018 | lude: itiating an are Plan Nurse will sport daily gnee will and report in setting ths to and will | |
| | i staff member with m i living). | most ADLs (activities of daily | | 1 | | : | : |
| | 3 , | | | | | : | |
| : | the following note da out for help and upo (sic) was sitting on t wheelchair legs she | #66's clinical record revealed lated 4/27/17: "Resident yelled on entering the room Resident the floor in between the e (sic) had stool all over (sic) over all extremities (sic) she | | : | | : | |

was assisted to chair and taken to the shower

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | <u>)MB NO</u> | <u>. 0938-0391</u> |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | E CONSTRUCTION | COM | E SURVEY MPLETED |
| | | 495142 | B. WING | i | | | C / 30/20 18 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 38 | 0 MILLWOOD AVENUE | | |
| EVERGE | REEN HEALTH AND R | EHAB | | | INCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | 1X | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | IX5) COMPLETION DATE |
| Г соо | | - | | 1 | | | |
| F 689 | Continued From pa | _ | F (| 689 | | | |
| | | ving any pain or discomfort | | | | | r I |
| | | some indentations on her back | | | | | |
| | | s leaning against the | | | | | |
| | | c) Resident was showered and | | | | | |
| | now resting quietly | in bed." | | | | | |
| | D. 2 | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | : |
| | | t #66's fall report dated 4/27/17 | | | | | |
| | | hat the care plan was updated | | | | | |
| | place to prevent fut | ition intervention was put into | | | | | |
| | place to prevent ful | ture rails. | : | | | | |
| | Review of Resident | t #66's comprehensive care | | | | | |
| | | tems and revisions, failed to | | | | | |
| | | are plan was updated after the | | | | | |
| | 4/27/17 fall. | are plan was apaated after the | | | | | |
| | 1,21,11 tall. | | | | | | |
| | Further review of R | esident #66's clinical record | | | · | | |
| | revealed that she h | ad a second fall on 2/8/18. | | | | | |
| | Her care plan was | updated after that fall and she | | | | | |
| | had no major injurie | | | | | | |
| | | | | | | | |
| | On 3/29/18 at 3:11 | p.m., an interview was | | | | | • |
| | | N (licensed practical nurse) #5, | : | | | | |
| | | linator, regarding the purpose | | | | | |
| | | PN #5 stated that the purpose | | | | | |
| | | s to plan the care of the | | | | | |
| | | goals and how the resident will | | | | | |
| | - | When asked if it was | | | | | |
| | | are plan was accurate, LPN | | | | | |
| | | s. When asked when the care | | | | | : |
| | | ated, LPN #5 stated that the | | | | | |
| ē | | updated for any changes in | i . | | | | |
| : | | new orders, any monitoring | | | | | ! |
| : | | care plans should be updated | | | | | İ |
| i | | stated yes. LPN #5 stated that | | : | | | |
| | | ce nurse updates and puts | | | | | |
| | | ce after a resident has a fall on | | | | | . |
| : | | n asked who has access to | : | | | | |
| | uie care pran, LPN | #5 stated that the IDT | | | | | · I |

| CENTE | NO FUR MEDICARE | & MEDICAID SERVICES | | | | <u>OMB NO. U</u> | <u> </u> |
|--------------------------|-------------------------------|--|----------------------|--------------------|--|----------------------|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | TIPLE CONSTRUCTION | J | (X3) DATE S COMPL | |
| | | 495142 | B. WING | | | 03/30 |)/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 380 MILLWOOD AV | | | |
| | | | | WINCHESTER, V | /A 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX (EACH CO | DER'S PLAN OF CORRECTI PRRECTIVE ACTION SHOUI FERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 689 | Continued From pa | age 226 | F | 689 | | | |
| | • | am) uses the care plan. | | | | i | |
| | · (, | 2, 2000 and 00 p.2 | | | | : | |
| | On 3/29/18 at 4:11 | p.m., an interview was | | | | | |
| | | N #8, the quality assurance | | | | | |
| | | d who was responsible for | : | | | | |
| | | plans after falls, LPN #8 stated | | • | | : | |
| | | #8 stated that after a fall, she vould try to come up with | | • | | : | |
| | | vent the resident from falling | | | | | |
| | | ed that if the IDT team could | | | | | |
| | . • | ny further intervention, then | | | | | |
| | | nt that the care plan was | | · | | | |
| | | stated that the date of each fall | | • | | | |
| | | ited on the care plan. When | | | | | |
| | | find out what intervention was Resident #66's fall, LPN #8 | | : | | | |
| | stated that she wou | | | | | | |
| | | 0.100/11 | | | | | |
| | On 3/29/18 at 4:38 | p.m., LPN #8 stated that she | | ; | | | |
| | | tervention that was put into | | | | | |
| | • | nt #66's fall. LPN #8 stated | | İ | | | |
| | | sponsible for determining | | | | | |
| | | pdating the care plan at that | | | | | |
| | time (May of 2017) | • | | | | | |
| | On 3/29/18 at 5:47 | p.m., ASM (administrative | | | | | |
| | | he administrator, ASM #2, the | | | | | |
| | DON (director of nu | ursing) and ASM #7, the facility | | | | | |
| | owner were made a | aware of the above concerns. | : | | | | |
| | | | : | | | : | |
| | | tled, "Falls Management | 1 | | | | |
| | | nts in part the following: "The Program is an interdisciplinary | | | | : | |
| | | Program is an interdisciplinary nt initiative. It is designed to | | | | : | |
| | | providing individualized, | | : | | | |
| | | are and improving the fall care | | | | | |
| | | mes through educational and | | | | | |
| | quality improvemen | nt tools. Procedure: When a | | | | | |
| : | fall occurs, staff wil | l conduct a careful evaluation. | | | | | |

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| CEMIE | 13 I OK MEDICAKE | & MEDICAID SERVICES | | | <u> </u> | <u>VID INO. 0936-039 [</u> | |
|--------------------------|-------------------------------|---|-------------------|----------------------------------|-----------------------|-------------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | · | | C 03/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | | |
| | | | | 380 MILLWOOD AVENUE | | | |
| EVERGR | REEN HEALTH AND R | EHAB | | | | | |
| | | | | WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | N SHOULD E APPROPR | BE COMPLÉTION | |
| | 1 : ! | | | | | į | |
| F 689 | Continued From pa | ge 227 | F | 689: | | | |
| | 2. Staff will monitor | and manage a resident's | | | | | |
| | | Assessments will done (sic) | | | | | |
| | | uarterly, annually and at | | | | į | |
| | | n. 4. A nurse will be appointed | | | | | |
| | | | | | | | |
| | | fall nurse coordinator, 5. The | | | | <u>:</u> | |
| | | tor will appoint a fall team that | | | | | |
| | | i. Specific goals and key et. 7. Comprehensive care plan | | | | | |
| | | | | | | 1 | |
| | | l assessment and MDS CAA ed by day 21 by care plan | | | | | |
| | | | | | | | |
| | | out from fall team. 8. Recurrent | | | | | |
| | a willingness to try | ustments to the care plan and | | | | | |
| : | interventions." | both flew and old | | ! | | | |
| | 2. The facility staff t | failed to develop and | | | | | |
| | | entive interventions after | : | • | | | |
| | | n 5/20/17 and 6/13/17. | : | • | | | |
| | Resident #47 was a | admitted to the facility on | | | | | |
| | | ses that included but were not | | | | | |
| | | sorder, Alzheimer's disease, | | | | • | |
| ; | | tia without behavioral | | | | | |
| | | lood pressure, muscle | | | | | |
| i · | | or depressive disorder. | | | | | |
| | | st recent MDS (minimum data | | | | | |
| | | as annual assessment with an | | | | | |
| | | reference date) of 1/1/18. | - | | | | |
| | | coded as severely cognitively | : | | | | |
| | | ity to make daily decisions | | | | | |
| | | on the BIMS (Brief Interview | | | | | |
| | | exam. Resident #47 was | | | | : | |
| | | extensive assistance from two | | | | | |
| | | th most ADLS (activities of | | | | | |
| ; | daily living). | an most ADEO (activities of | | | | : | |
| İ | adily living j. | | | | | ; | |
| | Review of Resident | #47's clinical record revealed | | ; | | : | |

that she had a fall on 5/20/17. The following was

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|---|---|----------------------|--------|---|------------------------------|----------------------------|--|
| | | 495142 | B. WING | | | T . | /30/2018 | |
| NAME OF | PROVIDER OR SUPPLIE | :R | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGR | REEN HEALTH AND | REHAB | | | MILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | DBE | (X5) COMPLETION OATE | |
| F 689 | Continued From | nage 228 | F | 889 | | | : ! | |
| . 555 | } | nursing note: "This nurse was | | | | | | |
| | | from day shift nurse and day shift | • | | | | ! | |
| | | irsing assistant) came to nurses | | 1 | | | 1 | |
| | | ted she observed (Name of | | ! | | | | |
| | | the floor on her buttocks in | | 1 | | | İ | |
| | | er tall dresser. Resident | : | | | | | |
| | | ries. No apparent injuries at this | | ٠ | | | | |
| | time" | | | | | | | |
| | 12/1/16 with revi | ent #47's current care plan dated sions and resolved items failed to e care plan was updated after her | | i : | | | | |
| | 5/20/17 failed to | ent #47's incident report dated evidence that an intervention the after her 5/20/17 fall. | | : | | | | |
| | revealed that she The following wa informed this nu floor, upon enter floor sitting on be | f Resident #47's clinical record e had another fall on 6/13/17. as documented: "Dietary managerse resident was observed on the ring the room resident was on the uttocks, when asked what she eplied, "I was trying to get into my | | | | | | |
| | | ," no injury, denies hitting head, | | | | | | |
| | denies any pain | or discomfort, VS (vital signs) as | | | | | | |
| | | od pressure) 1327/72 (sic), P | | | | | | |
| | | spirations) 18, T (temperature) | | | | | | |
| | 97.6, 02 (oxyger | n) sat (saturation) 95 percent on cower of attorney) and NP (nurse | | | | | | |
| | practitioner) noti | fied" | | | | | į | |
| | practitioner) not | nea. | : | | | | | |
| | 6/13/17 failed to | ent #47's incident report dated evidence that an intervention ce after her 6/13/17 fall. | ! | : | | | | |
| | On 3/29/18 at 3: | 11 p.m., an interview was | | | | | | |
| | | PN (licensed practical nurse) #5 | | | | | | |

Facility ID: VA0218

PRINTED: 04/13/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 495142 R WING 03/30/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 689 F 689 Continued From page 229 the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. LPN #5 stated that the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan. On 3/29/18 at 4:11 p.m., an interview was

On 3/29/18 at 4:11 p.m., an interview was conducted with LPN #8, the quality assurance nurse. When asked who was responsible for updating the care plans after falls, LPN #8 stated that she was. LPN #8 stated that after a fall, she and the IDT team would try to come up with interventions to prevent the resident from falling again. LPN #8 stated that if the IDT team could not come up with any further intervention, then she would document that the care plan was reviewed. LPN #8 stated that the date of each fall should still be updated on the care plan. When asked if she could find out what interventions were put into place after Resident #47's falls, LPN #8 stated that she would check.

On 3/29/18 at 4:38 p.m., LPN #8 stated that she could not find interventions that were put into place after Resident #47's falls. LPN #8 stated that she was not responsible for determining interventions and updating the care plan at that

Facility ID: VA0218

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | l | C 30/2018 |
| | PROVIDER OR SUPPLIER | 1 | | 380 M)1 | T ADDRESS, CITY, STATE, ZIP CODE LLWOOD AVENUE HESTER, VA 22601 | | 50/2010 |
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| F 690 | staff member) #1, t DON (director of null owner were made a | e 2017). p.m., ASM (administrative the administrator, ASM #2, the ursing) and ASM #7, the facility aware of the above concerns. ontinence, Catheter, UTI | F 689 | | F690 Corrective action has been accomplish | hed for | |
| | resident who is con admission receives maintain continence condition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is or becondition is assessed to remain prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the expension of the prevent uninary traccontinence to the pre | facility must ensure that intinent of bladder and bowel on a services and assistance to be unless his or her clinical omes such that continence is intain. It resident with urinary and on the resident's sessment, the facility must be enters the facility without an is not catheterized unless the condition demonstrates that is necessary; enters the facility with an it or subsequently receives one moval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder the treatment and services to continections and to restore extent possible. It is resident with fecal in the catheter and services to contine the catheter and services to contine the catheter and the c | | 3. | the alleged deficient practice in regard resident #132's catheter bag was not a the floor. The nurse immediately char position of the tubing and bag to keep tubing and bag from touching the floor. Current facility residents have the pot be affected by the alleged deficient proceeding and the audit of residents with catheters completed by the unit manager to associate the bag or tubing was touching the Rounds will be made daily by unit madesignee noting the catheter bag and the and report findings daily in morning in Measures put into place to assure allegedeficient practice does not recur include Nursing staff will be reeducated on proplacement of catheter and tubing so it touching the floor. Nursing staff will a reeducated in regards to infection conticuon concerning catheters. The Director of Nursing and/or design analyze/review for patterns/trends and the Quality Assurance committee mee quarterly for a minimum of six months evaluate the effectiveness of the plan a adjust the plan as the committee may recommend, based on outcomes/trends identified from date. Completion Date: May 11, 2018 | ds to kept off nged the o the or. tential to actice. A s was ure no ne floor. unager or ubing neeting. ged de: oper is not also be trol l report in ting s to and will | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF | DECAMPED OF SUPERIOR | 495142 | B. WING | | | 03, | /30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION] | ID PREF TAG | | SHOULD | BE | (X5) COMPLETION OATE | |
| F 690 | ensure that a resid receives appropriar restore as much no possible. This REQUIREME by: Based on observated document review a was determined the provide services for of 31 residents in the services of 31 residents in the findings included and the services of 31 residents in the servi | sessment, the facility must ent who is incontinent of bowel the treatment and services to ormal bowel function as NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to an indwelling catheter for one the survey sample, Resident the facility staff failed to the survey sample, Resident the facility on ted on 3/8/18. Resident the facility | F | 690 | | | | |
| : | | re plan initiated on 3/8/18 | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | JLTIPLE CONSTRUCTION DING | | | E SURVEY MPLETED |
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| | | 495142 | B. WING | | | | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | <u> </u> | 30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | FIX (EACH CORRECTIVE ACTION S | SHOULD | BE | (X5) COMPLETION DATE |
| | observed lying in a catheter bag was of fall mat lying on the On 3/29/18 at 3:47 conducted with LPN LPN #4 was asked be place when a restated the catheter resident, should not in a privacy bag. At to observed Resider #4 and this surveyor room. The resident the catheter bag war #4 stated Resident LPN #4 moved Resident LPN #4 moved Resident LPN #4 moved Resident LPN #4 moved Resident LPN #4 moved Resident the other side of the where it was not too On 3/29/18 at 5:48 staff member) #1 (to the director of nurse above concern. | a.m., Resident #132 was low bed. The resident's observed on the floor and on a e floor. p.m., an interview was N (licensed practical nurse) #4. If where a catheter bag should esident is lying in bed. LPN #4 ob bag should be below the obt touch the floor and should be at this time, LPN #4 was asked ent #132's catheter bag. LPN for entered Resident #132's not remained in a low bed and as observed on the floor. LPN if #132's bed had to remain low. If #132's catheter bag to be bed and positioned the bag suching the floor. p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the ent titled, "Indwelling Catheter I, "PURPOSE: To prevent ain drainage bag below bladder | | 690 | | | |
| | Ū | tion was presented prior to exit. | | | | | |
| : | bladder. 'Indwelling This catheter drains | ndwelling catheter (tube) in your g' means inside your body. s urine from your bladder into body." This information was | | | | | ! |

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | (| <u> </u> | <u>0391</u> | |
|--------------------------|--|--|--------------------|----------|--|--|-------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | · | 495142 | B. WING | | | C 03/30/201 | 18 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGE | REEN HEALTH AND R | EHAB | | | MILLWOOD AVENUE CHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE COMPL | ETION | |
| F 690 | Continued From pa | ge 233 | Fε | : :90 | | : | | |
| | obtained from the v | _ | | | | i : : | | |
| | Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care The facility must enneeds respiratory care and tracheal scare, consistent with practice, the compressed and 483.65 of this stand 483.65 of thi | and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ion, staff interview, facility and clinical record review, it e facility staff failed to provide d services for ten of 31 vey sample, Resident #37, 1, #235, #133, #130, #3 and ailed to change the oxygen | F 6 | | F695 Corrective action has been accomplishe alleged deficient practice in regaresident #37, 95, and 99 oxygen hum was not changed per policy. The oxy humidifier was changed immediately nurse. Regarding resident #69, 234, documentation was not provided for rate or saturation. The nurse correct oxygen concentrator to deliver the cafter clarifying order with the NP, the documented the saturation of the researching resident #133 and 130, 3, orders were clarified and O2 concentrator were set at flow rate per NP's order. Current facility residents have the per beaffected by the alleged deficient 100% audit of residents ordered oxycompleted by the unit manager to as components of oxygen therapy was per policy. The unit manager or desaudit oxygen humidifiers and tubing weeks then weekly for 2 more montreport their findings to the DON or | rds to hidifier rigen r by the 235 oxygen rd the orrect liters en hident and 87, all trators otential to oractice. A gen was sure all within date hignee will daily for 4 hs and | | |
| | the comprehensive 2. The facility staff f humidifier as ordere Resident #95. 3. The facility staff f oxygen humidifier a Resident #99. | ed by the physician and per care plan for Resident #37. ailed to change the oxygen ed by the physician for ailed to change and label the s ordered by the physician for ailed to document Resident | | 3 | assure continued compliance. 100% oxygen orders will be completed by Quality Assurance nurse and orders checked for accuracy daily in mome for 3 months. Measures put into place to assure al deficient practice does not recur inc Nursing staff will be reeducated on humidifiers and tubing per policy, f infection control. Reeducation will order clarification and documentation including following existing MD/N | audit of the will be ng meeting eged lude: changing ocusing on oe given on | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMEN | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPL | E CO | INSTRUCTION | (X3) DATE SURVEY |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILC | | | | COMPLETED |
| | | 495142 | B. WING | : | | | С |
| NAME OF | PROVIDER OR SUPPLIER | 793 142 | D. W114G | | | T4000000 000000000000000000000000000000 | 03/30/2018 |
| TWANTE OF | I NO VIDEN ON SOFFLIER | | | | | T ADDRESS, CITY, STATE, ZIP CODE | |
| EVERGE | REEN HEALTH AND R | EHAB | | | | | |
| (X4) ID | SUMMARYSTA | TEMENT OF DEFICIENCIES | . 15 | • | | CHESTER, VA 22601 | ••• |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE COMPLETION |
| F 695 | Continued From no | .co 224 | | | 4 | The Director of Nursing and/or desig | maa will |
| 1 030 | | - | F 6 | 95 | 7. | analyze/review for patterns/trends an | |
| | #69's oxygen rate v | vith the oxygen saturations. | | | | the Quality Assurance committee me | |
| | 5. The facility staff f | ailed to provide oxygen | | | | quarterly for a minimum of six month | |
| | | o professional standards of | | | | evaluate the effectiveness of the plan | |
| | practice for Resider | | | | | adjust the plan as the committee may recommend, based on outcomes/trend | |
| | | | | | | identified from date. | 13 |
| | therapy according to | ailed to provide oxygen o professional standards of | | | 5. | Completion Date: May 11, 2018 | |
| | practice for Resider | o professional standards of ht #235. | | | | | |
| | 7. The facility staff f orders for Resident | ailed to clarify physician's #133's oxygen. | | | | | |
| : | 8. The facility staff f orders for Resident | ailed to clarify physician's #130's oxygen. | | | | | |
| | oxygen orders were | failed to ensure Resident #3's written and followed in ofessional standards for the for oxygen therapy. | | | | | i |
| : | #87's oxygen orders | f failed to ensure Resident swere written and followed in ofessional standards for the of oxygen therapy. | | : | | | ± |
| : | The findings include | : : | | : | | | |
| i | 1/17/17 and readmit diagnoses that inclu | s admitted to the facility on tted on 12/11/17 with ded but were not limited to: ess of breath, diabetes, stroke | | | | | : |
| | quarterly assessment reference date) of 1/ | OS (minimum data set), a nt, with an ARD (assessment //22/18 coded the resident as to f 15 on the BIMS (brief | | | | | |

mental status), indicating the resident was

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) Mul A. Buile | TIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED | |
|--|--|--|----------------------|--|-------------------------------|----------------------------|
| | | 4 95142 | B. WING | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 1 03/ | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | BE . | (X5) COMPLETION DATE |
| ************************************** | resident was coded staff for all activities eating which the restray was prepared. receiving oxygen. An observation was p.m., of Resident #3 in the wheelchair neat two liters per min bottle was connected and was dated 3/19. An observation was of Resident #37. The wheelchair next to the two liters per minute was connected to the dated 3/19. Review of the residinitiated on, 11/4/17 resident has COPD pulmonary disease) oxygen equipment pulmonary disease) oxy | make daily decisions. The as requiring assistance from sof daily living except for sident could perform after the The resident was coded as a made on 3/27/18 at 2:50 at the resident was sitting up ext to the bed with oxygen on a made on 3/28/18 at 8:10 a.m. are resident was sitting in the he bed with the oxygen concentrator and as a made on 3/28/18 at 8:10 a.m. are resident was sitting in the he bed with the oxygen on at a made on a | F | 395 | | |
| | administration recording a sun 11-7 every nigh | rd (TAR) documented, and bottle and clean filter q t shift every Sun." It was e tubing and water bottle had | | | | |

been changed on 3/25/18.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | <u>RS FOR MEDICARE</u> | <u> & MEDICAID SERVICES</u> | _ | | OMB NC | <u>). 0938-0391 </u> |
|--------------------------|----------------------------------|---|--------------------|-------------------------------------|----------|---|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
| | | 495142 | B. WING | | 03 | C / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | |
| | · | | | 380 MILLWOOD AVENUE | | |
| EVERGR | REEN HEALTH AND R | ЕНАВ | | WINCHESTER, VA 22601 | | |
| (V.0.1D | STIMMADV STA | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORE | PECTION | 045 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | (X5) COMPLETION DATE |
| F 695 | Continued From pa | nge 236 | F6 | 95 | | |
| | • | | , | | | |
| | | onducted on 3/29/18 at 3:35 | : | | | • |
| | | nsed practical nurse) #6. | | | | • |
| | | often the oxygen tubing and anged, LPN #6 stated, "It | | | | |
| | | every Sunday, along with the | | | | |
| | | gen bottle." When asked to | | | | |
| | | 77's oxygen humidifier, LPN #6 | | | | |
| | | it didn't get done. I will pull up | • | | | : |
| | | definitely didn't get done." | : | | | |
| | The night nurse wa | s not available for interview. | | | | : |
| | member) #1, the ad | p.m. ASM (administrative staff dministrator, ASM #2, the and ASM #7, the facility owner of the findings. | : | | | : |
| | | ty's policy titled, "POLICY YGEN AND NEBULIZER | - | | | |
| | | ented, "Standard: To provide | | | | |
| : | | n adequate supply of oxygen | | | | |
| | via nasal cannula o | r mask to maintain oxygen | | | | |
| | | an optimum level. To provide | | | | |
| | | n adequate supply of aerosol | | | | ŀ |
| : | | er via mask or hand held | | | | |
| | | CY: All nursing/therapy staff is | | | | |
| : | | ntaining an adequate supply of lent requiring such or | | | | • |
| | , - | late amount of aerosol | | | | |
| | | er. PROCEDURE: 1. The night | • | | | : |
| | | nsible for cleaning oxygen | | | | : |
| i | • | en filters and nebulizer | | | | |
| | | ay. 2. The night nurse will be | | | | • |
| | | nging the water bottle and | | | | |
| : | | ell as the nebulizer tubing, | 1 | | | |
| | | ce weekly on Sunday. 3 All | | ± | | ĺ |
| į | water hottles, tubing | masks and mouthnieces will | | i | | |

be dated."

