PRINTED 02/15/2017

		& MEDICAID SERVICES			OMB NO 0938-0391
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SLPPLIER/CLIA DENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING	X3) DATE SURVEY COMPLETED
		49E131	B WING	·	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	02/09/2017
SW VA	M H INST GERI TRT C	TR .		340 BAGLEY CIRCLE	
				MARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		D. BE COMPLETION
F 000) INITIAL COMMENT	S	F(000	
F 156 SS=C	survey was conduct 02/09/17. Correctio compliance with 42 Term Care requirem survey/report will foll. The census in this 2 at the time of the surconsisted of 7 currer (Residents 1 through reviews (Resident 8) 483.10(d)(3)(g)(1)(4) RIGHTS, RULES, St. (d)(3) The facility mu	CFR Part 483 Federal Long ents. The Life Safety Code low. 5 certified bed facility was 19 lovey. The survey sample nt Resident reviews 17 and 1 closed record 1. (5)(13)(16)-(18) NOTICE OF ERVICES, CHARGES		66 tten Notice regarding how to apply	03/10/17
	of contacting the phy professionals respon §483.10(g) Information (1) The resident has his or her rights and of governing resident conducting his or her stay (g)(4) The resident has	as the right to receive	ben prev Med the Sam Auth	and use Medicare/Medicaid efits and how to receive refunds for vious payments covered by dicare/Medicaid provided to each of a active members of the Survey ple and to their respective norized Representatives by Clinical al Work Staff.	
	notices orally (meaning	ng spoken) and in writing format and a language he	indiv	y of this Notice to be filed in the vidual's paper medical record on Ward by Clinical Social Work Staff	03/24/17 & Ongoing
		s specified in this section. sh to each resident a written hts which includes -	elec	scanned into each of their tronic medical records by Health rmation Management staff upon	

personal funds, under paragraph (f)(10) of this LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE

(A) A description of the manner of protecting

THLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days. following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued es are cited an approveu proFacility ID VA0246

Approveu proFacility ID VA0246

Approveu proFacility ID VA0246 program participation.

FORM CMS-2567(02 99) Previous Versions Obsolete

Event ID USLM11

discharge.

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CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES		(FORM APPROVE
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICA: ION NUMBER		IPLE CONSTRUCTION	OMB NO 0938-039 (X3) DATE SURVEY COMPLETED
	:	49E131	3 WING_		02/09/2017
NAME OF	PROVIDER OR SUPPLIER	Extracted and Anti-Median recognition on the company of the compan		STREET ADDRESS CITY STATE ZIP CODF	02/03/201/
SW VA N	M H INST GERI TRT CT	TR		340 BAGLEY CIRCLE MARION, VA 24354	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 156	Continued From pag	ge 1	F 15		
(B) A description of the requirements and procedures for establishing eligibility for Medicaid including the right to request an assessment of resources under section 1924(c) of the Social Security Act (C) A list of names, addresses (mailing and		for ar bene previ Medi other	ten Notice regarding how to apply and use Medicare/Medicaid fits and how to receive refunds for ous payments covered by care/Medicaid provided to all respective individuals residing in tric Services and to their	03/10/17	
	email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the		respe by Cli	ective Authorized Representatives inical Social Work Staff.	
State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.		indivi the W and so electr	of this Notice to be filed in the dual's paper medical record on /ard by Clinical Social Work Staff canned into each of their ronic medical records by Health mation Management staff upon	03/24/17 & Ongoing	
		tate Survey Agency pected violation of state or ty regulations, including but nt abuse, neglect, ropriation of resident property mpliance with the advance nts and requests for g returning to the community.	Medio to rec paymo Medio Officia	e about how to apply for and use care/Medicaid benefits and how eive refunds for previous ents covered by care/Medicaid posted in the all Bulletin Board on public display	02/28/17
	and local advocacy o not limited to the Stat Long-Term Care Oml (established under se	ontact information for State organizations including but the Survey Agency, the State budsman program ection 712 of the Older 65, as amended 2016 (42	and o	Geriatric Services Entrance area n the Board in the Visitors Room e Geriatric Services Secretary.	