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILC | TIPLE CONST | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------|----------|--|------|----------------------------|
| | | 495142 | B. WING | | | | C / 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | 1 03 | 130/2010 |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | | WOOD AVENUE ESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE | (X5) COMPLETION OATE |
| F 695 | Continued From pa | ge 237 | F | 895 | | | |
| | No further informati | on was provided prior to exit. | | | | | |
| | | ailed to change the oxygen ed by the physician for | | | | | |
| | 2/17/16 and readmithat included but we | admitted to the facility on itted on 3/3/18 with diagnoses ere not limited to: intestinal tenia, heart failure and | | : | | | |
| | set), a quarterly ass (assessment refere the resident as have BIMS (brief mental was cognitively inta The resident was co | implete MDS (minimum data sessment, with an ARD ence date) of 2/23/18 coded ing scored 15 out of 15 on the status), indicating the resident of to make daily decisions. Ended as requiring supervision viving. The resident was oxygen. | | | | | |
| | 2018 documented, | cian's orders dated March "Change mask and water or q(every) Sunday night. Start | | | | | |
| : | | plan did not evidence ted to changing the oxygen ed by the physician. | | | | | |
| | of Resident #95. The with the oxygen ma The oxygen was se | s made on 3/27/18 at 2:55 p.m. he resident was lying in bed sk hanging over the side rail. t at three liters per minute via rator. The humidifier bottle | | · | | | : |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUI A. BUILE | ILTIPLE CONSTRUCTION DING | (| (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|----------------------|--|----------|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | | C 30/2018 |
| | PROVIDER OR SUPPLIER | | D. | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DDE I | Uar | 30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | (EACH CORRECTIVE ACTION S | SHOULD E | BE | (X5) COMPLETION DATE |
| | of Resident #95. The bed with eyes closed the resident. The or per minute via the conduction humidifier bottle was of Resident #95. The with eyes closed. To over the side rail. The labeled, "3/19/18." An interview was concern, with LPN (licent When asked how on humidifier were chast hould be at least establing and the oxygowhich apparently should be at Resident #6 stated, "Apparently should have apparently should be at Resident #6 stated, "Apparently should have apparently sho | s made on 3/28/18 at 8:05 a.m. he resident was lying in the ed, the oxygen mask was on oxygen was set at three liters oxygen concentrator. The | | 695 | | | |
| : | director of nursing a were made aware of An observation was of Resident #95. The with eyes closed. To over the side rail. To labeled, "3/19/19." | and ASM #7, the facility owner | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------|---|-------------|-------------------------------|--|
| | | 495142 | B. WING | | 0. | C 3/30/2018 | |
| | PROVIDER OR SUPPLIE | R | | STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 3/30/2016 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | _ ` | I SHOULD BE | (X5) COMPLETION DATE | |
| F 695 | Continued From p | page 239 | F 6 | 695 | | | |
| | humidifier as nee humidifier as order Resident #99. Resident #99 was 6/9/17 and readment that included but pneumonia, anen communication do The most recent significant change (assessment referesident as 99 on indicating the resident as 10 or indicating the resident as 10 or indicating of the exam. The resunderstanding of thaving intact shor resident was code | MDS (minimum data set), a e assessment, with an ARD rence date) of 3/5/18 coded the the BIMS (brief mental status), dent was not able to complete sident was coded as ners and being understood and t and long term memory. The ed as requiring assistance for all iving. The resident was coded | | | | | |
| | 3/27/18 at 2:35 p. with eyes closed. resident's nose at liters per minute water bottle was and was empty. T dated. An observation was 3/28/18 at 8:13 a. in bed eating brea | as made of Resident #99 on m. The resident was lying in bed A nasal cannula was in the nd the oxygen was on at four via the oxygen concentrator. A connected to the concentrator he bottle or tubing were not as made of Resident #99 on m. The resident was sitting up akfast. The oxygen was on the cannula via the oxygen | | | | | |
| i | | h was set at four liters/minute. | | | | ı | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | 03 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 130/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE |
| F 695 | 3/29/18 at 8:30 a.m in bed. The oxygen cannula at four liter concentrator. Review of the Marc documented, "char and clean filter eve | is made of Resident #99 on in. The resident was sitting up in was on the resident via nasal irs/minute via the oxygen in 2018 physician orders inge oxygen tubing water bottle ery Sunday on night shift." | F | 695 | | |
| | "change oxygen tulfilter every Sunday documented that the changed on 3/25/13. An interview was cop.m. with LPN #9. Noxygen water bottle." So it needs to be owned to be of the component of the | conducted on 3/29/28 at 3:15 When asked how often the e was changed, LPN #9 stated, changed every Sunday night. o his bubbler being empty and | | | | |
| | hospice gives it to utake care of it." Who bottle was checked they went into the rwater bottle was chated, "They are to case there's any bacould be empty." W | us but we are still supposed to nen asked when the water d, LPN #9 stated whenever room. When asked why the nanged every week, LPN #9 to be changed out weekly in acteria buildup and the bubbler when asked if the water bottle PN #9 stated it was. | | | | |
| | On 3/29/18 at 6:00 member) # 1 , the ac | p.m. ASM (administrative staff dministrator, ASM #2, the and ASM #7, the facility owner of the findings. | : : | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION | | ATE SURVEY DMPLETED |
|--|---|---|---------------------|--|------|----------------------------|
| | | 495142 | B. WING | | 0. | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 3/30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY) | LDBE | IX5) COMPLETION OATE |
| F 695 | Continued From pa | ge 241 | F 69 | 95 | | - |
| | No further informat | ion was provided prior to exit. | | | | |
| | | failed to document Resident with the oxygen saturations. | | | | |
| | 7/8/16 and readmit that included but we | admitted to the facility on ted on 8/25/17 with diagnoses ere not limited to: heart failure, , hypertension and difficulty | | | | |
| ; ; ; | quarterly assessment reference date) of 2 a 15 out of 15 on the The resident was confrom staff for all actions. | DS (minimum data set), a ent, with an ARD (assessment 2/14/18 coded the resident as the BIMS (brief mental status), coded as needing assistance divities of daily living. The las receiving oxygen. | | | | |
| | of Resident #69. The side of the bed with three liters/minute via | s made on 3/27/18 at 2:46 p.m. ne resident was sitting on the oxygen via nasal cannula at via the oxygen concentrator. Yed the oxygen and walked to | | | | |
| | of Resident #69. The side of the bed with liters/minute via the | made on 3/28/18 at 8:05 a.m. ne resident was sitting on the oxygen via nasal cannula at 5 oxygen concentrator. The e and alert and conversant. | | | | |
| | p.m. of Resident #6 | made on 3/28/18 at 4:20 9. The resident was sitting up her bed and the oxygen was | | | | |
| : | An observation was | made on 3/29/18 7:50 a.m. of | | • | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE | | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | 03 | C 8/ 30/2018 |
| | PROVIDER OR SUPPLIE | R | STI | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | 130/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | side of the bed wi one and a half lite Review of the Mardocumented, "O2 (soft plastic prong oxygen). May titra minute)-5 LPM to >90% every shift." Review of the Mardoministration reconsal cannula. Mardocumented was documented was not documen | the resident was sitting on the th oxygen via nasal cannula at the oxygen concentrator. The 2018 physician's orders (oxygen) via nasal cannual as that fit in the nose to deliver the from 2LPM (liters per maintain O2 SAT (saturation). The 2018 treatment cord (TAR) documented, O2 via any titrate from 2LPM-5LPM to 90%." The oxygen saturation every shift but the oxygen rate thed. The oxygen saturation every shift but the oxygen rate that oxygen flow rate. The oxygen flow rate. | F 695 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION DING | (× | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | 00,00,20,10 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD BE | |
| | to keep their oxyge ASM #5 stated, "Ye many liters they're An interview was cop.m. with LPN (lice #9 was asked to lothe oxygen. When what oxygen rate they're what oxygen rate they're with stated, "It should be #9 reviewed Resident's notes an It's a hit and miss was important for soxygen rate was, Leknow what her sate asked why staff neoxygen being admit much oxygen can be nurses think it's on rate) when it's reall On 3/29/18 at 6:00 ASM# 7 were made 5. The facility staff therapy according the practice for Reside Resident #234 was 3/13/18 with diagnolimited to: fracture chronic obstructive (COPD - a general | exygen a resident was needing en saturation levels above 90%, es. It's important to know how on." conducted on 3/29/18 at 2:23 ensed practical nurse) #9. LPN obk at the March 2018 TAR for asked how would staff know he resident was on, LPN #9 ein (name of software)." LPN ent #69's nurse's notes and ay here under the notes and #9 further reviewed the end stated, "There's one here. kinda thing." When asked if it staff to know what a resident's LPN #9 stated, "We need to so (saturations) are." When seded to know the amount of inistered, LPN #9 stated, "Too be dangerous, I think some aly for them (the oxygen flow by not." 1. p.m. ASM #1, ASM #2 and the aware of the findings. failed to provide oxygen to professional standards of ent #234. 3. admitted to the facility on oses that included but were not of her left femur, pain and a pulmonary disease (COPD) | F | 695 | | |
| | _ | physema and chronic | | | | : |

| OLITIC | 10 I OIT MEDIOAITE | A MILDIOAID OLIVIOLO | | | OND NO. 0330-0391 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | LTIPLE CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | 3 | C 03/30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | TION SHOULD BE COMPLETION THE APPROPRIATE DATE |
| F 695 | Continued From pa | age 244 | F(| 695 | |
| | assessment, an ad assessment referer resident as scoring interview for mental was capable of ma The resident was capable of one cassistance of one cassistance of one comost of her activitie in which she was cascition O - Special Programs, it was directived oxygen the period. The physician orde "O2 (oxygen) - 2 L | DS (minimum data set) mission assessment, with an nee date of 3/20/18, coded the a 14 on the BIMS (brief all status) score, indicating she king daily cognitive decisions. Toded as requiring extensive or more staff members for es of daily living except eating oded as independent. In I Treatments, Procedures and ocumented the resident erapy during the look back or dated, 3/13/18, documented, (liters) - NC (nasal cannula - a gs that insert into the nose) very shift." | | | |
| | March 2018 documneeded every shift. documented as add 3/13/18. Each documented in "2" documented in Observation was m 3/27/18 at 2:47 p.m 2.5 L/min (liters per observed on 3/28/1 | ministered each shift since umented shift had the rate of the box for liter rate. nade of Resident #234 on in the oxygen was in use at minute). The resident was 8 at 8:15 a.m. in bed with her | | | |
| | was observed on 3 oxygen was set at oxygen was set at oxygen at 9:22 nurse) #2 went to F | at 1.5 L/min. Resident #234 /29/18 at 8:25 a.m. The 1.5 L/min. and was in use. a.m., LPN (licensed practical Resident #234's room. LPN #2 the oxygen administration rate. | : | | |

| STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) OATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | | C 3/30/2018 |
| | PROVIOER OR SUPPLIER | J | | STR 380 | EET AOORESS, CITY, STATE, ZIP COOE MILLWOOD AVENUE NCHESTER, VA 22601 | | 0/30/2018 |
| (X4) IO PREFIX TAG | (EACH DEFICIENC | ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 695 | When asked how on oxygen level, LPN when I give them the has the correct rate at the beginning of one reads the rate concentrator, LPN in the center of the The comprehensive documented in part COPD." The "Interdocumentation related An interview was a staff member (ASN 3/29/18 at approximate about the order 'Matter of oxygen." We oxygen a medication ASM #5 was asked rate of oxygen is applied to the nurse's staff is in the nurse's staff. | oxygen was set at 1.5 L/min. often a nurse is to check the #2 stated, "I usually check it neir medications. Since no one e, I guess it should be checked the shift." When asked how of oxygen delivery on the #2 stated, "The line should be ball." e care plan dated, 3/15/18, t, "Focus: The resident has ventions" failed to evidence ated to the use of oxygen. onducted with administrative // #5, the nurse practitioner, on mately 1:20 p.m. When asked ay titrate O2 as needed,' ASM to keep them on the lowest // hen asked if she considers on, ASM #5 responded, "Yes." If how the nurse's know what oppopriate for a resident and if scope of practice to adjust the ASM #5 stated, "No, they | | 695 | | | |
| | edition, Elkin, Perry "Oxygen is a drug a | ns and Clinical Skills, 2nd and Potter 2000, page 936, and is administered and same care as any other | | | | | |
| | | director of nursing and owner made aware of the above at 6:10 p.m. | | | | | |
| : | No further informat | ion was provided prior to exit. | | | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION ING | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING_ | | 05 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 1130/20 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 695 | Continued From pa | age 246 | F 69 | 95 | | |
| ļ | | failed to provide oxygen to professional standards of ent #235. | | | | : |
| | 3/22/18 with diagnoral limited to: fracture of (a slowly progressive characterized by restooped posture, rodrooling, and musc chronic obstructive (COPD - a general non-reversible lung | s admitted to the facility on oses that included but were not of her leg, Parkinson's disease ive neurological disorder esting tremor, shuffling gait, olling motions of the fingers, cle weakness) (1), falls, and e pulmonary disease (COPD) Item for chronic, g disease that is usually a physema and chronic | | | | · : |
| | | pleted MDS (minimum data ompleted at the time of survey. | | | | |
| | | ission Assessment" dated, ed the resident was alert and lace and person. | | | | |
| | p.m., with oxygen in with two prongs that nostrils) at 2 L/min resident was observed a wheelchair by the oxygen in use. Resident was 3/29/18 at 8:17 a.m oxygen in use. Her | observed on 3/27/18 at 2:47 in use via nasal cannula (a tube at are inserted in the resident's (liters per minute). The rved on 3/28/18 at 8:25 a.m. in e nurse's station with no sident #235 was observed on in the dining room with no room was observed, the or was running, and it was set L/min. | : | | | |
| ! | Review of the care | plan dated, 3/23/18, | | | | • |

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

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 247 of 328



| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--|-------------------------------|-------------------------------|--|
| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE E APPROPRIATE | 1X5) COMPLETION DATE | |
| | altered respirator (related to) COPE The "Intervention documentation of The review of the (TAR) documents (liters) via n/c (na every shift." The cobeing administere 3/22/18. On 3/29/18 at 9:1 conducted with LI Resident #235 was in use. LPN #2 wis setting on the oxyverified the oxyge L/min. When asked order was for, LP the orders. The created, "It show asked what it means asked if a nurse of what rate the resistated, "Only a nuchange the order is considered a manual | page 247 art, "Focus: The resident has y status/difficulty breathing r/t and chronic respiratory failure." is failed to evidence the administration of oxygen. It reatment administration record ad, "O2 (oxygen) @ (at) 2 L sal cannula), titrate as needed oxygen was documented as ad every shift since admission on a every shift since admission on a saked to verify the flow rate agen concentrator. LPN #2 in was set between 1 and 1.5 and what Resident #235's oxygen was documented as a sked to verify the flow rate agen concentrator. LPN #2 in was set between 1 and 1.5 and what Resident #235's oxygen was set at 2L/min." When and to titrate as needed, LPN #2 it could go up or down." When can make the decision as to dent should be on, LPN #2 it could go up or down." When can make the decision as to dent should be on, LPN #2 it could go up or down." When can make the decision as to dent should be on, LPN #2 it conducted with administrative maked rate." When asked is oxygen edication, LPN #2 stated, "Yes." conducted with administrative M) #5, the nurse practitioner, on imately 1:20 p.m. When asked ay titrate O2 as needed, 'ASM in to keep them on the lowest when asked if she considers ion, ASM #5 responded, "Yes." we the nurse's know what rate of | F6 | 95 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| _ | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | The state of the s | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) | BE COMPLÉTION | |
| | nurse's scope of proxygen. ASM #5 stome to get orders." Nursing Intervention edition, Elkin, Perry "Oxygen is a drug a monitored with the stomedication." The administrator, of the facility were refindings on 3/29/18 No further information. On-Medical Readers | ate for a resident and is it in the ractice to adjust the rate of the stated, "No, they need to talk to ons and Clinical Skills, 2nd y and Potter 2000, page 936, and is administered and same care as any other director of nursing and owner made aware of the above 3 at 6:10 p.m. Ition was provided prior to exit. Inary for Medical Terms for the er, 5th edition, Rothenberg and | F€ | 695 | | | |
| | Non-Medical Reade Chapman, page 12 | nary for Medical Terms for the er, 5th edition, Rothenberg and 24. failed to clarify Resident | | ! | | | |
| | 3/8/18. Resident #' were not limited to h pressure and chron #133's most recent admission assessm | s admitted to the facility on 133's diagnoses included but heart failure, high blood nic kidney disease. Resident t MDS (minimum data set), an ment with an ARD (assessment 3/15/18, coded the resident's rately impaired. | | : | | | |
| | revealed a physicial documented, "O2 (0 | t #133's clinical record an's order dated 3/16/18 that Oxygen) @ (at) 2L (Liters) via at all times may titrate as | | : | | | |

| STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION | | (X3) OATE SURVEY COMPLETEO | |
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| | | 495142 | B. WING | - | 0. | C 3/30/20 1 8 | |
| | PROVIOER OR SUPPLIER | 3 | | STREET AOORESS, CITY, STATE, ZIP COOE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) IO PREFIX TAG | (EACH OEFICIENC | TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION) | IO PREFIX TAG | | TION SHOULO BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 695 | Continued From pa | age 249 | F 6 | 95 | | | |
| | initiated on 3/19/18 | omprehensive care plan 8 documented, "The resident is t (related to) wearing | | | | | |
| | observed lying in b | e a.m., Resident #133 was bed. The resident's oxygen set at a rate between two and 's. | | | | | |
| | conducted with ASI member) #5 (the n Resident #133's ox asked what is mea documents, "May t stated she usually documents to titrate always wants to ke lowest liter to keep keep the resident's percent. When asl ASM #5 stated, "Ye is supposed to kno oxygen to, ASM #5 not write orders to a nurse has the sor rate of oxygen a re stated, "If they are | 5 p.m., an interview was 5M (administrative staff nurse practitioner), regarding xygen order. ASM #5 was ant by a physician's order that titrate as needed." ASM #5 does not write an order that te oxygen. ASM #5 stated she seep a resident's oxygen at the orther esident comfortable and so oxygen saturation at 90 sked if oxygen is a medication, les." When asked how a nurse ow the acceptable rate to titrate 5 stated that is why she does titrate oxygen. When asked if cope and authority to decide the esident should receive, ASM #5 going to change how many its) get, they (the nurses) need ers." | | | | | |
| | conducted with LPI regarding Resident was asked what is | 7 p.m., an interview was I'N (licensed practical nurse) #6, t #133's oxygen order. LPN #6 meant by a physician's order is needed. LPN #6 stated, | : | | | | |

| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|--|--|---------------------|---|-----------|-------------------------------|--|
| | | 7 50.25 | | | С | |
| | 495142 | B. WING | | 03 | /30/2018 | |
| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | | ODE | | |
| (X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BITTAG REGULATORY OR LSC IDENTITY | E PRECEDED BY FULL | ID PREFI) TAG | PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| "Usually it means that we coneeded or bring them down have to check their oxygen." When asked if she can incomplete the stated, "I usually never how nurses definitively known when the order documents LPN #6 stated, "I guess the actually know." LPN #6 stated actually know." LPN #6 stated she calls the nurse is having issues. On 3/29/18 at 5:48 p.m., A administrator) and ASM #2 nursing) were made aware. The facility document titled Physician Orders" docume order for clarity and complete not clear or complete, contigiving the order and obtain. Discontinue the original order that is clear and commorder that is cl | can take them off if in to one liter but we in sats (saturations)." It is asternations and it is asternations and it is asternations and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation and it is asternation. It is asternation and it is asternation and it is asternation and it is asternation and it is asternation. It is asternation and i | n · | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---------------------------------------|--|---|--|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | C |
| NAME OF | PROVIDER OR SUPPLIER | | 1 5: | STREET ADDRESS, CITY, STATE, ZIP COD | | 03/30/2018 |
| | REEN HEALTH AND F | | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL ASC IDENTIFYING INFORMATION) | ID PREFI TAG | | IOULD BE | (X5) COMPLETION DATE |
| F 695 | Continued From p | age 251 | F6 | 695 | | |
| | revealed a physicial documented, "O2 n/c (nasal cannula) Resident #130's contitiated on 1/11/18 has pneumonia r/t immobilityOxyge maintain oxygen si On 3/29/18 at 7:30 observed in a wheresident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident #130's on asked what is meadocuments, "May the stated she usually documents to titrate always wants to kellowest liter to keep keep the resident's percent. When as ASM #5 stated, "Ye is supposed to know oxygen to, ASM #5 not write orders to a nurse has the sc | n therapy as ordered to aturation above 90%" a.m., Resident #130 was elchair in the bedroom. The ecciving oxygen. a.m., Resident #130 was elchair in the dining room. The ecciving oxygen. b.p.m., an interview was M (administrative staff curse practitioner), regarding exygen order. ASM #5 was ant by a physician's order that eitrate as needed." ASM #5 does not write an order that exe oxygen. ASM #5 stated she eep a resident's oxygen at the the resident comfortable and soxygen saturation at 90 ked if oxygen is a medication, es." When asked how a nurse ow the acceptable rate to titrate is stated that is why she does titrate oxygen. When asked if ope and authority to decide the | | | | |
| · · · · · · · · · · · · · · · · · · · | a nurse has the sc rate of oxygen a re | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|--------------------------------|-------------------------------|--|
| | | 495142 | B. WING | | 0.5 | C 3/ 30/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP | | J/30/2010 | |
| EVERGR | EEN HEALTH AND R | REHAB | | 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE LE APPROPRIATE | (X5) COMPLETION DATE | |
| F 695 | Continued From pa | age 252 | : F6 | 95 | | | |
| ! | liters they (residen | ts) get, they (the nurses) need rs." ASM #5 stated Resident | · · | · · · · · · · · · · · · · · · · · · · | | : | |
| | conducted with LPi regarding Resident was asked what is to titrate oxygen as "Usually it means to needed or bring the have to check their When asked if she #6 stated, "I usually how nurses definition when the order doo LPN #6 stated, "I gactually know." LP on wing two (in the the way staff has in | p.m., an interview was N (licensed practical nurse) #6, t #130's oxygen order. LPN #6 meant by a physician's order needed. LPN #6 stated, hat we can take them off if em down to one liter but we oxygen sats (saturations)." can increase the oxygen, LPN y never go up." When asked vely know how to titrate oxygen cuments "Titrate as needed," usess that there is no way to N #6 stated she has worked facility) for a while and that is nterpreted the order. LPN #6 enurse practitioner if a resident | | | | | |
| | nursing) were mad | p.m., ASM #1 (the ASM #2 (the director of e aware of the above concern. tion was presented prior to exit. | | | | | |
| | oxygen orders wer accordance with pr safe administration | failed to ensure Resident #3's e written and followed in ofessional standards for the for oxygen therapy. | | | | | |
| : <u>i</u> | 9/10/16 with the dia atrial fibrillation, mo disease, systemic i | agnoses of but not limited to orbid obesity, chronic kidney nflammatory response obstruction, chronic ischemic | | : | | i i | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--------------------|---|--------------------------------|-------------------------------|--|
| | | 495142 | B. WING | | | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | | l . | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 3/30/2018 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCE | FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION OATE | |
| | disease, diabetes bipolar disorder. (Minimum Data Swith an ARD (Assa 3/14/18. The resicognitively intact in decisions. The restotal care for bath dressing, toileting for eating; and as having an indwelli A review of the climal state of the companion of the comp | nizophrenia, Parkinson's high blood pressure, and The most recent MDS et) was a quarterly assessment essment Reference Date) of dent was coded as being high ability to make daily life sident was coded as requiring ring; extensive care for transfers, and hygiene; was independent incontinent of bowel and as high catheter for bladder. Inical record revealed one dated en at 2-3 L/minute (liters per cannula." There was nothing administer 2 and when to | F | 595 | | | |
| | 3/28/18 at 8:29 a.r revealed the resid | le on 3/17/18 at 3:17 p.m., m., and 3/29/18 at 8:12 a.m. ent's oxygen running at 3 liters on each observation. | | | | | |
| : | revealed one for " (chronic obstructive care plan was date included one for "Company") | mprehensive care plan The resident has COPD re pulmonary disease). This red 8/17/17. Interventions Dxygen per MD (medical res practitioner) orders. Monitor | | | | | |

| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) FREFIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FOR SIZE OF THIS Intervention was dated 8/17/17. On 3/29/18 at 11:07 a.m. in an interview with LPN #7 stated that she would increase the rate as needed within the confines of 2 to 3 liters, in order to keep sats (oxygen saturations) over 90. LPN #7 stated there should be parameters ordered (when to administer 2 and when to administer 3 liters). LPN #7 stated that Resident #3 has been maintained on 3 liters "since she has been here" and she wouldn't want to lower it because she would be afraid of causing respiratory distress. On 3/29/18 at 1:15 p.m. in an interview with ASM #5 (Administrative Staff Member, a Nurse) | | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--------|--|--|---|---|-------------------------------|----------------------------|
| EVERGREEN HEALTH AND REHAB X49 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | 495142 | B. WING | | 0; | C 3/30/2018 |
| F 695 Continued From page 254 for effectiveness." This intervention was dated 8/17/17. On 3/29/18 at 11:07 a.m. in an interview with LPN #7 (Licensed Practical Nurse, the unit manager) she stated that she would increase the rate as needed within the confines of 2 to 3 liters, in order to keep sats (oxygen saturations) over 90. LPN #7 stated there should be parameters ordered (when to administer 2 and when to administer 3 liters). LPN #7 stated that Resident #3 has been maintained on 3 liters "since she has been here" and she wouldn't want to lower it because she would be afraid of causing respiratory distress. On 3/29/18 at 1:15 p.m. in an interview with ASM #5 (Administrative Staff Member, a Nurse | | | ЕНАВ | | 380 MILLWOOD AVENUE | ODE: | |
| for effectiveness." This intervention was dated 8/17/17. On 3/29/18 at 11:07 a.m. in an interview with LPN #7 (Licensed Practical Nurse, the unit manager) she stated that she would increase the rate as needed within the confines of 2 to 3 liters, in order to keep sats (oxygen saturations) over 90. LPN #7 stated there should be parameters ordered (when to administer 2 and when to administer 3 liters). LPN #7 stated that Resident #3 has been maintained on 3 liters "since she has been here" and she wouldn't want to lower it because she would be afraid of causing respiratory distress. On 3/29/18 at 1:15 p.m. in an interview with ASM #5 (Administrative Staff Member, a Nurse | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREF | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | I SHOULD BE | (X5) COMPLETION DATE |
| Practitioner), she stated that normally oxygen would be ordered at 2 liters to keep sats above 90. She stated she normally would not write orders to titrate. ASM #5 stated that oxygen is a medication, and if the nurses are going to change the liters given, there needs to have an order. On 3/29/18 at 6:05 p.m. at the end of day meeting, the Administrator (ASM #1), Director of Nursing (ASM #2, and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey. 10. The facility staff failed to ensure Resident #87's oxygen orders were written and followed in accordance with professional standards for the safe administration of oxygen therapy. Resident #87 was admitted to the facility on | • | for effectiveness." 8/17/17. On 3/29/18 at 11:0' #7 (Licensed Pract she stated that she needed within the cto keep sats (oxyge #7 stated there sho (when to administe liters). LPN #7 state maintained on 3 lite and she wouldn't would be afraid of On 3/29/18 at 1:15 #5 (Administrative Practitioner), she swould be ordered a 90. She stated she orders to titrate. A medication, and if the liters given, the On 3/29/18 at 6:05 meeting, the Admin Nursing (ASM #2, were made aware information was prosurvey. 10. The facility state #87's oxygen order accordance with prosafe administration. | This intervention was dated 7 a.m. in an interview with LPN ical Nurse, the unit manager) would increase the rate as confines of 2 to 3 liters, in order en saturations) over 90. LPN ould be parameters ordered in 2 and when to administer 3 ted that Resident #3 has been ers "since she has been here" and to lower it because she causing respiratory distress. p.m. in an interview with ASM Staff Member, a Nurse tated that normally oxygen at 2 liters to keep sats above enormally would not write SM #5 stated that oxygen is a the nurses are going to change are needs to have an order. p.m. at the end of day nistrator (ASM #1), Director of and the facility owner (ASM #7) of the findings. No further ovided by the end of the | F 6 | 95 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-----------------------------|---|-------------------------------|----------------------------|
| | | 495142 | B. WING | | 02 | C /30/2018 |
| | PROVIDER OR SUPPLIE | R | 38 | TREET ADDRESS, CITY, STATE, ZIP C 80 MILLWOOD AVENUE /INCHESTER, VA 22601 | | 130/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | hypothyroidism, didepression, Parkii blood pressure, is pulmonary emboli disease, chronic or respiratory failure shortness of breatmost recent MDS quarterly assessm Reference Date) coded as being codaily life decisions requiring total care assistance for train hygiene; independincontinent of bow A review of the clidated 3/21/18 for titrate from 2LPM maintain 02 Sat > bedtime)." There administer 2 liters when to administer administer 5 liters A review of the ox 2018 revealed that saturation was at 3/17/18 and at 92' The remaining 49 saturation was do On 3/28/18 8:27 at 150 cm. | porosis, bronchitis, iabetes, morbid obesity, nson's disease, epilepsy, high chemic heart disease, sm, stroke, peripheral vascular obstructive pulmonary disease, spinal stenosis, fibromyalgia, th, dysphagia, and ataxia. The (Minimum Data Set) was a nent with an ARD (Assessment of 3/12/18. The resident was ognitively intact in ability to make a for bathing; extensive nsfers, dressing, toileting, and dent for eating; and as wel and bladder. Inical record revealed an order "02 via nasal cannula. May (liters per minute)-5LPM to 90% (above 90%) QHS (at was no directions for when to when to administer 3 liters, and when to the resident's oxygen 94% on one occasion on 3/13/18. Opportunities the oxygen cumented, at 95% or higher. I.m., and on 3/29/18 at 8:09 7's oxygen was running at 3 | F 695 | | | |
| | A review of the ca | re plan revealed one dated | : | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN | | MULTIPLE CONSTRUCTION IILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|-------------|----------------------------|
| | | 495142 | B. WING | | 03 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP O 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 695 | Interventions included via nasal cannula and doctor) or NP (nurseaturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations fall below the saturations for the saturation for the saturation | sident has oxygen therapy." ded one dated 3/22/18 for "O2 as ordered. Notify MD (medical se practitioner) if O2 ow 90%." | F6 | 95 | | |
| | LPN #7 (Licensed manager) she state rate as needed with in order to keep sa 90. She stated the ordered (when to a administer 3 liters). #3 has been maint been here" and she | 7 a.m., in an interview with Practical Nurse, the unit ed that she would increase the nin the confines of 2 to 3 liters, its (oxygen saturations) over are should be parameters dminister 2 and when to LPN #7 stated that Resident ained on 3 liters "since she has a wouldn't want to lower it it be afraid of causing increase. | : | | | |
| | #5 (Administrative Practitioner), she s would be ordered a 90. She stated she orders to titrate. A medication, and if | p.m., in an interview with ASM Staff Member, a Nurse tated that normally oxygen at 2 liters to keep sats above a normally would not write SM #5 stated that oxygen is a the nurses are going to change are needs to have an order. | | | | |
| | meeting, the Admir Nursing (ASM #2, a were made aware information was pro survey. | p.m., at the end of day nistrator (ASM #1), Director of and the facility owner (ASM #6) of the findings. No further ovided by the end of the ally Related Social Service | : : F 7 | 45 | | |
| | §483.40(d) The fac | cility must provide | | | | · · ! |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | LTIPLE CONSTRUCTION DING | (> | X3) DATE SURVEY COMPLETED |
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| | | 495142 | B. WING | | | C |
| NAME OF | PROVIDER OR SUPPLIER | <u></u> | D. VV II V | <u> </u> | | 03/30/2018 |
| | REEN HEALTH AND R | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | | SHOULD BE | |
| | maintain the highes and psychosocial was This REQUIREMENT by: Based on staff interest and facility document the facility staff failed social services for survey sample, Resurve | social services to attain or est practicable physical, mental well-being of each resident. ENT is not met as evidenced erview, clinical record review, ent review, it was determined ed to provide medically related seven of 31 residents in the esidents #55, #74, #114, #98, | F 7 | 1. PASARR's have been comp #55, #74, #114, #98, #90, ar services have been obtained 2. A 100% audit will be comple residents have had a Preadm Resident Review. The screet those residents identified as 100% audit will be conducted have requested dental service dental needs have been adds 3. Admissions and Social Service reeducated on obtaining the on admission. Social Service reeducated on following podental services. 4. Residents in need of dental residents will be discussed management meetings to et appointments are being material particles will be obtained a of noncompliance will be of QA meetings so that a plant developed. 5. Completion Date: May 11 | nd #89. De I for Reside I for R | ental ent #37. sure reening and be done for g one. A reents who are their Will be PASARR fill be rocedure for and new risk al t nission. Any issues n quarterly |
| | related social service | failed to ensure medically ces were provided in regards eadmission screening and | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | | C /30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 0 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | 00,20,0 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | N SHOULD I E APPROPR | BE | (X5) COMPLETION DATE | |
| F 745 | Continued From pa | age 258 | ; F 7: | | | | | |
| | 1 | eing completed for Resident | | | | | | |
| | related social servi to the PASARR (pr resident review) be #89. 7. The facility staff | failed to ensure medically ices were provided in regards readmission screening and eing completed for Resident failed to assist the resident in ervices for Resident #37. | : | | | | | |
| | The findings includ | | | | | | | |
| i | related social servi to the PASARR (Pr | failed to ensure medically ices were provided in regards re-admission screening and eing completed for Resident | | • | | | | |
| | 10/25/04 with the deparkinson's diseas hyperplasia, diabet depression, mood pseudobulbar affect dysphagia. The mediate Set) was a quantum ARD (Assessment The resident was compaired in ability to the resident was coare for bathing, hy | tes, dementia, psychosis, disorder, anxiety disorder, ct, high blood pressure, and tost recent MDS (Minimum parterly assessment with an a Reference Date) of 2/7/18. Coded as severely cognitively to make daily life decisions. Coded as requiring extensive tygiene, toileting, dressing, and as | | | | | | |
| | reveal the resident' | at #55's clinical record failed to 's PASARR. Resident #55's re plan failed to reveal | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | 49 FOR MEDICARE | WIEDICAID SERVICES | | | | OWR M | O. 0938-0391 | |
|--------------------------|--|--|--------------------|--|--|--------|-------------------------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | ÷ | | 0 | C 3/30/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| /- DAG | | | | | 380 MILLWOOD AVENUE | | | |
| EVERGR | REEN HEALTH AND R | EHAB | | 1 | WINCHESTER, VA 22601 | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | ٦IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F 745 | Continued From pa | age 259 | F. | 745 | 5: | | | |
| ! | • | arding the PASARR. | | 1 | | | | |
| | On 3/20/18 at 6:05 | p.m., at the end of day | | | | | | |
| | meeting, the Admin staff member) #1, [| nistrator, ASM (administrative Director of Nursing, ASM #2 | : | | | | | |
| | | acility owner were made aware | | | | | | |
| i | of the Indings. Are of the PASARR. | equest was made for evidence | | | • | | e e | |
| | or the rate of the control of the co | | | | | | • | |
| : | #3 (Other Staff Mer | a.m., in an interview with OSM mber, the social worker) she as not told it was something | | | | | · , | |
| | PASARR's). She fu did not have them for what the purpose of | urther stated that the facility for Resident #55. When asked of a PASARR, OSM #3 stated, | | | | | | |
| | purpose of it is for." | uation. I don't know what the | | | | | | |
| . ! | | a.m., in an interview with OSM worker. OSM #4 stated, | | | | | | |
| | | RR, "It is done at the hospital. | | | | | i | |
| i | They review the cha | art to make sure the resident | | | | | · : | |
| | • | nental illness or a mental ine if there is a level 2 | | | | | · | |
| | • | ds to be processed by a | | | | | : | |
| į | _ | ler to make sure they (the | | | | | | |
| | residents) are safe | to come to a facility, and are | | | | | <u>;</u> | |
| | | n take care of them safely." | | | | | | |
| : | | ASARR does not come from social worker responsible for | | | | | : | |
| | | SM #4 stated, "That was not | | | ŧ | | | |
| | | ne here." When asked the | : | | • | | : | |
| ! | purpose of one, OS | SM #4 stated, "To make sure | : | | | | | |
| į | | sue, that we are able to handle | | | | | | |
| ! | their needs and how needs. | w we can best meet their | | | | | | |
| | necus. | | | | | | | |

A review of the facility policy, "Job Description,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------------|---|-------------------------------|--|
| | | 495142 | B. WING _ | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLÉTION | |
| F 745 | her primary duties a worker shall exercicarrying out a varie the well-being and residentsAdminist policies and proced interdisciplinary teastate and federal reviewing and settil care and quality of developing facility so Develop, maintain a community resource and their families/s in quality assurance meetings. 6. Under government required documentation. 7. meeting the psychological at the dentifies social and psychological at the identifies social needs" There we directly specified Proceedings are with the survey. 2. The facility staff or related social service to the PASARR (Proceedings) and the passage of the passage | cumented, "In fulfilling his or and responsibilities, the social se professional judgment in try of activities that maximize quality of life of strative: 1. Review facility dures as part of the facility's am to assure compliance with egulations. 2. Participate in ang policies concerning resident life. 3. Participate in social work policies. 4. and utilize a listing of current ses that are useful to residents ignificant others. 5. Participate in interdisciplinary team restand and meet all ements for social service Document progress in | F 74 | | | |
| : | 8/26/13 with the dia stroke, intestinal dis | admitted to the facility on ignoses of but not limited to sease, depression, metabolic ementia, schizoaffective | | : : : | : - - - - - | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-------------------|---|-------------------------------|------------------------|
| | | 495142 | B. WING | ······································ | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | 03/30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | (X5) E COMPLETION TE OATE | | |
| F 745 | cataracts, presbyo schizophrenia, biphigh blood pressur obstructive pulmor MDS (Minimum Datassessment with a Reference Date) of coded as severely make daily life decoded as requiring dressing, and hyginand as incontinent Review of Resident reveal the resident comprehensive candocumentation regressing and as incontinent Comprehensive candocumentation regression (On 3/30/18 at 9:33 #3 (Other Staff Mestated that she "was that I had to do" (O PASARR's). She find not have them what the purpose of construction of the construct | a, gastrostomy feeding tube, pia, Parkinson's disease, olar disorder, angina, diabetes, e, hypothyroidism, and chronic hary disease. The most recent ata Set) was a quarterly in ARD (Assessment f 2/16/18. The resident was cognitively impaired in ability to isions. The resident was total care for transfers, ene; extensive care for eating; of bowel and bladder. It #74's clinical record failed to 's PASARR. Resident #74's re plan failed to reveal parding the PASARR. a.m., in an interview with OSM mber, the social worker) she as not told it was something braining, performing further stated that the facility for Resident #55. When asked of a PASARR, OSM #3 stated, uation. I don't know what the | F | 745 | | |
| | #4, another social regarding a PASAF They review the choosen't have any nodisability to determ screening that nee psychologist, in ordesidents) are safe | a.m., in an interview with OSM worker. OSM #4 stated, RR, "It is done at the hospital. art to make sure the resident nental illness or a mental ine if there is a level 2 ds to be processed by a der to make sure they (the to come to a facility, and are in take care of them safely." | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUI | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|-------------------|-----|--|--------|----------------------------|
| | | 495142 | B. WING | | | | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | 3.03.23.10 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION] | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 745 | the hospital, is the completing one, Os communicated to repurpose of one, Os that if there is an is their needs and honeeds. No further informat the survey. 3. The facility staff related social servito the PASARR (President review) be #114. Resident #114 was 4/7/17 with the diag deep vein thrombo pneumonia, shortninsomnia, dementia anxiety disorder, hiemphysema, chrordisease, osteoarthickidney disease,. T (Minimum Data Sewith an ARD (Asse 3/6/18. The reside impaired in ability to the resident was cobathing; extensive transfers; limited as independent for ea and bladder. | ASARR does not come from social worker responsible for SM #4 stated, "That was not me here." When asked the SM #4 stated, "To make sure sue, that we are able to handle we can best meet their ion was provided by the end of failed to ensure medically ces were provided in regards re-admission screening and ing completed for Resident admitted to the facility on gnoses of but not limited to sis, ankle fracture, aspiration ess of breath, edema, a, schizophrenia, depression, gh blood pressure, nic obstructive pulmonary ritis, fibromyalgia, and chronic he most recent MDS to was a quarterly assessment sement Reference Date) of the most recent MDS to make daily life decisions. The coded as requiring total care for care for hygiene, dressing, and as continent of bowel ing; and as continent of bowel | | 745 | | | |
| | | t #114's clinical record failed to s PASARR. Resident #114's | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIÌ | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-----------------------|---|-------------------------------|--------------------------------|
| | | 495142 | B. WING_ | | 03 | C / 3 0/ 2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | , | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 100/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION OATE |
| F 745 | On 3/29/18 at 6:05pmeeting, the Adminstaff member) #1, I and ASM #7, the far of the findings. A reof the PASARR. On 3/30/18 at 9:33a #3 (Other Staff Merstated that she "wathat I had to do" (ob PASARR's). She fudid not have them f what the purpose of "some type of evaluating purpose of it is for." On 3/30/18 at 9:44a #4, another social wregarding a PASAR They review the chadoesn't have any midisability to determinscreening that needs | e plan failed to reveal arding the PASARR. D.m., at the end of day istrator, ASM (administrative Director of Nursing, ASM #2 cility owner were made aware equest was made for evidence a.m., in an interview with OSM mber, the social worker) she is not told it was something partial interview that the facility or Resident #55. When asked f a PASARR, OSM #3 stated, ration. I don't know what the a.m., in an interview with OSM worker. OSM #4 stated, R, "It is done at the hospital. Bart to make sure the resident mental illness or a mental me if there is a level 2 les to be processed by a | F 74 | 1 | | |
| | residents) are safe deemed that we can When asked if a PA the hospital, is the scompleting one, OS communicated to multiple purpose of one, OS that if there is an issue. | er to make sure they (the to come to a facility, and are in take care of them safely." SARR does not come from social worker responsible for M #4 stated, "That was not be here." When asked the M #4 stated, "To make sure sue, that we are able to handle we can best meet their | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | ILTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---|---|-------------------------------|--|----------------------------|
| | | 495142 | B. WING | - ,, <u> :</u> | | | C 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP 0 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 745 | the survey. 4. The facility staff related social service to the preadmission review (PASARR) is #98. Resident #98 was a 4/21/15 with diagnoral limited muscle weat pain, paranoid schild disease, and high is #98's most recent if assessment was a ARD (assessment Resident #98 was dimpaired in cognitive possible 15 on the Mental Status) example extensive member with most. The most recent condition of the most recent condition of the with an assessment with an assessment with an assessment coded in Section A Screening and Resident passes to being currently passes to and/or intellectual conditions. | failed to ensure medically ces were provided in regards a screening and resident being completed for Resident admitted to the facility on eses that included but not kness, diabetes mellitus, chest zophrenia, chronic kidney blood pressure. Resident MDS (minimum data set) quarterly assessment with an reference date) of 2/28/18. Coded as being moderately refunction scoring 10 out of BIMS (Brief Interview for m. Resident #98 was coded as assistance from one staff ADLs (activities of daily living). Imprehensive MDS (minimum ent, an annual assessment, threference date of 11/1/18, 1500 - Preadmission ident Review, the resident as considered by the state level II on have a serious mental illness lisability or a related condition. | | 745 | | | |
| : : : : : : | having been comple On 3/30/18 at 9:23 | a.m., an interview was | | : | | | : |
| : | | M (other staff member) #3, the M #3 stated that she was not | | : | | | |