U.S.C. 3001 et seq) and the protection and

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

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				<u> </u>
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
		49E131	3 WING	02/09/2017
	PROVIDER OR SUPPLIER M H INST GERI TRT C	TR	STREET ADDRESS CITY STATE ZIP CODE 340 BAGLEY CIRCLE MARION, VA 24354	(02/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 156	Continued From pa	ige 2	F 156	
	advocacy system (a as established under Disabilities Assistan 2000 (42 U.S.C. 150 [§483.10(g)(4)(ii) will November 28, 2017 (iii) Information regal eligibility and covera	as designated by the state, and er the Developmental noce and Bill of Rights Act of 1001 et seq.) iff be implemented beginning 7 (Phase 2)] arding Medicare and Medicaid age;	Referenced Notice to be included in Admission Packet provided to each individual and their respective Authorized Representative upon their admission to Geriatric Services by Clinical Social Work Staff.	03/03/17 & Ongoing
	[§483.10(g)(4)(iii) wi November 28, 2017 (iv) Contact informat Disability Resource Section 202(a)(20)(E Act); or other No Wr	rill be implemented beginning (Phase 2)] Ition for the Aging and Center (established under B)(iii) of the Older Americans Frong Door Program:	Geriatric Services Secretary to monitor Display Board in Visitors Room each month to ensure Notice is present for observation by all individuals and all visitors to Geriatric Services.	03/01/17 & Ongoing
	November 28, 2017 (v) Contact informatic Control Unit; and [§483.10(g)(4)(v) will November 28, 2017 (vi) Information and ogrievances or complete suspected violation of facility regulations, in resident abuse, neglemisappropriation of recility, non-compliant directives requirement	ion for the Medicaid Fraud If be implemented beginning (Phase 2)] contact information for filing laints concerning any of state or federal nursing including but not limited to lect, exploitation, resident property in the ince with the advance ints and requests for	Clinical Social Work Supervisor/LNHA to monitor 100% of Admission Packets provided to individuals and/or Authorized Representatives each month to ensure referenced Notice included in the respective Packets. Monitoring to be discontinued upon 6 consecutive months of 100% compliance achieved.	03/24/17 & Ongoing
	(g)(5) The facility mus	g returning to the community. Ist post, in a form and and understandable to epresentatives:		

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CENTERS FOR MEDICARE & MEDICAID SERVICES							O. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRI			(X3) D	ATE SURVEY OMPLETED
		49E131	B √/ING	W. p			2/09/2017
NAME OF	PROVIDER OR SUPPLIER		1		REET ADDRESS CITY STATE Z.P.CC		210312017
SWVAN	H INST GERI TRT C	TR			BAGLEY CIRCLE ARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	X6 COMPLETION DATE
F 156	and telephone numagencies and advo Survey Agency, the protective services jurisdiction in long-tof the State Long-T program, the protechome and communand the Medicaid F (ii) A statement that complaint with the Sconcerning any susfederal nursing facilimited to resident a misappropriation of facility, and non-cordirectives requiremed) and requests for it to the community. (g)(13) The facility rivinten information, applicants for admisinformation about he Medicare and Medicare and Medicare receive refunds for such benefits. (g)(16) The facility rivind services to the admission and during a services to the admission and during a services are services.	age 3 addresses (mailing and email), abers of all pertinent State cacy groups, such as the State State licensure office, adult where state law provides for term care facilities, the Office form Care Ombudsman option and advocacy network, alty based service programs raud Control Unit; and I the resident may file a State Survey Agency pected violation of state or lity regulation, including but not abuse, neglect, exploitation, resident property in the mpliance with the advanced ents (42 CFR part 489 subpart information regarding returning must display in the facility and provide to residents and assion, oral and written ow to apply for and use caid benefits, and how to previous payments covered by must provide a notice of rights resident prior to or uponing the resident's stay.	F	56			
		nguage that the resident					

understands of his or her rights and all rules and regulations governing resident conduct and

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

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CENIE	RS FOR MEDICARE	& MEDICAID SERVICES					0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		49E131	B WING			0.0	2/00/2004**
-	PROVIDER OR SUPPLIER 1 H INST GERI TRT C	TR		340	REET ADDRESS CITY STATE ZIP CODE D BAGLEY CIRCLE ARION, VA 24354	U4	2/09/2017
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	X5: COMPLETION DATE
F 156	Continued From pa	ge 4	F 1	56			
		ng the stay in the facility.	, ,	00			
	(ii) The facility must the State-developed obligations, if any.	also provide the resident with notice of Medicaid rights and					
		information, and any nust be acknowledged in					
	(g)(17) The facility n	nust					
	writing, at the time o	caid-eligible resident, in fadmission to the nursing resident becomes eligible for					
	nursing facility service	ervices that are included in ses under the State plan and it may not be charged;					
	facility offers and for	s and services that the which the resident may be ount of charges for those					
;	changes are made to	caid-eligible resident when the items and services the (g)(17)(i)(A) and (B) of					
 	before, or at the time periodically during the available in the facility services, including ar	ust inform each resident of admission, and e resident's stay, of services y and of charges for those ny charges for services not are/ Medicaid or by the					

facility's per diem rate.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			,	FORM	MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DA	0 0938-039 TE SURVEY MPLETED
		49E131	B WING			0.2	//09/2017
NAME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS CITY STATE ZIP CODE		70012017
SW VA N	M H INST GERI TRT C	TR			BAGLEY CIRCLE ARION, VA 24354		
(X4; ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS REFERENCED TO THE APPROF DEFICIENCY:	DBF	X5 COMPLETION DATE
F 156	Continued From pa	ge 5	F 1	56		Park and an analysis of the second	
	and services covered Medicaid State plan notice to residents or reasonably possible (II) Where changes a items and services the facility must inform the services covered to the services	n coverage are made to items d by Medicare and/or by the the facility must provide if the change as soon as is are made to charges for other hat the facility offers, the he resident in writing at least ementation of the change.					
	(iii) If a resident dies transferred and does facility must refund to representative, or es deposit or charges a per diem rate, for the resided or reserved of	or is hospitalized or is anot return to the facility, the othe resident, resident tate, as applicable, any lready paid, less the facility's adays the resident actually or retained a bed in the any minimum stay or					
	resident representativ	refund to the resident or ve any and all refunds due days from the resident's m the facility					
: : : :	behalf of an individua facility must not confl these regulations. This REQUIREMENT by: Based on observatio facility staff failed to p	Imission contract by or on I seeking admission to the ct with the requirements of is not met as evidenced in and staff interview, the rominently display any out how to apply for and use					

medicare and medicaid benefits, and how to receive refunds for previous payments covered

by medicare and medicaid benefits.