| CLIVIL | 10 I OK MEDICAKE | A MILDICAID SLIVVICES | | | | OND IN | <u>J. 0936-039 (</u> | |
|---------------|---|--|-------------|------|---|-------------------------------|-----------------------|--|
| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER | | 1 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 495142 | B. WING | i | | 0 | C 3/30/2018 | |
| NAME OF | PROVIDER OR SUPPLIER | • | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | | | |
| EVERGR | EEN HEALTH AND R | ЕНАВ | | ! | MILLWOOD AVENUE ICHESTER, VA 22601 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | 1D | | PROVIDER'S PLAN OF CORRECT | TION | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | | COMPLETION DATE | |
| F 745 | Continued From pa | age 265 | F. | 745 | | | | |
| | aware that social s | ervices was responsible for | | | | | | |
| | | SAAR. OSM #3 stated that it | | : | | | | |
| | | attention that she had to | | | | | : | |
| | • | S. When asked how long she | | ! | | | : | |
| | | Il worker, OSM #3 stated since | | | | | : | |
| | | en asked the purpose of the stated that she was not sure | | | | | ÷ | |
| | of the purpose or use of the PASAAR. | | | | | | 1 | |
| | | | | | | | | |
| | | a.m., an interview was | | | | | | |
| | conducted with OSM #4, another social worker | | | | | | ! | |
| | | ired at the facility. When | | | | | İ | |
| : | | AAR was, OSM #4 stated that ly happens at the hospital and | | | | | | |
| | | ident's chart to see if a | | | | | | |
| | | ital illness or disability and then | | | | | | |
| | | evel two PASAAR needs to be | | | | | | |
| | | ted that it ensures residents | | | | | | |
| | | the facility and that the facility ent's needs. OSM #4 stated | | | | | : | |
| | | mmunicated to her that social | | | | | į | |
| | | nplete the PASAAR if the | | | | | | |
| | | one. OSM #4 stated that in | | | | | | |
| : | | e she had worked previously, | | | | | ! | |
| | another departmen completing PASAA | t was responsible for | | | | | 1 | |
| | completing FASAA | 1.0. | | | | | | |
| | OSM #4 could not | provide a PASAAR for | | | | | : | |
| | Resident #98. | | | | | | | |
| | 0-00080 | | : | | | | | |
| | | p.m., ASM (administrative | 1 | | | | ; | |
| | | he administrator, ASM #2, the ursing) and ASM #7, the facility | | : | | | : | |
| | | aware of the above concerns. | | | | | : | |
| | | failed to ensure medically | | | | | | |
| | | ces were provided in regards | | | | | | |
| | | eadmission screening and | | | | | | |
| | | ing completed for Resident | | | | | | |
| İ | <i>#</i> 90. | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|-----|---|-------------------------------|----------------------------|
| | | 495142 | B. WING | i | | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | , 30 | 700/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 745 | Continued From pa | ge 266 | F | 745 | | | |
| | 5/2/12 with diagnos limited to: Huntingto hereditary condition involuntary rapid, je deterioration, leadir | admitted to the facility on es that included but were not on's chorea (abnormal ocharacterized by progressive rky motions and mental og to dementia) (1), muscle orenia (any of a group of | | : | | | ! |
| | mental disorders ch distortions of reality contacts, and distur perception and emo- dysphagia (a condit difficult or painful du | naracterized by gross, withdrawal from social bances of thought, language, otional response.) (2), and ion in which swallowing is use to obstruction of the cular abnormalities of the | | : | | | |
| | assessment, with a of 2/22/18, coded the on the BIMS (brief is score indicating the to make cognitive dwas coded as required.) | OS assessment, a quarterly n assessment reference date ne resident as scoring a two interview for mental status) resident is severely impaired ally decisions. The resident ring extensive assistance of embers for all of his activities | | | | | |
| | | al record failed to evidence a ening and Resident Review eted. | | | | | |
| | | nd of the day meeting, a for the PASARR for Resident | : | : | | | : |
| | member (OSM) #3, at 9:28 a.m. When a | nducted with other staff the social worker, on 3/30/18 asked if she had any ASARR for the residents, | | : | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|---|-------------------------------|----|--------------------------------|
| | | 495142 | B. WING | | | | C / 3 0/ 2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD I | BE | (X5) COMPLETION DATE |
| F 745 | manager that I was I should be doing. yesterday. The other this morning about we don't have any casked what a PASA some type of evaluasked what the pur #3 stated she did nother social worker When asked what a "My understanding and to determine if or mental disability come to the facility psychologist or docor them." When asl PASARR, OSM #4 to the facility. If one hospital the admission where I worked, but social worker to cois more to a PASAA the facility, OSM #4 so we can meet the typically we get a nother doctor sometimes if going to come here "Unfortunately it was that social services she was provided we stated, "Yes, there is basic." | explained to the business office is not told it was something that It came to our attention er social worker spoke with me PASARR. To my knowledge, of the PASARRs." When ARR is, OSM #3 stated, "It's ration of that person." When rpose of a PASARR is, OSM mot know. I Conducted with OSM #4, the r, on 3/30/18 at 9:45 a.m. a PASARR is, OSM #4 stated, is that it starts at the hospital fa resident has a mental illness to make sure they are safe to rand if they need a ctor so we can safely take care ked the purpose of the stated it is so they can come is does not come from the sion did it in West Virginia, at in Virginia it's referred to the emplete." When asked if there AR then being safe to come to 4 stated, "If they have an issue eir needs. Level 2 screening is notice with yes or no. The has to decide if a resident is | | 745 | | | |
| | | u a.m. the director of nursing y team the facility did not have | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|--|---|-----------------------------------|-------------------------------|--|--|
| | | 495142 | B. WING | | 03 | C 3/30/2018 | | |
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | FION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | | |
| F 745 | administrator, wa findings on 3/30/ No further inform (1) Barron's Dictive Non-Medical React Chapman, page (2) Barron's Dictive Non-Medical React Chapman, page (3) Barron's Dictive Non-Medical React Non-Medical React Chapman, page (3) Barron's Dictive Non-Medical React Chapman, page (3) Barron's Dictive Non-Medical React Chapman, page (3) Barron's Dictive Non-Medical React Chapman, page (4) Resident React Resident Review) 1 #89. Resident #89 was 5/4/14 with a receding Noses that in left shoulder pain of her leg, diabet pressure, stroke, | staff member) #1, the as made aware of the above 18 at 12:57 p.m. ation was provided prior to exit. conary for Medical Terms for the ader, 5th edition, Rothenberg and 246. conary for Medical Terms for the ader, 5th edition, Rothenberg and 522. conary for Medical Terms for the ader, 5th edition, Rothenberg and 521. | F 74 | 45 | | | | |
| | from reality and he thinking, responsive relationships. (1) The most recent with an assessment coded the resident (brief interview for | nas impaired perceptions, es and interpersonal MDS, a quarterly assessment, ent reference date of 2/22/18, nt as scoring a 15 on the BIMS r mental status) score, indicating capable of making daily | : | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDI | FIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | 0. | C 3/3 0/2018 |
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 330/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION OATE |
| F 745 | requiring extensive staff members for living. In Section I resident was code Review of the clin Preadmission Scribaving been compared to the request was made was member (OSM) # at 9:28 a.m. When knowledge of the OSM #3 stated, "I manager that I was I should be doing yesterday. The other this morning about we don't have any asked what a PAS some type of eval | is. The resident was coded as the assistance of one or more is most of her activities of daily in a Restraints and Alarms, the ed as using bed rails daily. Ical record failed to evidence a reening and Resident Review pleted. The end of the day meeting, a refor the PASARR for Resident reconducted with other staff resident residents, asked if she had any PASARR for the residents, explained to the business office as not told it was something that the came to our attention her social worker spoke with me at PASARR. To my knowledge, of the PASARRs." When SARR is, OSM #3 stated, "It's uation of that person." When urpose of a PASARR is, OSM | F7 | 45 | | |
| | other social works When asked what "My understanding and to determine or mental disabilit come to the facilit psychologist or do of them." When a | conducted with OSM #4, the er, on 3/30/18 at 9:45 a.m. ta PASARR is, OSM #4 stated, g is that it starts at the hospital if a resident has a mental illness y to make sure they are safe to y and if they need a actor so we can safely take care sked the purpose of the | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | 0 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | <u>9</u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION DATE |
| F 745 | hospital the admiss where I worked, but social worker to co is more to a PASA/ the facility, OSM #/so we can meet the typically we get a n doctor sometimes I going to come here "Unfortunately it was that social services she was provided v | e does not come from the sion did it in West Virginia, t in Virginia it's referred to the mplete." When asked if there AR then being safe to come to stated, "If they have an issue eir needs. Level 2 screening is otice with yes or no. The has to decide if a resident is | F 7 | 745 | | |
| | informed the survey any policy on PASA ASM (administrative | e staff member) #1, the made aware of the above | | | | |
| | (1) Barron's Diction Non-Medical Read Chapman, page 48 7. The facility staff t | ary for Medical Terms for the er, 5th edition, Rothenberg and 3. Failed to assist the resident in rvices for Resident #37. | | | | |
| : | 1/17/17 and readmidiagnoses that include | admitted to the facility on ted on 12/11/17 with uded but were not limited to: ess of breath, diabetes, stroke | | ! | | |

| OLITICI | VO I OIN MILLDIOAINE | - G MILDIOAID SLIVVICES | | | <u> </u> | <u>VID INO. 0936-039 I</u> | |
|--------------------------|--|--|---------------------|---|-----------------------------|-------------------------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | ULTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | G | | C 03/30/2018 | |
| NAME OF E | PROVIDER OR SUPPLIER | | | | | U3/3U/ZU 16 | |
| | REEN HEALTH AND R | | | STREET ADDRESS, CITY, STATE, 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | FIX (EACH CORRECTIVE AC | CTION SHOULD THE APPROPE | BE COMPLÉTION | |
| F 745 | quarterly assessmentereference date) of 1 having scored 15 or interview for mental resident was cognit decisions. The resident state assistance from state except for eating where the transport of the company of the c | and the second s | | 745 | | | |
| : | supposed to perform gum issues we report asked what staff did dentures, LPN #9 st from the NP (nurse for the oral surgeon | m their oral care, if there's any ort it to the doctor." When d if a resident was requesting stated, "We would get a consult practitioner) to get an order n." | . ! | | | | |
| : | An interview was co | onducted on 3/30/18 at 9:23 | | | | : | |

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | C | <u>MR </u> | <u>). 0938-0391</u> |
|--|------------------------------------|--|------------------------------------|-----|---|---|----------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | | E CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | | 495142 | B. WING | | | 1 | C 5/ 30/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CVEDOD | YEEN VIEWLEN AND D | FUAD | | 3 | 80 MILLWOOD AVENUE | | |
| EVERGR | REEN HEALTH AND R | EHAB | | V | VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 745 | Continued From pa | age 272 | : . F7 | 745 | | | |
| | | ner staff member) #3, the | : | 70 | • | | |
| | | en asked how she was made | : | ٠ | | | : |
| į | | ent was asking for dental | | | | | |
| | | stated, "If they themselves tell | | ٠ | | | |
| : | • | staff. Also in the care plan | | | | | |
| - | | rerything's okay vision and | | | | | |
| | | asked what the process was | | : | : : | | |
| | | dent who asked for dentures, | | ; | | | |
| | | or long term care residents l | | | | | |
| : | | edicaid program they have. I'll | | | | | |
| | • | entist takes that insurance. I | | | | | |
| | | ist and ask how much would | | | | | |
| | | l residents could get a MAP | : | | | | : |
| | | n asked why a Medicaid | | | | | |
| : | | old the cost of the dentures | | | | | |
| | | cket if funds were available | : | | | | : |
| | | OSM #3 stated, "Um. It would | | | | | |
| | | through to get a map | | | | | · |
| į | | asked if any resident had | | | | | |
| | | dentures, OSM #3 stated, | | | | | |
| | | ed about Resident #37's | | | | | |
| | | tated, "She did recently ask | | | | | |
| | : | ut. I did check her insurance | | | | | |
| | , | ered." When asked about the | | | | | |
| | | OSM #3 stated, "That's my inking that far out that it could | | | | | |
| | | when asked if she told the | | | | | |
| | | have to pay for her dentures, | | | | | |
| | OSM #3 stated, "I o | | | : | · • | | |
| : | : | na, 50y. | | | | | |
| | On 3/30/18 at appr | oximately 2:30 p.m. ASM | | | | | : |
| į | (administrative staff | | | | | | |
| | | ASM #2, the director of nursing | | 1 | | | |
| : | were made aware o | • | | |) : | | |
| F 755 | Pharmacy Srvcs/Pr | rocedures/Pharmacist/Records | F 7 | 755 | | | • |
| | CFR(s): 483.45(a)(l | | | | | | |
| 1 | §483.45 Pharmacy | Services | | | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CON | NSTRUCTION | (X3) DATE SURVEY |
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| • | ! | A. BUILDI | ING | | COMPLETED |
| | 495142 | B. WING | ··· | | C 03/30/2018 |
| NAME OF PROVIDER OR SUPPLIER | | ' | STREE | T ADDRESS, CITY, STATE, ZIP CODE | 03/30/2010 |
| | | | | LLWOOD AVENUE | |
| EVERGREEN HEALTH AND REHA | В | | | HESTER, VA 22601 | |
| PREFIX (EACH DEFICIENCY MUS | ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| F 755 Continued From page 2 | | F 7 | 755 | F755 | |
| The facility must provide drugs and biologicals to them under an agreeme §483.70(g). The facility personnel to administer permits, but only under a licensed nurse. §483.45(a) Procedures. pharmaceutical services that assure the accurate dispensing, and administiologicals) to meet the §483.45(b) Service Commust employ or obtain the pharmacist whospharmacist whospharmacist whospharmacist of the provision the facility. §483.45(b)(1) Provides aspects of the provision the facility. | e routine and emergency its residents, or obtain ent described in may permit unlicensed drugs if State law the general supervision of A facility must provide (including procedures acquiring, receiving, stering of all drugs and needs of each resident. Isultation. The facility he services of a licensed consultation on all of pharmacy services in es a system of records of of all controlled drugs in e an accurate es that drug records are in int of all controlled drugs dically reconciled. In one met as evidenced estaff interview, facility inical record review, it lity staff failed to provide | | 1. 2. 3. 4. 5. | Corrective action has been accomplish the alleged deficient practice in regard residents #236 calcium citrate. The nuclarified the order and medication was and received from pharmacy per NP Current facility residents have the pobe affected by the alleged deficient pure The Unit Managers or designee will a 100% audit of new medication order on 3/19/18 til 4/15/18, then 10 reside week x 4 weeks, then 15 residents x 2 Results will be submitted to QAP1 quensure compliance. | rds to nurse as ordered 's order. tential to ractice. complete ers starting nts per 2 months. narterly to eged ade: egarding g nedication nee will d report in eting as to and will |

The facility pharmacy failed to dispense and

| 0 = 1, 1, 1 = 1 | TO TOTAL VIEW TO THE | G MEDIO ND OLIVIOLO | | | | 7 | . 0000 000 1 | |
|--------------------------|--|--|-------------------|-----|--|------|-------------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 405440 | B. WING | | | C | | |
| | | 495142 | D. WING | | | 03 | /30/2018 | |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .DBE | (X5) COMPLETION DATE | |
| F 755 | Continued From no | ao 274 | · | 755 | | | | |
| 1 700 | Continued From pa | - | : Г | 755 | | | | |
| | | tion Calcium Citrate, as sician, for Resident #236. | ! | | | | : : | |
| : | The findings include | e: | | : | | | | |
| | 3/19/18 with diagnor limited to: diabetes, blood pressure, low specified disorders and heart failure. was oriented to per situation. There was not com set) assessment common the "Nursing Admis 3/19/18, documented the medication adraconducted on 3/28/(licensed practical in Resident #236's medication card with with Vitamin D) 315 can't give that, it do says. I won't give in | admitted to the facility on uses that included but were not cancer of the colon, high back pain, heart attack, of bone density and structure, son and place, not to time and pleted MDS (minimum data empleted at the time of survey. Ssion Assessment" dated at the resident ministration observation was 18 at 8:27 a.m. with LPN murse) #4. LPN #4 prepared edications. LPN #4 pulled a the Calcitrate (calcium citrate 5/250 tablet. LPN #4 stated, "I sesn't match what the order it until I've checked the orders." | | | | | | |
| | The physician orde "Calcium citrate + ((milligram); Give 1 for supplement." (C salt of calcium. An nerve, muscle, and the citrate salt helps | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTE | 42 FOR MEDICARE | & MEDICAID SERVICES | | | | <u> DMB NC</u> | <i>).</i> 0938-0391 |
|--------------------------|--|---|----------------------|-----|---|-------------------------------|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | 0: | C 3/30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | TENUEALTU AND D | EU A D | | 3 | 80 MILLWOOD AVENUE | | |
| EVERGR | EEN HEALTH AND R | EHAB | | V | VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION OATE |
| | member (OSM) #7, 2:45 p.m., OSM #7 #236's order for Ca #7 was asked if the order says and what pharmacy, OSM #7 should have clarifie have been commurand the facility." An interview was consider and the facility of the nurse practition and how many time pharmacy and tell the nurse practition and they sent some pharmacy today and that strength, they consider the medication. If acility to get the order that strength, and they were no records registered to the nurse property and they were no records registered to the nurse property and spok back to the nurse property and they were no records registered to the nurse property and spok back | onducted with other staff the pharmacist; on 3/28/18 at was asked to review Resident lcitrate. Once reviewed, OSM are is a discrepancy in what the at is dispensed by the stated, "Yes the pharmacy d that order. There should nication between the pharmacy onducted with LPN #4 on . When asked what happens screpancy between the what the pharmacy sent, LPN don't give the medication. I tell er. I see when it was started is it was given. I call the hem the order says one thing othing else. I called the did they told me they didn't carry only carry the 315/250 strength asked if they had called the der changed to the 315/250 e pharmacist told me there garding this indicating the ten to the facility. I then went reactitioner and she changed what we had in the medication | | 755 | | | |
| | pharmacist at the pl p.m. When asked a there is an order tha have in stock, OSM the facility and tell th | binducted with OSM #8, the harmacy on 3/27/18 at 4:34 bout the process followed if at doesn't match what you #8 stated, "We should call nem that what the doctor retock and this is the dose we | | : | | | |

carry." When asked what happened with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | | l . | C /30/2018 | |
| | PROVIDER OR SUPPLIE | | | 380 MIL | ADDRESS, CITY, STATE, ZIP CO LLWOOD AVENUE HESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (XS) COMPLETION DATE | |
| F 755 | don't see a note of | page 276 Calcitrate, OSM #8 stated, "I on her profile that we called the | F 7 | 55 | | | | |
| | documented in particular follow (Name of Follow (Name of Follow) medication admir from the pharmac medications as particular follows: The administrato member) #1, directions as particular follows: | , "Medication Administration" art, "Procedure: The facility will Pharmacy)'s policy for histration." The attached policies by did not address providing the rescribed by the physician. T, ASM (administrative staff ctor of nursing, ASM #2, and | | : : | | | | |
| | No further inform (1) This informati following website https://pubchem. | f the facility were made aware of s on 3/29/18 at 6:10 p.m. ation was provided prior to exit. on was obtained from the : ncbi.nlm.nih.gov/compound/Calc on=Pharmacology-and-Biochemi | : | · | | | | |
| F 756 SS=D | Drug Regimen R CFR(s): 483.45(c) §483.45(c) Drug §483.45(c)(1) Th must be reviewed licensed pharmad §483.45(c)(2) Th of the resident's i §483.45(c)(4) Th irregularities to the facility's medical | Regimen Review. e drug regimen of each resident d at least once a month by a cist. is review must include a review | F 7 | | Corrective action has been at alleged deficient practice in r 83. Resident #83 was schedu 0730 and iron at 0900, less the The pharmacy and NP was mand the Synthroid was resche apart. Current facility residents have affected by the alleged deficity Quality Assurance Nurse or 10 residents medication ordethen 20 residents a month for compliance. Any irregularities with the NP/MD and pharmatics. | regards to residentled Synthroid at than 4 hours apartiotified of irreguled and to be 4 hower the potential to designee will autors a week x 4 word months to asses will be clarific | nt # t. larity ours to be edit dit eeeks, sure | |

| | | WHILE OF THE OFFICE OF THE OFFI | | | | ON GIVID | . <u>0900</u> ~039 |
|--------------------------|--|--|-------------------|-----|---|--|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
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| | <u> </u> | 495142 | B. WING | ,== | | 03/ | 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGE | REEN HEALTH AND R | ЕНАВ | | | 80 MILLWOOD AVENUE | | |
| <u> </u> | | | | W | /INCHESTER, VA 22601 | | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 756 | drug that meets the (d) of this section for (ii) Any irregularities during this review meets attending physician director and director and director minimum, the resident the irregularity (iii) The attending physician the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's medical meets at the physician should do the resident's meets at the physician should be physician sho | ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. In noted by the pharmacist must be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a sent's name, the relevant drug, the pharmacist identified. In the ecord that the identified or reviewed and what, if any, en to address it. If there is to medication, the attending cument his or her rationale in the ecord. | F | 756 | Measures put into place to assure deficient practice does not recur i will be reeducated to notify NP/N pharmacy with all medication irreclarification. The Director of Nursing and/or deanalyze/review for patterns/trends the Quality Assurance committee quarterly for a minimum of six mevaluate the effectiveness of the padjust the plan as the committee recommend, based on outcomes/t from date. Completion Date: May 11, 2018 | clude: Nurs D and gularities fo signee will and report i meeting onths to lan and will | r n |
| | maintain policies an drug regimen review limited to, time fram the process and ste when he or she ider requires urgent actic This REQUIREMEN by: Based on observati record review, and f was determined that ensure the medicati medication irregular in the survey sample. | d procedures for the monthly that include, but are not es for the different steps in ps the pharmacist must take attifies an irregularity that on to protect the resident. IT is not met as evidenced on, staff interview, clinical acility document review, it the facility staff failed to on regimen was free of ities, for one of 31 residents | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 405440 | ļ | | | | С |
| WALE OF | DDAMBER OF SURE | 495142 | B. WING | | | 03/ | 30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP (380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD E APPROPF | BE | IX5) COMPLETION DATE |
| F 756 | 4/11/17 with the dia acute kidney failure respiratory failure with chronic obstructive depression, shortne hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, syndrome, sleep apperipheral vascular osteoporosis, chronic benign prostatic hypothyroidism, chronic decisions. The bathing; extensive toileting, and hygier | ~ | F 7 | 756 | | | |
| | Practical Nurse) wa administering the for Resident #83: Synthroid [1] 25 mo 7:30a.m.) Allopurinol [2] 100 r Breo [3] 200-25 mo Iron [4] 325 mg Neurontin [5] 300 m Hydralazine [6] 50 r Metoprolol [7] 100 r Miralax [8] 17 gm (g Zoloft [9] 100 mg Spiriva [10] 18 mcg | g ng ng ng grams) (resident refused) | | | | | |
| : | Colace [11] 100 mg On 3/28/18 at 8:58 | (resident refused) a.m., LPN #2 took the above | | | | | : |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------|--|----------|-------------------------------|--|
| | | 495142 | B. WING | | | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 0.00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULDBE | (X5) COMPLETION DATE | |
| F 756 | them, including adr Iron together. The shour and a half late after the resident have an empty stor administered at lea | ident #83 and administered ministering the Synthroid and Synthroid was administered an er than the scheduled time, ad eaten breakfast and did not | F 7 | 756 | | | |
| | 2017 Physician's O indicated the Synth and the Iron was or of the March 2017 Record revealed th 7:30a.m. and the Ir 9:00a.m. Further revealed the month resident's medicatic | rder Sheet. This document roid was ordered on 1/31/18 dered on 11/30/17. A review Medication Administration e Synthroid was scheduled for on was scheduled for review of the clinical recorduly pharmacy review of the on regimen, for February 2017. | | | | | |
| | nurses should have synthroid are being together. LPN #2 s When asked why the administered at the | a.m., LPN #2 was asked if e identified the iron and administered too close stated that they should have. The Synthroid was not scheduled time of 7:30 a.m., four and a half late, LPN #2 o reason. | | | | | |
| | #7 (Other Staff Mer that a lot of meds ir Synthroid. OSM #7 be separated by 4 han empty stomach. | a.m. in an interview with OSM mber, a pharmacist), he stated nterfere with the absorption of stated it (Synthroid) should nours from iron, and taken on OSM #7 stated he should irregularity. When informed ng this medication's | | | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED | | |
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| | | 405442 | | | | 1 | С |
| | | 495142 | B. WING | | | 03/ | 30/2018 |
| | PROVIDER OR SUPPLIER | EHAB | | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 756 | were obtained from he stated the inform be the FDA approvemedication. *According to Synth - "Use SYNTHROI doctor. Take SYNT preferably on an enhour before breakfa Products such as ir and antacids can leabsorb levothyroxin | ministration recommendations the website Synthroid.com, nation on that website would ed information for this proid.com, D only as ordered by your HROID as a single dose, npty stomach, one-half to one | F 7 | 756 | | | |
| | Staff Member, a Nu Synthroid should be before a resident e | o.m., ASM #5 (Administrative urse Practitioner) stated that e given a half-hour to an hour ats breakfast; and that "It many hours before or after ber why." | | | | | · · · · · · · · · · · · · · · · · · · |
| | Regimen Review (No Regimen Review (No feed the medication region of the goal of promoting minimizing adverse with medication. To identifying, reporting medication-related or other irregularities members of the interpretation of the interpreta | lity policy, "Medication documented, "Medication MRR) is a thorough evaluation egimen by a pharmacist, with a positive outcomes and consequences associated he review includes preventing, g, and resolving problems, medication errors, es in collaboration with other erdisciplinary team." | | | | | |
| | meeting, the Admin | istrator (ASM) #1, Director of and the facility owner (ASM | | : | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | | TE SURVEY MPLETED |
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| | | 495142 | B. WING | - | | i | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | | 00/201 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 756 | | age 281 are of the findings. No further ovided by the end of the | F 7 | 756 | | | |
| : | Information obtaine | ed to treat thyroid deficiency. ed from s.gov/druginfo/meds/a682461.h | | | | | |
| : | [2] Allopurinol is use Information obtaine https://medlineplustml | | | | | | |
| | pulmonary disease Information obtaine | | : | | | | |
| | Information obtaine https://vsearch.nlm meta?v%3Aproject medlineplus-bundle | reat iron deficiency. ed from n.nih.gov/vivisimo/cgi-bin/query- t=medlineplus&v%3Asources= e&query=iron&_ga=2.3413386 2702603-191684010.15108527 | : | | | | |
| | postherpetic neural syndrome. Information obtaine | ed to treat seizures, lgia, and restless leg ed from a.gov/druginfo/meds/a694007.h | | | | | |
| : | [6] Hydralazine is u pressure. Information obtaine | used to treat high blood | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | ISTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|--|---|--------------------|-----------|--|---|--|--|
| | | 495142 | B. WING | | · <u></u> | 03/30/2018 | | |
| | PROVIDER OR SUPPLIER | | | 380 MII | ADDRESS, CITY, STATE, ZIP CODE LLWOOD AVENUE LESTER, VA 22601 | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | DBE COMPLÉTION | | |
| F 756 | tml [7] Metoprolol is us pressure. Information obtaine | s.gov/druginfo/meds/a682246.h | F 7 | 756 | | | | |
| | tml [8] Miralax is used Information obtain | to treat constipation. ed from s.gov/druginfo/meds/a603032.h | | | | | | |
| : | Information obtained https://medlineplustral [10] Spiriva is used pulmonary disease Information obtained https://medlineplustral | ed from s.gov/druginfo/meds/a697048.h d to treat chronic obstructive e. ed from s.gov/druginfo/meds/a604018.h | | | | | | |
| | Information obtain https://medlineplus ml Free from Unnec I CFR(s): 483.45(c) §483.45(e) Psychology \$483.45(c)(3) A psychology affects brain activity processes and believed. | s.gov/druginfo/meds/a601113.ht Psychotropic Meds/PRN Use n(3)(e)(1)-(5) | | 758 1. | F758 Corrective action has been accomplalleged deficient practice in regards #97, 235, and 99. Resident #97 had appropriate diagnosis added for Ser Resident # 235 had an appropriate danxiety for Xanax, and resident #99 reeducated to document non-pharma interventions attempted before medipm anti-anxiety medication. | to resident an oquel, iagnosis of nurse was acological | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|---------------------------------|--|---|----------------------------|
| | | 495142 | B. WING _ | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 M | ET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE CHESTER, VA 22601 | 1 00 | 30/2016 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | : | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | sychotropic drugs unless the medicati specific condition as in the clinical record \$483.45(e)(2) Residugs receive gradubehavioral intervent contraindicated, in a drugs; \$483.45(e)(3) Residugs; \$483.45(e)(3) Residugs; \$483.45(e)(3) Residugs; \$483.45(e)(4) PRN are limited to 14 day \$483.45(e)(5), if the prescribing practition appropriate for the Febeyond 14 days, he rationale in the residudicate the duration | hensive assessment of a must ensure that lents who have not used are not given these drugs on is necessary to treat a diagnosed and documented it; lents who use psychotropic and dose reductions, and ions, unless clinically an effort to discontinue these pursuant to a PRN order on is necessary to treat a condition that is documented; and orders for psychotropic drugs as. Except as provided in attending physician or ner believes that it is PRN order to be extended or she should document their lent's medical record and | F 75 | 3.5. | Current facility residents have the affected by the alleged deficient processor Assurance Nurse or designee will of 100% audit of psychotropic medical proper diagnosis and documentation non-pharmacological interventions, residents a week x 4 weeks, then 20 month x 2 months. Measures put into place to assure a deficient practice does not recur in will be reeducated to add approprial psychotropic medications and documentation with proper policy. The Director of Nursing and/or designallyze/review for patterns/trends at the Quality Assurance committee in quarterly for a minimum of six more evaluate the effectiveness of the place adjust the plan as the committee material recommend, based on outcomes/tree from date. Completion Date: May 11, 2018 | actice. Qual complete a utions for n, including then 10 0 residents a lleged clude: Nurse te diagnosis ment non- inpted befor nedications ignee will and report in teeting withs to in and will | e s to |
| 1 | drugs are limited to | orders for anti-psychotic 14 days and cannot be attending physician or | | : | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|---------------------|--|----------------------|--|--|
| | | 495142 | B. WING _ | | 03/30/2018 | | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLÉTION | | |
| F 758 | the appropriatenes This REQUIREME by: Based on staff intereview, and clinical determined the fact of 31 sampled residand #99) were free 1. The facility staff appropriate diagnouse Quetiapine Fur antipsychotic medical. 2. The facility staff appropriate diagnouse Appropriate diagnouse | oner evaluates the resident for s of that medication. NT is not met as evidenced erview, facility document record review, it was illity staff failed to ensure three dents, (Residents #97, #235 of unnecessary medications. failed to ensure there was an sis for the administration and marate (Seroquel) an cation, for Resident #97. failed to ensure there was an sis for the use of Xanax an ation, for Resident #235. failed to ensure there were documented and cal interventions were se of an anti-anxiety ident #99. | F 75 | · · · · · · · · · · · · · · · · · · · | | | |
| | 1. The facility staff appropriate diagnouse Quetiapine Fur antipsychotic media Resident # 97 was 11/19/17, with a model of the state of | failed to ensure there was an sis for the administration and marate (Seroquel) an cation, for Resident #97. admitted to the facility on est recent readmission on loses that included but were not infections, hypotension (too low alnutrition, depression, asthma, and has a colostomy. | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | LTIPLE CONSTRUCTION DING | | ATE SURVEY DMPLETED |
|--------------------------|---|---|----------------------|--|-----------|----------------------------|
| | | 495142 | B. WING | - | <u>a</u> | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 0,00,2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD BE | (X5) COMPLETION OATE |
| F 758 | assessment, a Me with an assessme coded the resident (brief interview for she was capable of Section N - Medicas receiving sever medication during The physician ord "Quetiapine Fuma (milligrams); give related to other sp. *Quetiapine Fuma antipsychotic medication for the con 3/15/18, failed to ethe use of an antip Resident #97. | page 285 MDS (minimum data set) edicare 14 day assessment, ent reference date of 2/27/18, et as scoring a 15 on the BIMS emental status) score, indicating of making her daily decisions. In ations, the resident was coded en days of an antipsychotic ethe look back period. eer dated, 3/15/18, documented, earate * Tablet 100 mg ethe tablet by mouth at bedtime elecified anxiety disorders." earate (Seroquel) is an elication used to treat est bipolar disorders. (1) exprehensive care plan dated, evidence a care plan to address esychotic medication for conducted with administrative M) #5, the nurse practitioner on | | 758 | | |
| | 3/29/18 at approx why Resident #97 stated, "That was psychiatrist). He w When asked if Se anxiety, ASM #5 s in this setting. I de #5 verified the ord ASM #5 stated, "T as I am the full tim asked if that make | imated 1:20 p.m. When asked was on Seroquel, ASM #5 prescribed by (name of would give the diagnosis for it." roquel is administered for stated, "I would not use that here efer to psych (psychiatry). ASM ler was written under her name. They put them under my name ne nurse practitioner." When es her responsible for those tated, "It means I agree with | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|-------------------------------|----------------------------|--|
| | | 495142 | B. WING | | 03 | C 3/ 30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 758 | Continued From pa | ge 286 | F 7 | 58 | | | |
| | QA (quality assurar p.m. When asked in Resident #97, LPN her. She came from An interview was condirector of nursing, regarding what Sensan antipsychotic maschizophrenia, Tour psychotic diagnose the physician order When asked if the estated, "No, it's not. record and I can't find an acceptable of the facility policy," documented, "Policy will be free of unner Procedure: 1. All psappropriate diagnos reviewed by pharma addressed with the psychotropic medic psychiatrist or phys." | Psychotropic Drug Policy" y: All resident drug regimen cessary psychotropic drugs. sychotropic drugs will have an sis. 2. Medications will be acy monthly and concerns physician. 3. The resident on ation will be followed by a ician. ASM #1, director of nursing, | | | | | |
| | | of the facility, ASM #7, were above findings on 3/29/18 at | | | | : | |
| | No further informati | on was provided prior to exit. | | i i | | | |
| | following website: | was obtained from the | | | | : | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | , 00, | 00/2510 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PREFIX (EACH CORRECTIVE ACTION SHOUL | | BE | (X5) COMPLETION DATE |
| F 758 | 2. The facility staff appropriate diagnoranti-anxiety medicanti-anxiety medicanti-anxiety medicanti-anxiety medicanti-anxiety medicanti-anxiety medicanti-anxiety medicanti-anxiety facility and musc characterized by restooped posture, redrooling, and musc chronic obstructive (COPD - a general non-reversible lung | failed to ensure there was an usis for the use of Xanax an ation, for Resident #235. Is admitted to the facility on uses that included but were not of her leg, Parkinson's disease we neurological disorder esting tremor, shuffling gait, colling motions of the fingers, cle weakness) (1), falls, and e pulmonary disease (COPD) | F 7 | 58 | | | |
| | set) assessment of The "Nursing Admi 3/22/18 documents oriented to time, pl The physician order "Xanax* Tablet 0.2 tablet by mouth evinsomnia take one for sleep." There we "Xanax is used to tincluding anxiety caused to treat panic | er dated, 3/22/18, documented, 5 MG (milligrams); Give 1 ery 24 hours as needed for tab (tablet) at night as needed as no stop date ordered. Treat symptoms of anxiety, aused by depression. It is also attacks in some patients." (3) | | | | | |
| | | ministration record for March "Xanax Tablet 0.25 MG: Give | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|-----------------------------|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | - | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE | (X5) COMPLETION OATE |
| F 758 | insomnia take one sleep." The medic administered since Review of the care evidence documenthe use of an anti-An interview was opractical nurse) #1 When asked what stated, "For anxiet be prescribed for shelieve so." When PRN (as needed) used, LPN #10 stated, LPN #10 stated, and LPN medication should | every 24 hours as needed for ation had not been e admission to the facility. e plan dated, 3/22/18, failed to ntation related to insomnia or anxiety medication. conducted with LPN (licensed 10, on 3/29/18 at 8:44 a.m. Xanax is used for, LPN #10 is. When asked if Xanax can sleep, LPN #10 stated, "I don't asked how long a prescribed anti-anxiety medication can be ated, he would need to check. #10 stated, "A PRN anti-anxiety be re-evaluated every 14 if it should have a stop date, | F 758 | | | |
| | staff member (AS 3/29/18 at 9:03 a.i used for, ASM #5 asked if it can be stated, "I don't usu resident is having (psychiatry)." Whe anti-anxiety medic ASM #5 stated, "T | conducted with administrative M) #5, the nurse practitioner, on m. When asked what Xanax is stated, "Mostly anxiety." When prescribed for sleep, ASM #5 vally prescribe that if the problems, then I refer to psychen asked how long a PRN eation can be prescribed for, The new regulations are for it to 14 days and then reevaluated." | | | | |
| | of the facility were findings on 3/29/1 | , director of nursing and owner made aware of the above 8 at 6:10 p.m. | | | | : |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | • |
|--------------------------|---|---|----------------------|---|-------------------------------|---|
| | | 495142 | B. WING | | C 0 3/30/2018 | |
| | PROVIDER OR SUPPLIER | · | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION | 7 |
| F 758 | Continued From pa | ge 289 | F 7 | 58 | | |
| | Non-Medical Reade Chapman, page 43 (2) Barron's Diction Non-Medical Reade Chapman, page 12 (3) This information following website: https://www.ncbi.nlr.T0008896/?report=3. The facility staff it targeted behaviors non-pharmacologic attempted for the unanti-anxiety medical Resident #99 was a 6/9/17 and readmitt that included but we | ary for Medical Terms for the er, 5th edition, Rothenberg and 4. In was obtained from the m.nih.gov/pubmedhealth/PMH details. Failed to ensure there were documented and al interventions were se of Lorazepam an antion, for Resident #99. Admitted to the facility on the don 2/26/18 with diagnoses ere not limited to: heart failure, a, depression and cognitive | | | | |
| | significant change a (assessment refere resident as 99 on the mental status) indicable to complete the coded as understar understood and have memory. The reside assistance for all action Review of the reside 3/19/18 documente anti-anxiety medical disorder. Intervention | DS (minimum data set), a assessment, with an ARD ence date) of 3/5/18 coded the ne BIMS (breif interview for eating the resident was not e exam. The resident was ading others and being ving intact short and long-terment was coded as requiring ctivities of daily living. ent's care plan initiated on d "Focus. The resident uses tions r/t (related to) Anxiety ons. Monitor/record ic) target behavior symptoms | | | | |

| STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | (X2) MUL A. BUILO | TIPLE CONSTRUCTION | () | (X3) OATE SURVEY COMPLETEO | |
|---|--|---|----------------------|---|------------|-------------------------------|--|
| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIOER OR SUPPLIER | | | STREET AOORESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | OOE | | |
| (X4) IO PREFIX TAG | (EACH OEFICIENC | TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION) | IO PREFI TAG | | N SHOULO B | | |
| F 758 | documented, "LOF (milligrams) Give hours as need for Review of the Mar administration reco"LORazepam Tablet by mouth evanxiety." It was do received the medic 2018. Review of the MAF documentation regord agitation. | r facility protocol." rch 2018 physician's orders Razepam (1) Tablet 0.5 MG 1 tablet by mouth every four anxiety." rch 2018 medication cord (MAR) documented, let 0.5 MG (milligrams) Give 1 very four hours as need for ocumented that the resident ication eleven times in March R did not evidence garding the resident's behaviors | F 7 | 758 | | | |
| | documentation as behaviors or why to on one occasion. An interview was op.m. with LPN (lice When asked about to giving an anti-arstated, "You would LPN #9 stated, "Trwith him, change to When asked if tha #9 stated, "Yes the non-pharmacologic When asked when stated, "In the nurs Resident #99's target stated, "He's very of the one of the work of the stated, "He's very of the one of the work of the stated, "He's very of the one of the work of the w | se's notes did not evidence to the resident's targeted the lorazepam was given except conducted on 3/29/18 at 2:32 ensed practical nurse) #9. ut the process staff follows prior nxiety medication, LPN #9 d go in and assess his anxiety." ry to distract them. Verbalize the TV show, put on music." at would be documented, LPN ere should be some ical items that are written." re that would be written, LPN #9 ses' notes." When asked about rgeted behaviors, LPN #9 obvious, he gets hallucinations usion." When asked to review | | | | | |

| ANO PLAN OF CORRECTION 10EN | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | COV | (X3) OATE SURVEY COMPLETEO | |
|--|---|---------------------|---|---|-------------------------------|--|
| | 495142 | B. WING | | 1 | C /30/2018 | |
| NAME OF PROVIOER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | STREET AOORESS, CITY, STATE, 2 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) IO SUMMARY STATEMENT OF PREFIX (EACH OEFICIENCY MUST BE REGULATORY OR LSC IOENTI | PRECEOEO BY FULL | IO PREFIX TAG | PROVIOER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCEO TO OEFICIENCE | TION SHOULO BE THE APPROPRIATE | (X5) COMPLETION OATE | |
| the resident's notes for the administration, LPN #9 state as it should be." On 3/29/18 at 6:00 p.m. AS member) #1, the administration director of nursing and ASN were made aware of the fine No further information was 1. Lorazepam Lorazepam benzodiazepine used widel anxiety and insomnia. As well been associated with serum alkaline phosphatase eleval apparent liver injury from loreported and must be very This information was obtain https://livertox.nih.gov/Lora Label/Store Drugs and Biol CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drug By and biologicals used labeled in accordance with professional principles, and appropriate accessory and instructions, and the expiral applicable. §483.45(h) Storage of Drug Syas.45(h)(1) In accordance Federal laws, the facility must biologicals in locked compatemperature controls, and get a controls and get appropriate accessory and instructions. | ed, "That's not written M (administrative staff ator, ASM #2, the M #7, the facility owner dings. provided prior to exit. In is an orally available yin the therapy of with most m therapy has not n aminotransferase or tions, and clinically razepam has not been rare, if it occurs at all. ned from: zepam.htm ogicals gs and Biologicals in the facility must be currently accepted include the cautionary tion date when gs and Biologicals es with State and ust store all drugs and artments under proper | | | actice in regards to f Levemir insulin on ed bottle of lorazepan in refrigerator, and an zepam intensol in the on the journey unit. Bened and an open date bottle, the bottles of yed and reordered and | e | |

| 0 12. 1 1 1 1 | TO TOTTIME DIONITE | G WILDIOAID OLIVIOLO | | | | 1 650-0260 ONL BIND |
|---------------|-----------------------------------|---|--------------|-----|---|-------------------------------|
| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495142 | B. WING | | | C 02/20/2040 |
| N14145 05 | | 100112 | | | | 03/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | |
| EVERGE | REEN HEALTH AND R | EUAD | | 38 | 80 MILLWOOD AVENUE | |
| LVLICON | CENTIESEIN AND K | ENAB | | W | INCHESTER, VA 22601 | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | · | PROVIDER'S PLAN OF CORRECTIO | N (VE) |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE COMPLETION |
| F 761 | Continued From pa | ge 292 | F 7 | 761 | 2. Current facility residents have the p | |
| | personnel to have a | = | | | be affected by the alleged deficient 100% audit of the facilities medicated | ion carts |
| | C400 45/k\/0\ TI 4 | | | : | and medication refrigerators were a | |
| | | facility must provide separately | | ! | the Unit Managers for expired and | |
| | | y affixed compartments for | | : | medications. The Unit Managers or | |
| | | d drugs listed in Schedule II of | | : | will audit med carts and med refrig | |
| | | Drug Abuse Prevention and | | - 1 | daily x 4 weeks then weekly x 2 mo | onths to |
| | | and other drugs subject to | | | assure compliance. | |
| | | n the facility uses single unit | | | Measures put into place to assure al | |
| | | bution systems in which the | | : | deficient practice does not recur inc | |
| | quantity stored is m | inimal and a missing dose can | | į | Nurses were reeducated to date med | dication |
| | be readily detected. | | | | bottles when opened per policy. | |
| | This REQUIREMEN | NT is not met as evidenced | | | The Director of Nursing and/or des | |
| | by: | : | | : | analyze/review for patterns/trends a | |
| | Based on observat | ion, staff interview and facility | | | the Quality Assurance committee n | |
| | document review, it | was determined that the | | | quarterly for a minimum of six mor | |
| | facility staff failed to | label and store medications | | | evaluate the effectiveness of the pla | |
| | in a safe manner in | one of seven medication | | | adjust the plan as the committee ma | |
| | | cart on wing three) and two of | | | recommend, based on outcomes/tre | nds |
| : | | refrigerators (wing three unit | | | identified from date. | |
| | and journey unit). | 5 - (5 | | | 5. Completion Date: May 11, 2018 | |
| | | ailed to label an open date on | | | | |
| | a vial of opened lev | emir insulin in a medication | | | | |
| - | cart on wing three. | | | • | | |
| | 2. The facility staff f | ailed to label an open date on | | - | | |
| | | orazepam intensol in the wing | | : | | |
| | three medication re | frigerator | | • | | |
| i | | | | | | |
| | 3. The facility staff fa | ailed to label an open date on | | | | · |
| | a bottle of opened lo | orazepam intensol in the | | | | ; |
| | | ator on the journey unit. | | ŀ | | ; ; |
| į | | | | | | |
| | The findings include | e: | | | | ; |
| | 1. The facility stoff for | oiled to lebel on ones data | | 1 | | |
| | | ailed to label an open date on | | | | |
| | a vial of opened leve | | | | | |
| | medication cart on v | wing inree. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-------------------|-----|--|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | L | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | 1 00 | 100/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 761 | medication cart or LPN (licensed pracof levemir insulin vart. The vial was LPN #2 was asked vial of levemir is of an open date on it stated, "So we know confirmed no open levemir. The levemir manu documented, 'Refribe discarded 42 di Unrefrigerated LEV | age 293 50 a.m., observation of a wing three was conducted with ctical nurse) #2. An open vial was observed in the medication not labeled with an open date. d what should be done when a pened. LPN #2 stated, "Write ." When asked why, LPN #2 bw when it expires." LPN #2 of date was labeled on the vial of facturer's instructions rigerated LEVEMIR vials should ays after initial use. VEMIR vials should be after they are first kept out of | | 761 | | | |
| | Expiration of Mediand Needles" doct medication or biological folloguidelines with resupened medication the date opened owhen the medication date once opened. On 3/29/18 at 5:48 member) #1 (the addrector of nursing above concern | acy policy titled, "Storage and cations, Biologicals, Syringes umented, "5. Once any ogical package is opened, ow manufacturer/supplier spect to expiration dates for ins. Facility staff should record in the medication container on has a shortened expiration." Spm., ASM (administrative staff administrator) and ASM #2 (the of were made aware of the staff staff was presented prior to exit. | | | | | |
| | (1) Levemir insulin | is used to treat diabetes. This stained from the website: | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | CONSTRUCTION | (X3) DAT | E SURVEY MPLETED |
|--------------------------|--|---|----------------------|---|---------------------------------------|----------|----------------------------|
| | | 495142 | B. WING | | - | | C |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | 1 57 17 11 10 | | REET ADDRESS, CITY, STATE, ZIP CODE | 03/ | /30/2018 |
| EVERGE | REEN HEALTH AND R | REHAB | | 380 | MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY) | |) BE | (X5) COMPLETION DATE |
| F 761 | | age 294 .gov/druginfo/meds/a606012.h | , F | 761 | | | |
| | 2. The facility staff a bottle of opened wing three medical | failed to label an open date on lorazepam intensol (1) in the ion refrigerator. | | | | | |
| | On 3/28/18 at approximately 10:50 a.m., observation of the wing three medication refrigerator was conducted with LPN (licensed practical nurse) #2. An open bottle of lorazepam intensol was observed in the refrigerator. The bottle was not labeled with an open date. LPN #2 was asked if staff should have labeled the bottle with an open date. LPN #2 stated, "They should have." When asked why, LPN #2 stated, "Cause it's only good for a certain amount of time after opened." | | | | | | : |
| | | ensol manufacturer's ented, "Discard opened bottle | | | | | |
| | Expiration of Medic and Needles" docu medication or biolo Facility should follo guidelines with responsed medication the date opened or | acy policy titled, "Storage and cations, Biologicals, Syringes mented, "5. Once any gical package is opened, w manufacturer/supplier pect to expiration dates for s. Facility staff should record in the medication container on has a shortened expiration | | | | | |
| | member) #1 (the ad | pm., ASM (administrative staff dministrator) and ASM #2 (the were made aware of the | | i | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|----------|---|-------------------------------|----------------------------|
| | | 4 95142 | B. WING | | | 03 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION OATE |
| F 761 | Continued From p | age 295 | F 7 | '61 ' | | | |
| | No further informa | tion was presented prior to exit. | | | | | |
| | This information w | ensol is used to relieve anxiety. as obtained from the website: s.gov/druginfo/meds/a682053.h | | | | | |
| | a bottle of opened | failed to label an open date on lorazepam intensol (1) in the rator on the journey unit. | | | | | |
| | journey unit medic conducted with LP An opened bottle cobserved in the relabeled with an opbottle was open withe bottle. LPN #1 medication was go LPN #1 stated the was 6/19/18 and the opened so she wo nursing if the mediamount of time after On 10/28/18 at appinterview was conducted. | proximately 10:50 a.m., an ducted with LPN #2. LPN #2 | | | | | |
| | lorazepam intenso confirmed they sho | should label a bottle of I with an open date and ould. When asked why, LPN it's only good for a certain er opened." | | | | | |
| | | ensol manufacturer's nented, "Discard opened bottle | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|----------|--|--|----------------------------|
| | | 49 514 2 | B. WING | | <u></u> | 1 | C / 30/2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | 380 M | ET ADDRESS, CITY, STATE, ZIP CODE IILLWOOD AVENUE CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 791 | Expiration of Medicand Needles" documedication or biolo Facility should follo guidelines with responent medication the date opened or when the medication date once opened. On 3/29/18 at 5:48 member) #1 (the addirector of nursing) above concern No further informat (1) Lorazepam inte This information was https://medlineplustml Routine/Emergence | acy policy titled, "Storage and cations, Biologicals, Syringes mented, "5. Once any gical package is opened, ow manufacturer/supplier pect to expiration dates for as. Facility staff should record a the medication container on has a shortened expiration " pm., ASM (administrative staff dministrator) and ASM #2 (the were made aware of the tion was presented prior to exit. ensol is used to relieve anxiety. as obtained from the website: a.gov/druginfo/meds/a682053.h | F7 | 791 | F791 | | |
| SS=D | §483.55(b) Nursing The facility- §483.55(b)(1) Musi- outside resource, in of this part, the follo- the needs of each | rvices ssist residents in obtaining ar emergency dental care. g Facilities. t provide or obtain from an n accordance with §483.70(g) owing dental services to meet resident: services (to the extent covered | | 2. | Corrective action has been acco the alleged deficient practice in facility failing to provide dental resident #37. A dental exam was Friday, March 30, 2018 for resident | regards to services for s scheduled o dent #37. he potential to ent practice. of residents ices or been off since 1, 2018 addressed, | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|----------|---|---|----------------------------|
| | | 495142 | B. WING | | _ | | | C (20/2018 |
| | PROVIDER OR SUPPLIER | | D . (1.1.) | STI 380 | 0 M | T ADDRESS, CITY, STATE, ZIP CODE ILLWOOD AVENUE CHESTER, VA 22601 | <u> U31-</u> | 30/2018 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | IX | - | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 791 | assist the resident- (i) In making appoir (ii) By arranging for dental services local §483.55(b)(3) Must residents with lost of dental services. If a 3 days, the facility in what they did to ens and drink adequate services and the ex led to the delay: §483.55(b)(4) Must circumstances whe dentures is the facil charge a resident for dentures determine policy to be the facil §483.55(b)(5) Must eligible and wish to reimbursement of d medical expense ur This REQUIREMEN by: Based on resident clinical record review facility staff failed to | t, if necessary or if requested, ntments; and r transportation to and from the | | | 3. 4. | Measures put into place to assure alle deficient practice does not recur inclus Social Workers will be reeducated to facility policy and procedure for dent services. The Director of Nursing and/or designanalyze/review for patterns/trends and the Quality Assurance committee mea quarterly for a minimum of six month evaluate the effectiveness of the plan adjust the plan as the committee may recommend, based on outcomes/trend identified from date. Completion Date: May 11, 2018 | ude: o follow tal nee will d report in eting as to and will | |
| i . | The facility staff faile as requested by Re | led to provide dental services esident #37. | | | | | : | : : |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|------------------------------|---|-------------------------------|----------------------------|
| | | 495142 | B. WING | | l ' | C 30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | <u>.l., .</u> | STI | REET ADDRESS, CITY, STATE, ZIP CODE | 1 00, | 30/2010 |
| EVERGR | REEN HEALTH AND R | EHAB | | 0 MILLWOOD AVENUE INCHESTER, VA 22601 | | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 791 | Continued From pa | age 298 | F 791 | | | |
| | The findings include | e : | | | | |
| | 1/17/17 and readm diagnoses that include heart failure, shortry and kidney disease. The most recent M quarterly assessment reference date) of the having scored 15 of interview for mental resident was cognit decisions. The resident was cognit decisions. The resident was resident was cognit decisions. The resident was resident was cognit decisions. The resident was resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. The resident was cognit decisions. | admitted to the facility on litted on 12/11/17 with uded but were not limited to: ness of breath, diabetes, stroke e. IDS (minimum data set), a lent, with an ARD (assessment 1/22/18 coded the resident as but of 15 on the BIMS (brief al status), indicating the litively intact to make daily lident was coded as requiring laff for all activities of daily living which the resident could lay was prepared. In section L us documented the resident ng no dental issues. | | | | |
| | p.m. with Resident resident stated that because she has many gums hurt sometime told it would be out afford them. When requested the dent couple weeks ago." Review of the clinical resident resident that the dent couple weeks ago." | cal record did not evidence parding the resident's request | | | | |
| | | conducted on 3/29/18 at 2:30 ensed practical nurse) #9. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | (| C |
| | | 495142 | B. WING |) | | 03/3 | 30/2018 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | SHOULD E | 3E | (X5) COMPLETION DATE |
| F 791 | When asked how resident's dental is (certified nursing a perform their oral we report it to the did if a resident wastated, "We would (nurse practitioner surgeon." | staff are made aware of a sues, LPN #9 stated, "CNAs assistants) are supposed to care, if there's any gum issues doctor." When asked what staff as requesting dentures, LPN #9 get a consult from the NP) to get an order for the oral | F. | 791 | | | |
| | a.m. with OSM (ot social worker. What ware a resident worker. What ware a resident worker. It they tell the staff. A ask if everything's When asked what resident who aske "For long term car Medicaid program dentist takes that it dentist and ask how Medicaid residents When asked why told the cost of the pocket if funds we OSM #3 stated, "Uthrough to get a many resident had rosm #37's request, OS ask me if I could fi insurance and it wabout the map adj | conducted on 3/30/18 at 9:23 her staff member) #3, the en asked how she was made was asking for dental services, they themselves tell me or Also in the care plan meeting. I okay vision and dental wise." the process was for a Medicaid d for dentures, OSM #3 stated, e residents I look at see what they have. I'll look to see what nsurance. I would call the w much would they cost, is could get a MAP adjustment." a Medicaid resident would be a dentures would be out of the available through Medicaid, I'm. It would have to be thought ap adjustment." When asked if ecently asked for dentures, lo." When informed of Resident M #3 stated, "She did recently nd out. I did check her as not covered." When asked ustment, OSM #3 stated, | | | | | |
| | that it could be do told the resident sl | e I wasn't thinking that far out ne for her." When asked if she ne would have to pay for her stated, "I did, sorry." | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|-----------------------------|--|---|----------------------------|
| | | 495142 | B. WING | | | | C / 30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 | EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE ICHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 791 | Continued From p | age 300 | F7 | ['] ' 91 | | | : |
| | staff member (ASI 3/30/18 at 8:52 a.r contract with a der did not. They do h will see resident, e have been addition new Medicaid rule social services is g for dentures. On 3/30/18 at app (administrative state administrator and were made aware No further informate Food Procurement CFR(s): 483.60(i)() §483.60(i) Food state or local authority in the facility mustate or local authority in the facilities from using gardens, subject to safe growing and it (iii) This provision from consuming forms. | tion was provided prior to exit. t,Store/Prepare/Serve-Sanitary 1)(2) afety requirements. cure food from sources dered satisfactory by federal, orities. le food items obtained directly ers, subject to applicable State | F | | F812 Corrective action has been accome the alleged deficient practice in refacility failing to store, prepare, as in a sanitary manner. The wet ness were immediately cleaned and dristorage rack containing steam tabic cleaned and free from debris. The educated on infection control and serving. Current facility residents have the be affected by the alleged deficient. The dietary manager or designeer stainless steel storage racks in the weekly x 30 days then monthly, to is no items wet nesting or in need. All racks in the kitchen will be poon an annual basis. Dining room of will be done in at least three dining weekly x 4 weeks, then one dining weekly x 2 months. | egards to nd serve food ted dishes ed and the le pans was estaff was proper food e potential to nt practice. will monitor kitchen to ensure ther of cleaning. wer washed observations g room areas | e |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDI | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|----------------|---|---|----------------------------|
| | | 495142 | B. WING | | | | C |
| NAME OF I | PROVIDER OR SUPPLIER | 700172 | D. 17/110 | | | | 30/2018 |
| | EEN HEALTH AND R | EHAB | | 380 N | ET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE CHESTER, VA 22601 | į | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | standards for food some standards for food some standards. This REQUIREMENT by: Based on observat document review, it facility staff failed to food in a sanitary man. The facility staff not wet nesting; and containing steam to from debris. The facility staff sanitary manner during steam to be servation. The facility staff is sanitary manner of a bow bare hands. The facility staff facility staff facility staff facility staff facility staff facility staff facility staff facility staff facility manner in the standard mann | dance with professional service safety. It is not met as evidenced ion, staff interview, and facility was determined that the store, prepare, and serve anner. failed to ensure dishes were I that a storage rack ble pans was clean and free failed to serve food in a ring the 3/27/18 dinner service cility staff touched the inside ere the resident would drink which served to residents with her served touching room. The served touching resident | F 8 | 3. 12 4. | deficient practice does not recur will be reeducated on infection of serving food to the residents. Die be reeducated on procedures of vand cleanliness of kitchen with a infection control. The Director of Nursing and/or danalyze/review for patterns/trend the Quality Assurance committed quarterly for a minimum of six in evaluate the effectiveness of the adjust the plan as the committee recommend, based on outcomes/identified from date. | include: Staff control r/t tary staff will yet nesting focus on esignee will s and report in meeting conths to plan and will may trends | |
| ! | The findings include | : | | | | | |
| | not wet nesting; and | ailed to ensure dishes were that a storage rack ble pans was clean and free | | : | | | |
| | kitchen was conduct | o.m., an inspection of the sed with OSM #1 (Other Staff manager). During this ving was observed: | | : | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING _ | (X3) DATE SURVEY COMPLETED | | |
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| | | 495142 | B. WING | | C 03/30/2018 |
| | PROVIDER OR SUPPLIER | | 38 | REET ADDRESS, CITY, STATE, ZIP CODE O MILLWOOD AVENUE INCHESTER, VA 22601 | 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | DBE COMPLÉTION |
| F 812 | drinking cups, which | e tubs containing plastic ch were all, stacked within each | F 812 | | |
| | a slightly tacky resi- rack surface, and d each shelf. A large pans were stored o the rim of the top si | wire-rack storage cart was with idue substance on the wire dust sticking to the surface on a assortment of steam table on this rack, inverted, so that ide that the food goes in, was be of the dusty, sticky rack | | | |
| | stated that these its way. She stated th | roximately 3:15 p.m., OSM #1 ems should not be stored this ne glasses should be dry before stated the wire rack is only | | | |
| | documented, "a. Di shelving and floor of | ility policy, "Food Storage" ry Storage Practice: 3. Keep clean and dry at all times." in the policy regarding the nes. | : | | |
| | made aware of the | OAM, the Administrator was findings. No further ovided by the end of the | | | |
| | According to the Fe regulations: | ederal Food and Drug | | | |
| | Nonfood-Contact S (A) Equipment food shall be clean to sig (B) The food-contact | nt, Food-Contact Surfaces, Surfaces, and Utensils. d-contact surfaces and utensils ght and touch. ct surfaces of cooking ns shall be kept free of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | TIPLE CONSTRUCTION | (X3) DA CO | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|--|--------------------------------|-------------------------------|--|
| | | 495142 | B. WING | | 03/30/2018 | | |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIF 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 70072010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| | accumulations. (C) Nonfood-contar be kept free of an a residue, and other 4-901.11 Equipmer Required. Items must be allow before being stacked items such as pans and may allow an emicroorganisms can of equipment and uthe possible transfer equipment or utens 2. The facility staff sanitary manner durobservation. A dining observation 5:20 p.m. CNA (cell was observed stirricher bare hands who where the resident left the dining room and returned with put into her pocket CNA #5 then took ther bare thumb ins served it to a reside An interview was op.m. with CNA #5. washed their hands contact with a resident contact with a resid | deposits and other soil of surfaces of equipment shall accumulation of dust, dirt, food debris. Int and Utensils, Air-Drying wed to drain and to air-dry ed or stored. Stacking wet is prevents them from drying environment where in begin to grow. Cloth drying atensils is prohibited to prevent er of microorganisms to sils. failed to serve food in a uring the 3/27/18 dinner service on was conducted on 3/27/18 at a triffied nursing assistant) #5 ng sugar into a cup of tea with ille holding the rim of the glass would drink from. CNA #5 then in without washing her hands appear covered straws that she and then sanitized her hands when it is a bowl of soup, put ide the rim of the bowl, and ent. Onducted on 3/29/18 at 3:45 When asked when staff is, CNA #5 stated after any lent. When the dining shared, CNA #5 stated, "Oh, I | F 8 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-----------------------|---|-------------------------------|----------------------------|--|
| | | 495142 | B. WING | | C 03/30/2018 | | |
| | PROVIDER OR SUPPLIER | EHAB . | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | IX5) COMPLETION DATE | |
| F 812 | member) #1, the addirector of nursing a were made aware of Review of the facility Washing" did not ad No further information 3. The facility staff is sanitary manner in facility staff were obplates, and food with On 3/27/17 at 5:30 experience was concertified nursing as grabbing the top (rinhands and giving the CNA #6 was observed in the same has served it to a different sanitize her hands in resident to her chair glass. At 5:33 p.m., holding a plate so couching her scrub plate to a resident. To observed for a second close to her body; it CNA #6 then served 5:41 p.m., CNA #6 to occasions using her | p.m. ASM (administrative staff dministrator, ASM #2, the and ASM #7, the facility owner of the findings. y's policy titled, "Hand ddress food service. on was provided prior to exit. ailed to serve food in a the journey dining room. The eserved touching resident the their bare hands. p.m., observation of the dining aducted. At 5:30 p.m., CNA esistant) #6 was observed m) of glasses with her bare em to residents. At 5:31 p.m., and guiding a resident to her earm. CNA #6 then grabbed and) the rim of a glass and ent resident. CNA #6 did not an between guiding the rand grabbing the rim of a condition of the condition of the served this At 5:38 p.m., CNA #6 was observed lose to her body; it was top. CNA #6 then served this At 5:38 p.m., CNA #6 was ond time holding a plate so was touching her scrub top. If this plate to a resident. At was observed on two rebare hands to remove a | F8 | 12 | | | |
| | the chicken. At 5:42 opening a butter wro Her bare fingers to | e of chicken so she could cut p.m., CNA #6 was observed apper with her bare hands. iched the edge of the butter en mixed the entire butter | | | | | |

| STATEMENT | F OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | T | (X3) DATE SURVEY | | |
|-------------------|----------------------|--|------------|-----|---|-----------|--------------------|
| AND PLAN | OF CORRECTION | DENTIFICATION NUMBER: | A. BUILD | | | COMPLETED | |
| | | | | | | C | |
| | | 495142 | B. WING | | | 03 | /30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| EVERGE | REEN HEALTH AND R | EHAB | | | BO MILLWOOD AVENUE | | |
| | | | | N | VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREF | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL | D BE | (X5) COMPLETION |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROF DEFICIENCY) | PRIATE | DATE |
| | | | <u> </u> | | | | <u> </u> |
| F 812 | Continued From pa | nge 305 | F | 312 | | | : |
| | square into a puree | e dish and served this to a | | | | | |
| | | id not sanitize her hands | | | | | |
| | during the entire di | ning observation. | | | | | |
| | On 3/29/18 at 4:54 | p.m., an interview was | | | | | |
| | | A #6. When asked how she | | | | | |
| | : | residents in a sanitary | | | | | |
| | | ated that she would not touch | | | | | |
| | · | is possible. When asked if | | | | | |
| | | e food during dinner on | | | · · | | |
| | | ated that she might have | | | | | • |
| | touched something | . When asked why the staff | | | | | : |
| | should not be touch | ning food with their bare | : | | | | |
| | hands, CNA#6 sta | ted that hands could transfer | | | | | |
| | germs. CNA #6 sta | ted she also did not wash her | | | | | |
| | hands in between s | serving residents. When | | | | | |
| | asked how she sho | ould hold a plate, CNA#6 | | | | | |
| | | nold the plate away from her | | | | | 1 |
| | | why a plate should not be | | | | | |
| | | p, CNA #6 stated, "For the | | | : | | : |
| | | A#6 stated germs from the | | | | | |
| | | transferred to to the plate. | | | | | |
| | | e could be bodily fluids on | : | | | | |
| | | ce they stand close to | | | | | |
| | | nging and turning them. CNA | | | | | |
| | | night have been holding the | | | | | |
| | plate too close to h | er scrub top. | | | | | : |
| | On 3/29/18 at 5:47 | p.m., ASM (administrative | | | | | • |
| | | the administrator, ASM #2, the | 1 | | | | : |
| | | ursing) and ASM #7, the facility | | | | | |
| | | aware of the above concerns. | | | | | 1 |
| | | pe provided regarding the | : | | | | |
| | above concerns. | | : | | | | |
| F 842 | | - Identifiable Information | F | 842 | | | ! |
| SS=D | | | | | | | : |
| -U- D | | -,,(-,(-, (-) | : | | | | |
| | §483.20(f)(5) Resid | lent-identifiable information. | | | ! ' | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | & MEDICAID SERVICES | | | | MB NO. | 0938-0391 |
|--|--|--|--|-------|--|---|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | ONSTRUCTION | | E SURVEY IPLE TED |
| | | 495142 | B. WING _ | | | 1 | C 30/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | <u>' </u> | STREE | ET ADDRESS, CITY, STATE, ZIP CODE | , , , , , , | |
| | | | | 380 N | ILLWOOD AVENUE | | |
| EVERGR | EEN HEALTH AND R | EHAB | | | CHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 842 | (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extent to do so. §483.70(i) Medical services (i) Medical services (ii) Medical standards must maintain med that are- (i) Complete; (ii) Accurately docur (iii) Readily accessitives (iv) Systematically of services (iv) Systematically of services (iv) Systematically of services (iv) Systematically of services (iv) To the individual, representative where (ii) Required by Law (iii) For treatment, poperations, as permy with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial array enforcement pupurposes, research medical examiners, a serious threat to health neglect. | release information that is to the public. release information that is to an agent only in contract under which the agent release the information the facility itself is permitted records. Fordance with accepted and practices, the facility itself records on each resident records on each resident records on each resident records on each resident records and practices, the facility itself records on each resident records on each resident remeted; ble; and reganized release is or their resident records repermitted by applicable law; or their resident records and in compliance records on ealth care release is repermitted by and in compliance repermitted by and in compliance repermitted by and in compliance repermited, reporting of abuse, or violence, health oversight administrative proceedings, reposes, organ donation purposes, or to coroners, funeral directors, and to avert realth or safety as permitted | F 84 | 1. | Corrective action has been accomplished alleged deficient practice in regard paper containing the resident's name information for wing 2 was found on in resident #234 room. The paper was and the CNA was educated on HIPA importance of protecting health infor For resident #130, the resident did not complete documentation of resident's of oxygen therapy. Documentation to the resident's record to reflect the oxygen and a care plan was developed resident's refusal also. Current facility residents have the post of the affected by the alleged deficient part and an audit of daily rounds will be mad unit manager or designee of the units weeks, then biweekly x 4 weeks, the 4 weeks, to assure no health informat unattended in a resident area, assuring compliance. An audit of 20 resident's will be audited for resident refusals at then 20 residents x 2 months. Care pushed be updated as needed. Measures put into place to assure all deficient practice does not recur includes and compliance of conficient practice does not recur includes and compliance of Nursing and/or designallyze/review for patterns/trends at the Quality Assurance committee magnature of the plan as the committee magnature of the plan as the committee magnature of the plan as the committee magnetic of the plan as | ds to a s and a dresser s removed A and the mation. of have s refusal was added refusal of od for otential to oractice. We by the s x 4 n weekly x tion is a HIPAA s records x 4 weeks, lans will eged ude: d on dentiality gnee will nd report in eeting ths to a and will y | |
| i | | ealth or safety as permitted be with 45 CFR 164.512. | | : | recommend, based on outcomes/trer identified from date. | ıds | |

5. Completion Date: May 11, 2018

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
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| | | 4 95142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | ЕНАВ | , | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | COMPLETION OATE | |
| F 842 | record information unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under State §483.70(i)(5) The m (i) Sufficient information in A record of the results of a and resident review determinations conce (v) Physician's, nursy professional's progressional's prog | acility must safeguard medical against loss, destruction, or cal records must be retained are required by State law; or the date of discharge when ment in State law; or rears after a resident reaches ate law. Inedical record must containation to identify the resident; esident's assessments; isive plan of care and services any preadmission screening or evaluations and ducted by the State; se's, and other licensed | F 8 | B42 | () | | |
| | #234 and #130.1. A paper, containing the unit and some of | ne survey sample, Resident ng all the resident names on of the vital signs recorded, was er in Resident #234's room. | | | | | |
| | 2. The facility staff f | ailed to document Resident | | | | : | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | | C 03/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 00/00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | HOULD BE | (X5) COMPLETION DATE | |
| F 842 | the unit and some of found on the dress. Resident #234 was 3/13/18 with diagnor limited to: fracture of chronic obstructive (COPD - a general non-reversible lung combination of emplorements). (1). The most recent Massessment, an adassessment refere resident as scoring interview for mental was capable of material was a sessioned in the resident of #234's unit was found fresser in Resident contained names, woxygen, if the resident dand what kind of lift required. The dresser | e: ning all the resident names on of the vital signs recorded, was er in Resident #234's room. admitted to the facility on oses that included but were not of her left femur, pain and pulmonary disease (COPD) | | .42 | | | |
| | beds. Resident #23 chair in the corner. paper to get to her | 34's daughter was sitting in the She would have passed the mother's side of the room. The the dresser from 8:15 a.m. | | | | | |

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

Event ID: QP4M11

Facility ID: VA0218

If continuation sheet Page 309 of 328

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| | OF DEFICIENCIES OF CORRECTION | (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
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| | | | | | | С |
| | | 495142 | B. WING | | | 03/30/2018 |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | EHAB | | STREET ADDRESS, CITY, STATE, 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | CTION SHOULD THE APPROPE | BE COMPLÉTION |
| | into Resident #234' paper should be in it shouldn't be here. The facility policy, "Storage" document this facility to maintaconfidential personasensitive data it coll when applicable." The administrator, a (ASM) #1, director of owner of the facility of the above finding. No further information. When applicable in the facility of the above finding. No further information. When a policient is a facility staff of the facility staff for the facility staff fo | a.m., this surveyor (licensed practical nurse) #4 s room. When asked if the the room, LPN #4 stated, "No, " Electronic Medical Record red in part, "It is the policy of ain the privacy and security of al information and other highly lects in electronic format, administrative staff member of nursing, ASM #2, and r, ASM #7, were made aware as on 3/29/18 at 6:10 p.m. ion was provided prior to exit. ary for Medical Terms for the er, 5th edition, Rothenberg and 4. failed to document Resident regen. admitted to the facility on red on 2/2/18. Resident included but were not limited to the sand urinary tract infection. The passessment with an ARD ance date) of 3/9/18, coded the rely intact. #130's clinical record | F & | 842 | | |
| i | revealed a physicial | n's order dated 2/2/18 that Oxygen) @ (at) 2L (Liters) via | ! | | | : : : |

| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 842 Continued From page 310 n/c (nasal cannula) may titrate as needed." On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen. On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | I , , | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| EVERGREEN HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTION SHOULD BE COMPETING INFORMATION) F 842 Continued From page 310 n/c (nasal cannula) may titrate as needed." On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen. On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The | | | 495142 | B. WING | | 03 | |
| F 842 Continued From page 310 n/c (nasal cannula) may titrate as needed." On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen. On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The | | | | | 380 MILLWOOD AVENUE | | <u> </u> |
| n/c (nasal cannula) may titrate as needed." On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen. On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The | PRÉFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | PREFI | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | I SHOULD BE | (X5) COMPLETION OATE |
| resident was not receiving oxygen. On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner), regarding Resident #130's oxygen therapy. ASM #5 stated Resident #130 refuses oxygen when she is up during the day. On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding Resident #130's oxygen therapy. LPN #6 stated Resident #130 does not like to use oxygen when she goes off the unit and the resident uses the oxygen at night. When asked if Resident #130's refusal of oxygen should be documented, LPN #6 stated the refusal should be documented in nurses' notes. Review of Resident #130's January 2018, February 2018 and March 2018 nurses' notes failed to reveal documentation of Resident #130's refusal of oxygen. Review of Resident #130's comprehensive care plan initiated on 1/11/18 failed to reveal documentation regarding Resident #130's refusal of oxygen. On 3/29/18 at 5:48 p.m., ASM #1 (the administrator) and ASM #2 (the director of | F 842 | n/c (nasal cannular On 3/29/18 at 7:30 observed in a wheresident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident was not resident #130's on Resident #130's on Resident #130 refident was the resident uses the resident uses the Resident #130's resident was the Resident #130's resident was the Resident #130's resident was the Resident was the Resident was the Resident #130's resident was the Re | a) may titrate as needed." a.m., Resident #130 was relchair in the bedroom. The receiving oxygen. a.m., Resident #130 was relchair in the dining room. The receiving oxygen. b.p.m., an interview was respectively. The receiving oxygen was repractitioner, regarding receiving oxygen when she is up a.m., an interview was repractical nurse practical nurse practical nurse practical nurse is up b. M. (licensed practical nurse) #6, at #130's oxygen therapy. LPN the representation of like to use goes off the unit and the poxygen at night. When asked if refusal of oxygen should be reserved the refusal should be reserved. b. M. #130's January 2018, at #130's January 2018, at #130's January 2018, at #130's January 2018, at #130's comprehensive care 11/18 failed to reveal parding Resident #130's refusal regarding Resident #130's refusal regarding Resident #130's refusal | | 42 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | (X3 | B) DATE SURVEY COMPLETED |
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| EVEDOD | EEN HEALTH AND F | DELIAD | | 380 MILLWOOD AVENUE | | |
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| F 842 | Continued From p | age 311 | F 84 | 42 | | |
| | · | de aware of the above concern. | | | | |
| | | 80 p.m., ASM #2 stated the e a policy regarding the clinical record. | | ; ; ; | | |
| | No further informa Infection Prevention CFR(s): 483.80(a) | | F 8 | 80 | | |
| | infection prevention designed to provide comfortable environments. | stablish and maintain an n and control program le a safe, sanitary and nment and to help prevent the transmission of communicable | | F880 1. Corrective action has be | | |
| | program. The facility must e and control progra a minimum, the fo §483.80(a)(1) A sy reporting, investigand communicable staff, volunteers, v providing services arrangement base | stablish an infection prevention am (IPCP) that must include, at flowing elements: "stem for preventing, identifying, ating, and controlling infections e diseases for all residents, isitors, and other individuals under a contractual ad upon the facility assessmenting to §483.70(e) and following | | the alleged deficient pra Legionella water testing into place a policy and p water for Legionella. Re bag was touching the flo readjusted the bag and to off the floor. The O2 tul contaminated when the and tubing on the bed, the tubing and replaced with policy. Resident # 47's and sanitized by CNAs staff. Nurse placed resid pocket, the nurse remov | g, the facility has procedure for test esident #132's caroor, the nurse ubing to keep the bing for #235 was CNA place the care the nurse discarded h new tubing per bathroom was cleand Housekeepindent's #83 inhaler | put ing theter bag s annula d the eaned ig |
| substituted according to \$463.70(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 | | | disinfected it per policy resident #49's medication touched her face and ne her hands and did not sa pressure cuff and stetho pointed out the nurse im hands and equipment. | After administer ons the nurse the eck without sanitize anitize the blood oscope, when this | ring nurse zing was | |

| CENTE | KS FOR MEDICARE | & MEDICAID SERVICES | | | | OWR NO | <u>. 0938-0391</u> |
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| NAME OF | PROVIDER OR SUPPLIER | | | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | | |
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| | persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre (iv)When and how i resident; including the depending upon the involved, and (B) A requirement the least restrictive pose circumstances. (v) The circumstance must prohibit emplor disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in or §483.80(a)(4) A sys identified under the corrective actions to §483.80(e) Linens. Personnel must har transport linens so a infection. §483.80(f) Annual re The facility will cond IPCP and update th This REQUIREMEN by: | ey can spread to other ty; nom possible incidents of case or infections should be ansmission-based precautions event spread of infections; solation should be used for a cout not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the case under which the facility eyes with a communicable skin lesions from direct to the disease; and the procedures to be followed direct resident contact. Interference of the facility incidents facility's IPCP and the taken by the facility. | F8 | 3. 4. | be affected by the alleged deficient 100% audit of residents rooms was assuring rooms were clean, then Ut will audit 20 rooms per week x 4 w 50 rooms per month x 2 months to rooms are clean per policy. Medica related to infection control will be unit Manager or designee, 5 nurses 4 weeks, then 2 nurses per week x 100% audit of residents with cathet completed by the unit managers to catheter bag or tubing was touching Rounds will be made daily by unit designee noting the catheter bag an and report findings daily in mornin. Measures put into place to assure a deficient practice does not recur inc Nurses and CNAs will be reeducate infection control and hand washing compliance. The Director of Nursing and/or des analyze/review for patterns/trends a the Quality Assurance committee m quarterly for a minimum of six mor evaluate the effectiveness of the pla adjust the plan as the committee ma recommend, based on outcomes/tre identified from date. | practice. completed nit managers reeks, then validate tion pass observed by s per week x 2 months. A ers was assure no g the floor, manager or d tubing g meeting. lleged clude: ed in , to assure ignee will und report in neeting oths to un and will ey | |
| | | nd clinical record review, it | | | | | : |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | ` сом | (X3) DATE SURVEY COMPLETED | |
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| | 495142 | B. WING | | l l | C 30/2018 | |
| | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | <u> </u> | |
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| was determined the maintain a complete and failed to follow five of 31 residents Residents #132, #2 1. The facility staff implement policies management and begionella. 2. The facility staff #132's indwelling of floor. 3. The facility staff practice for the addresident #235. 4. The facility staff control practices at clean bathroom. 5. The facility staff control practices deand administration. 6. The facility staff after touching her is sanitize the blood pafter using it on Resident. The findings included. | at the facility staff failed to the infection control program infection control program infection control practices for an in the survey sample, 235, #47, #83, and #49. failed to develop and and procedures for water the detection and prevention of failed to ensure Resident eatheter bag was kept off the failed to follow infection control ministration of oxygen for failed to maintain infection and ensure Resident #47 had a failed to follow infection for Resident #83. failed to sanitize her hands face and neck and failed to pressure cuff and stethoscope esident #49. | F | 380 | | | |
| | | | | | | |
| | PROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa was determined the maintain a comple and failed to follow five of 31 residents Residents #132, #3 1. The facility staff implement policies management and the Legionella. 2. The facility staff practice for the add Resident #235. 4. The facility staff control practices at clean bathroom. 5. The facility staff control practices de and administration 6. The facility staff after touching her if sanitize the blood pafter using it on Resident 1. The facility staff implement policies management and if | PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 313 was determined that the facility staff failed to maintain a complete infection control program and failed to follow infection control practices for five of 31 residents in the survey sample, Residents #132, #235, #47, #83, and #49. 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Legionella. 2. The facility staff failed to ensure Resident #132's indwelling catheter bag was kept off the floor. 3. The facility staff failed to follow infection control practice for the administration of oxygen for Resident #235. 4. The facility staff failed to maintain infection control practices and ensure Resident #47 had a clean bathroom. 5. The facility staff failed to follow infection control practices during medication preparation and administration for Resident #83. 6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49. The findings include: 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of | PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 313 was determined that the facility staff failed to maintain a complete infection control practices for five of 31 residents in the survey sample, Residents #132, #235, #47, #83, and #49. 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Legionella. 2. The facility staff failed to ensure Resident #132's indwelling catheter bag was kept off the floor. 3. The facility staff failed to follow infection control practice for the administration of oxygen for Resident #235. 4. The facility staff failed to maintain infection control practices and ensure Resident #47 had a clean bathroom. 5. The facility staff failed to follow infection control practices during medication preparation and administration for Resident #83. 6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49. The findings include: 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of | PROVIDER OR SUPPLIER 495142 PROVIDER OR SUPPLIER EEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION] Continued From page 313 was determined that the facility staff failed to maintain a complete infection control practices for five of 31 residents in the survey sample, Residents #132, #235, #47, #83, and #49. 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Resident #235. 4. The facility staff failed to follow infection control practices or five of 31 residents and ensure Resident #132's indwelling catheter bag was kept off the floor. 3. The facility staff failed to follow infection control practices for the administration of oxygen for Resident #235. 4. The facility staff failed to maintain infection control practices during medication preparation and administration for Resident #83. 6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49. The findings include: 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of management and the detection on procedures for water management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of management and the detection and prevention of the province of the province of the province of the province of | A BUILDING COM 495142 B. WING REVIDER OR SUPPLIER REEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RESULATORY OR LISC IDENTIFYING INFORMATION) COntinued From page 313 was determined that the facility staff failed to maintain a complete infection control program and failed to follow infection control program and failed to follow infection control program and failed to facility staff failed to ensure Resident #132, #235, #47, #83, and #49. 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Legionella. 2. The facility staff failed to maintain infection control practice for the administration of oxygen for Resident #235. 4. The facility staff failed to maintain infection control practices and ensure Resident #47 had a clean bathroom. 5. The facility staff failed to follow infection control practices and ensure Resident #83. 6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49. The findings include: 1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of the procedure of t | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | CLIA (X2) MULTIPLE CONSTRUCTION ER: A. BUILDING | | | TE SURVEY MPLETED | |
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| F 880 | Continued From pa | age 314 | F 88 | 0 | | |
| | conducted with ASI member) #1 (the addirector of nursing) not have any policite for water managem prevention of Legio looked at a comparwas in the process | p.m., an interview was M (administrative staff administrator) and ASM #2 (the). ASM #1 stated the facility did les, procedures, or a programment and the detection and onella. ASM #1 stated she had ny that does water testing and sof developing a program. #2 was made aware this was a | | | | |
| : | No further informat | tion was presented prior to exit. | | | | |
| | lungs and airways. bacteria. Causes: The bacte disease have been systems. They car conditioning system hospitals." This infethe website: | sease is an infection of the It is caused by legionella eria that cause Legionnaire found in water delivery a survive in the warm, moist air ms of large buildings, including formation was obtained from a.gov/ency/article/000616.htm | | | | |
| | | failed to ensure Resident atheter bag was kept off the | | | | |
| | 2/6/18 and readmitt #132's diagnoses ir acute respiratory fa weakness. Resider (minimum data set) assessment with ar | s admitted to the facility on ted on 3/8/18. Resident included but were not limited to ailure, stroke and muscle int #132's most recent MDS), a significant change in status in ARD (assessment reference | | | | |
| į. | date) of 3/15/18, co | oded the resident's cognition | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l'' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| <u> </u> | | 495142 | B. WING | з | | 0 | C 3/30/2018 |
| | PROVIDER OR SUPPLIER | | | 380 | REET ADDRESS, CITY, STATE, ZIP CODE D MILLWOOD AVENUE NCHESTER, VA 22601 | | NOVIEW 10 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | FIX : | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION OATE |
| F 880 | Continued From pa | - | F | 880 | | | |
| | as severely impaire Resident #132 as re of two or more staff coded the resident catheter (1). | ed. Section G documented requiring extensive assistance ff with bed mobility. Section H as having an indwelling | | | | | |
| | | at #132's clinical record an's order dated 3/9/18 for a vound. | | ; ; ; | | | : |
| i | | are plan initiated on 3/8/18 information regarding an | | | | | |
| ; ! | observed lying in a | a.m., Resident #132 was low bed. The resident's observed on the floor and on a e floor. | | | | | |
| | conducted with LPN LPN #4 was asked be place when a restated the catheter resident, should not in a privacy bag. At to observed Reside #4 and this surveyoroom. The resident the catheter bag was | p.m., an interview was N (licensed practical nurse) #4. where a catheter bag should esident is lying in bed. LPN #4 bag should be below the st touch the floor and should be at this time, LPN #4 was asked ent #132's catheter bag. LPN or entered Resident #132's t remained in a low bed and as observed on the floor. LPN #132's bad bad to remain law. | | | | | |
| | LPN #4 moved Res | #132's bed had to remain low. sident #132's catheter bag to e bed and positioned the bag uching the floor. | | : | | | |
| | staff member) #1 (th | p.m., ASM (administrative he administrator) and ASM #2 sing) were made aware of the | | · · | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | 1 ' ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|---|----------------|--|
| | | 495142 | B. WING | | 0: | C 3/30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 880 | F 880 Continued From page 316 | | F8 | 80 | | | |
| | Care" documented infection8. Maintand cover with digrard No further information (1) "You have an inbladder. 'Indwellin This catheter drain a bag outside your obtained from the https://medlineplus 00140.htm 3. The facility staff | tion was presented prior to exit. Idwelling catheter (tube) in your g' means inside your body. s urine from your bladder into body." This information was | : | | | | |
| | 3/22/18 with diagnormal limited to: fracture (a slowly progressi characterized by restooped posture, restooped posture, restooling, and must chronic obstructive (COPD - a general non-reversible lung combination of embronchitis). (2) | s admitted to the facility on oses that included but were not of her leg, Parkinson's disease ve neurological disorder esting tremor, shuffling gait, olling motions of the fingers, cle weakness) (1), falls, and e pulmonary disease (COPD) term for chronic, g disease that is usually a physema and chronic pleted MDS (minimum data ompleted at the time of survey. | | | | | |
| | | ission Assessment" dated, ed the resident was alert and ace and person. | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|--------------------------|---|-------------------------------|
| | | 495142 | B. WING | | C |
| | PROVIDER OR SUPPLIER REEN HEALTH AND RI | EHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | 03/30/2018 |
| | 0(1) () () () | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLÉTION |
| F 880 | Continued From pa | ge 317 | F 88 | n: | |
| | Resident #235 was p.m. in bed with her | observed on 3/27/18 at 2:47 oxygen on via a nasal two prongs that insert in the | | | |
| | observed in the dini by a staff member. Observation was mathis time; the oxyger on the incontinence was documented as Resident #235 was station area in her was. On 3/29/18 at observed in the dinibreakfast. There was Observation was mathis time. The nasa was observed in the incontinence pad. Ton 3/29/18 at 8:39 assistant) #1 took R | a.m., Resident #235 was ng room, being assisted to eat No oxygen was in use. ade of the resident's room at a tubing was lying on the bed pad. The date on the tubing a "3/26/18." At 8:25 a.m., observed in the nurse's wheelchair with no oxygen in 8:17 a.m., Resident #235 was ng room being assisted with as no oxygen in use. ade of the resident's room at I cannula and oxygen tubing resident's bed sitting on the tubing was dated 3/26/18. a.m. CNA (certified nursing esident #235 back to her e oxygen tubing that was on | | | |
| : ! : | | dated, 3/22/18, documented, 2L (liters per minute) via N/C titrate as needed." | | | |
| | The care plan dated documentation relate | , 3/23/18, failed to evidence ed to the use of oxygen. | | | |
| | 3/29/18 at 8:50 a.m. cannula and oxygen use, CNA #3 stated, hanging off the conc | nducted with CNA#3 on When asked where a nasal tubing is stored when not in "In the patient's set up bag entrator." When asked if a xygen tubing that was on the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|----------------------|-------------|---|------|----------------------------|
| | | 495142 | B. WING | | | 1 | C 3/ 30/2018 |
| | PROVIDER OR SUPPLIER | | | 3 80 | REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601 | 1 00 | 13012010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN DF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRDPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 880 | bed, on an incontin a resident, CNA #3 An interview was c | nent pad would be reapplied to 3 stated, "No." conducted with LPN (licensed | F 8 | 880 | | | |
| | practical nurse) #2 asked where a nas should be stored w "We have a bag or with the room num LPN #4 was inform Resident #235's na being on the incont was informed of the tubing being reappl stated, "That needs LPN #4 proceeded #235. | on 3/29/18 at 9:12 a.m. When sal cannula and oxygen tubing when not in use, LPN #4 stated, in the concentrator. It's labeled ber and the resident's name." ned of the observations of asal cannula and oxygen tubing tinence pad on the bed and the nasal cannula and oxygen whiled to Resident #235. LPN #4 is to be changed immediately." | | : | | | |
| : | | "Policy Related to Oxygen and " did not address the storage of en not in use. | | | | | |
| | Patricia A. Potter a Inc; Page 648. "Bo of Health Care-Ass | of Nursing" 7th edition, 2009: and Anne Griffin Perry: Mosby, ox 34-2 Sites for and Causes sociated Infections under Contaminated respiratory | | | | | |
| , | member) #1, ASM ASM #7. the owner | ASM (administrative staff #2, the director of nursing and r of the facility were made e findings on 3/29/18 at 6:10 | | | | | |
| ! | No further informat | tion was provided prior to exit. | : | : | | | |
| | | nary for Medical Terms for the er. 5th edition. Rothenberg and | | · | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | (| | E SURVEY PLETED |
|--------------------------|--|--|----------------------|---|---------|----|--|
| | | 495142 | B. WING | | | | 30/ 2018 |
| | PROVIDER OR SUPPLIER | ЕНАВ | | STREET ADDRESS, CITY, STATE, ZIP COI 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | DE | | <u>, </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD E | 3E | (X5) COMPLETION DATE |
| | Non-Medical Read Chapman, page 12 4. The facility staff control practices ar clean bathroom. Resident #47 was 3/23/16 with diagnoral limited to anxiety di unspecified demen disturbance, high be weakness, and ma Resident #47's mosset) assessment was codent #47 was a cognitively impaired decision scoring 03 Interview for Menta was coded as required from two or more propositive of the bathroom was substance resemble to the bathroom flood 13/28/18 at 7:30 #47's bathroom was substance remained On 3/28/18 at 7:42 conducted with CN. #5. When asked heresidents, CNA #5. | ary for Medical Terms for the er, 5th edition, Rothenberg and et. failed to maintain infection and ensure Resident #47 had a eadmitted to the facility on oses that included but were not sorder, Alzheimer's disease, tia without behavioral lood pressure, muscle jor depressive disorder. It is recent MDS (minimum data as annual assessment with an reference date) of 1/1/18. Coded as being severely in the ability to make daily to out of 15 on the BIMS (Brief II Status) exam. Resident #47 iring extensive assistance ersons with most ADLS ving). p.m., observation of Resident s conducted. A brown ing feces was observed dried or. a.m., observation of Resident s conducted. The brown | F | 380 | | | |

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

| <u> </u> | TO 1 OIL MILDICARL | A MEDICAID CENTICES | | | | OND IN | <u>J. 0930-039 I</u> |
|--------------------------|--|---|------------------------|-------------------------|---|-------------------------------|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTI | | (X3) DATE SURVEY COMPLETED | |
| | | 495142 | B. WING | | | 0: | C 3/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRES | S, CITY, STATE, ZIP C | ODE | - |
| EVERGR | EEN HEALTH AND R | EHAB | | 380 MILLWOOD WINCHESTER | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH (| VIDER'S PLAN OF COR CORRECTIVE ACTION EFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 880 | stated that she pas CNA #5 stated that unit they should be the rooms. CNA #5 rooms included the that she would also cleanliness. When Resident #47's room had. When asked if #47's bathroom, CNA #5 followed the bathroom. When a on the bathroom flowas a brown substated identify what it was lift to go to the bath why that is on the flimplying the brown stated, "It better not conducted with LPN Resident #47's nurs first starts her rounds first starts her rounds asked who was resident's bathroom stated, "We are all if this writer to Reside confirmed that there the floor. LPN #1 cosubstance was. LP yet been in Resider sure, how often hou unit. LPN #1 stated | when CNAs first get onto the checking their residents and stated that checking the bathrooms. CNA #5 stated check the rooms for asked if she had been in myet, CNA #5 stated that she if she had checked Resident NA #5 stated that she had not. is writer to Resident #47's sked CNA #5 what she saw for, CNA #5 confirmed there ance on the floor but could not CNA #5 stated, "She uses a room, so there is no reason foor." When asked if she was substance was feces, CNA #5 to e." a.m., an interview was N (licensed practical nurse) #1, se. When asked when she ding in the morning, LPN #1 will get report, and then do esidents and rooms. When ponsible for checking the last for cleanliness, LPN #1 responsible." LPN #1 followed ant #47's bathroom. LPN #1 to was a brown substance on buld not identify what the N #1 stated that she had not at #47's room and she was not is ekeeping rounded on the I, "It depends." | F 84 | 30 | | | |
| | On 3/30/18 at 8:18 | a.m., further interview was | | : | | | |

conducted with LPN #1. When asked who

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---|-----------------------|-------------------------------|----------------------------|
| | | 495142 | B. WING | | | | C / 30/2018 |
| | NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | | 30/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | (EACH CORRECTIVE ACTIO | N SHOULD E APPROPI | BE | (X5) COMPLETION DATE |
| | Resident #47's bat did, and then told it behind her. When bathroom was a cl stated, "No I don't environment." On 3/30/18 at 8:30 conducted with OS Director of Housek housekeeping schestaff will do rounds trays come onto the staff will clean offic stated that when the staff would go back asked what cleaning her staff would sweincluding the bathroos #9 stated that rounds throughout for trash, things on that her staff leave nursing staff will can anything like that of stated that typically bodily fluids and the behind them and set they have to be also which room to san has a floor tech that that can sanitize room to san that the sanitize room to san that can sanitize room to san that can sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the sanitize room to san that the s | rage 321 In substance off the floor of throom, LPN #1 stated that she housekeeping to sanitize in asked if Resident #47's lean environment, LPN #1 consider that a clean Dia.m., an interview was SM (other staff member) #9, the keeping. When asked the redule, OSM #9 stated that her is in the morning until breakfast ine floor. During breakfast, her ces and the lobby. OSM #9 he trays are off the floor, her isk to cleaning the rooms. What ing entailed, OSM #9 stated that reep, and mop both the floors, rooms, dust and collect trash, at her staff would make several at the day and check the rooms in the floor. etc. OSM #9 stated at 3 p.m. When asked if all/alert them if there is feces or on the bathroom floor, OSM #9 y nursing staff clean up any then housekeeping will come canitize. OSM #9 stated that she at is present after 3:00 p.m. ooms. OSM #9 stated that her de aware of the brown | | 880 | | | |
| | substance in Resid | dent #47's bathroom. OSM #9 /as no communication to her | | ; ! | | | |
| : | On 3/30/18 at 8:55 | 5 a.m., an interview was | | | | | 1 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495142 | B. WING | | 0. | C 3/30/2018 | |
| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION OATE | |
| F 880 | important to ensure the residents' floor, fluids can carry dise to prevent cross corresident has a room. On 3/29/18 at 5:47 staff member) #1, the DON (director of nure owner were made at 5. The facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durand administration of the facility staff control practices durant facility staff control practices du | A #4. When asked why it was a bodily fluids were free from CNA #4 stated that bodily eases and that staff should try ntamination, especially if a nmate. p.m., ASM (administrative he administrator, ASM #2, the ursing) and ASM #7, the facility aware of the above concerns. failed to follow infection uring medication preparation | F 8 | 80 | | | |
| | 7:30AM) Allopurinol [2] 100 n | ng (milligrams) | : | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. Bolebino | | | С | |
| | | 495142 | B. WING | | 03 | /30/2018 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION OATE | |
| F 880 | Zoloft [9] 100 mg Spiriva [10] 18 mc Colace [11] 100 m On 3/28/18 08:55 medications, LPN cups (2 cups), the her hands. LPN # pocket. Locked ca took the medication was on another ha had the medication On 3/28/18 at 9:08 #2, she stated she inhalers in my poor would be a concert control." LPN #2 at the med cart to his prevented all the is everything. On 3/29/18 at 6:08 meeting, the Admit staff member] #1) and the facility own aware of the findin provided by the enterprovided by the enterprovided to Potter According to Potter | mg mg (grams) (resident refused) g g (resident refused) a.m., after preparing the #2 collected the medication water cup, and both inhalers in 2 then put the inhalers into her art with using her elbow, and ons to the resident, whose room all, far removed from where she in cart positioned. a.m., in an interview with LPN probably should not put the ket." When asked why that in, LPN #2 stated, "Infection stated she should have moved is room and that would have sues of trying to carry p.m., at the end of day inistrator (ASM [administrative in, Director of Nursing (ASM #2), iner (ASM #7), were made ings. No further information was | F 8 | 80 | | | |
| : | administration, the | n, page 847, "For safe nurse uses aseptic technique digiving medications." | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495142 | | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------|---|--------------------------------|-------------------------------|--|
| | | B. WING | | | C 03/30/2018 | | |
| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | | STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | CODE | 03/30/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION OATE | |
| F 880 | Continued From pa | age 324 | F8 | 380 | | | |
| | Information obtained https://medlineplustml [2] Allopurinol is us Information obtained https://medlineplustml [3] Breo is used to pulmonary diseased Information obtained https://medlineplustml [4] Iron is used to the Information obtained https://vsearch.nlmmeta?v%3Aprojection | .gov/druginfo/meds/a682461.h ed to treat gout. ed from .gov/druginfo/meds/a682673.h treat chronic obstructive . ed from .gov/druginfo/meds/a613037.h reat iron deficiency. ed from .nih.gov/vivisimo/cgi-bin/query- =medlineplus&v%3Asources= | | | | | |
| : | 5.955481667.1522 99 [5] Neurontin is use postherpetic neura syndrome. Information obtains | e&query=iron&_ga=2.3413386 702603-191684010.15108527 ed to treat seizures, Igia, and restless leg ed from .gov/druginfo/meds/a694007.h | | | | | |
| | pressure. Information obtained | sed to treat high blood ed from .gov/druginfo/meds/a682246.h | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 105110 | | 3. WING | | | С |
| NAME OF C | | 495142 | B. WING | | | 03 | /30/2018 |
| NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | : | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE BO MILLWOOD AVENUE VINCHESTER, VA 22601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION OATE |
| F 880 | pressure. Information obtained https://medlineplus.tml [8] Miralax is used to Information obtained https://medlineplus.tml [9] Zoloft is used to Information obtained | ed to treat high blood ed from .gov/druginfo/meds/a682864.h to treat constipation. ed from .gov/druginfo/meds/a603032.h treat depression. | F 8 | 880 | | | |
| | pulmonary disease. Information obtained | | | | | | |
| | Information obtained | to treat constipation. d from gov/druginfo/meds/a601113.ht | | : | | | |
| | after touching her fa | ailed to sanitize her hands ace and neck and failed to ressure cuff and stethoscope sident #49. | | i . | | | : |
| : | 5/10/14 and readmit that included but we | admitted to the facility on itted on 6/7/17 with diagnoses ere not limited to: stroke, es, kidney disease and | | | | | |

| <u> </u> | ING I ON MEDIOMINE | A MEDIO/ ND OFTATION | | | | IND INC | . 0300-038 1 |
|---|---|---|-------------|---------------------------------------|---|---------|----------------------------|
| STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | 1 ' ' | X2) MULTIPLE CONSTRUCTION . BUILOING | | | TE SURVEY MPLETEO |
| | | 495142 | B. WING | | | 1 | C |
| | PRO180ER 05 | 453 42 | D. WING | | | 03 | /30/2018 |
| | PROVIOER OR SUPPLIER REEN HEALTH AND R | ЕНАВ | | 380 | REET AOORESS, CITY, STATE, ZIP COOE MILLWOOD AVENUE NCHESTER, VA 22601 | | |
| (X4) IO | SUMMARY STA | TEMENT OF OEFICIENCIES | IO | | PROVIDER'S PLAN OF CORRECTION | ıN | (VE) |
| PREFIX TAG | (EACH OFFICIENCY | Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROF OEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 000 | ! !a | | _ | ! ! | | | |
| F 880 | Continued From pa | _ | F | 380 | | | |
| | The most recent M | DS (minimum data set), a | | | | | |
| | quarterly assessme | ent, with an ARD (assessment | | | | | |
| | | 2/2/18 coded the resident as | | | | | |
| | | ut of 15 on the BIMS (brief | | | | | |
| | | status) exam, indicating the | | | | | |
| | | cognitively to make daily | | | | | |
| | | dent was coded as requiring | : | | | | |
| | | off for all activities of daily | ! | | | | |
| | living. | in for all activities of daily | | | | | : |
| | iwing. | | ; | | | | : |
| | A modication admir | nistration observation was | : | | | | |
| | 1 | | : | | | | |
| | | 18 at 8:12 a.m. with LPN | | | | | ! |
| | | nurse) #6. LPN #6 wiped her | | | | | |
| | | index finger and then rubbed | | : | | | : |
| | | ght hand. She did not wash | | | | | : |
| | | brought Resident #49 via | | | | | ! |
| | | his room. LPN #6 got the | | | | | : |
| | | and stethoscope out of the | | | | | |
| | | I took them into the resident's | | | | | : |
| | | d the stethoscope off with an | | , | | | : |
| | | e blood pressure cuff on the | | | | | |
| | resident's arm and | checked the blood pressure. | | | | | |
| | LPN #6 then took the | ne blood pressure cuff off the | | | | | |
| | resident put it unde | r her arm and returned it to the | | | | | : |
| | medication cart with | nout sanitizing it. | İ | 1 | | | : |
| | ! | | | : | | | : |
| | An interview was co | onducted on 3/28/18 at 2:40 | | | | | 1 |
| | i contract of the contract of | When asked when staff wash | 1 | | | | |
| | | stated, "Sometimes before | : | | | | |
| | | seeing a resident." When | | | | | |
| | | d if they touched their face or | • | | | | |
| | | d, "We can use the hand | | | | | |
| | | ked why staff sanitized their | | | | | |
| | | ed, "To keep from spreading | | | | | |
| | | face." When asked what staff | | | | | |
| | | | | : | | | ; |
| | | uipment after using it on a | : | | | | |
| | | putting it back into the | | | | | 1 |
| | | N #6 stated, "I usually don't do | | | | | • |
| | i anything." When as | ked if the blood pressure cuff | | | | | |

| STATEMENT OF OEFICIENCIES (X1 ANO PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILOING | | | (X3) OATE SURVEY COMPLETEO | |
|--|---|---|---|---|--------|-------------------------------|--|
| | | 495142 | B. WING | | 03 | C 3 /30/2018 | |
| NAME OF PROVIOER OR SUPPLIER EVERGREEN HEALTH AND REHAB | | | | STREET AOORESS, CITY, STATE, ZIP COOE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 | | 100/2010 | |
| (X4) IO PREFIX TAG | (EACH OEFICIENCY | TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION) | IO PREFIX TAG | PROVIOER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI OEFICIENCY) | ULO BE | (X5) COMPLETION DATE | |
| | resident, LPN #6 st On 3/29/18 at 6:00 member) #1, the ac director of nursing a were made aware of Review of the facility Preparation and Me documented, "Applity forth the procedures preparation and me staff should also resimedication administance applicable law and when administering Prior to preparing of authorized and comfollow facility's infection handwashing). 6.4 to or supplies." | ere dirty after using them on a ated, "Yes." p.m. ASM (administrative staff dministrator, ASM #2, the and ASM #7, the facility owner | F 8 | 80 | | | |
| : | | | | | | | |