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

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i .		A MEDICAID SERVICES			OMB NO.	0938-039
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		49E131	B WING		TTTAVARAGE	
	F PROVIDER OR SUPPLIER M H INST GERI TRT C	1		STREET ADDRESS CITY STATE, ZIP COI 340 BAGLEY CIRCLE MARION, VA 24354	02/0 DE	09/2017
(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	HOULD BE	(X5) COMPLETION DATE
F 150	Continued From page	ge 6	F 15	56		
	The Findings Includ	ed.				
	a.m. during an initial surveyor was unable regarding how to ap and how to receive repayments covered b On 02/09/17 at appre (social worker) #1 winformation regarding	oximately 10:35 a.m. SW as asked about the g medicare/medicaid. SW #1				
	and verbalized to the	vas not specific in regards to				
•	missing posting(s) re medicare/medicaid ir with the survey team approximately 11:40 administrative team v	nformation during a meeting				
F 514	No further information provided to the survey conference. 483.70(i)(1)(5) RES	n regarding this issue was y team prior to the exit	F E 1 A			
	RECORDS-COMPLE LE	TE/ACCURATE/ACCESSIB		14 VMHI Facility Director and Assis ector for Administrative Services	· ·	3/17 hours
	standards and practic	n accepted professional es, the facility must ords on each resident that	lead	e to facilitate DBHDS Central Off dership approval for Surveyor's estricted access.		_

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

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STATEME	NT OF DEFICIENCIES	WEDIOTAL SERVICES		OMB NO. 0938-039
AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
hinkir o		49E131	B WING	02/09/2017
	F PROVIDER OR SUPPLIER M H INST GERI TRT C		STREET ADDRESS, CITY, STATE, ZIP CODE 340 BAGLEY CIRCLE MARION, VA 24354	1 02/03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD RE COMPLETION
F 514	4 Continued From pagare-	ge 7	F 514 DBHDS Central Office approval for	02/08/17
	(i) Complete;		unrestricted Surveyors access to electronic medical records referenced	1545 hours
	(ii) Accurately docum	,	above was also extended to all of the other respective individuals residing in	
	(iii) Readily accessib		Geriatric Services.	
	(iv) Systematically or		Unrestricted Surveyor "read only" access to individual electronic medical	02/24/17 &
	(5) The medical reco		records will be provided by the DBHDS	Ongoing
	(i) Sufficient informat	ion to identify the resident;	Director of Health Information Technology 804-840-8390 — or the	
	(ii) A record of the re-	sident's assessments;	OneMind Development and Support	
	(iii) The comprehens provided;	ive plan of care and services	Manager 804-840-8597 – by direct telephone call to them by designated	
	(iv) The results of any and resident review e determinations condu	preadmission screening evaluations and acted by the State;	Facility staff shall subsequently open a Critical Ticket with the OneMind Electronic Health Record (EHR) Help	
	(v) Physician's, nurse professional's progres	's, and other licensed ss notes; and	Desk – 866-281-2837 and provide the Surveyor's credential information – Surveyor's name and name of the	
	services reports as re	ogy and other diagnostic quired under §483.50. is not met as evidenced	auditing/reviewing organization. The Help Desk is available 24 hours per day 7 days per week.	
	Based on observation	n and staff interview the nsure a complete, accurate, clinical record.	Individual Surveyor logons to access the electronic medical record will be provided by the DBHDS Health	02/24/17 & Ongoing
	The findings included:		Information Technology Department within 2 hours of receipt of Survey or	
	The facility staff failed records were readily a review	to ensure electronic clinical ssessable for surveyor	credential information referenced above.	

review.

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CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES		FORM APPROVE	
STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	OMB NO 0938-039 (X3) DATE SURVEY COMPLETED	
		49E131	B WING		
NAME O	F PROVIDER OR SUPPLIER		STREET ADDRESS CITY, STATE ZIP CODE	02/09/2017	
SW VA	M H INST GERI TRT C	TR	340 BAGLEY CIRCLE MARION, VA 24354		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULI TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE COMPLETIEN	
F 51/	1 Continued From pa	ge 8	F 514		
	at approximately 08 met with the facility survey team leader administrator that the documentation. The access to the clinical At approximately 11 director informed the	ntered the facility on 02/08/17 300. The survey team leader administrator at this time. The was informed by the facility he facility now uses electronic e team leader requested all records for the survey team. 25 on 02/08/17, the assistant e survey team that she had	A Facility staff member with Commonwealth of Virginia access will log a device onto the Commonwealth of Virginia network and direct the Surveyor(s) to the OneMind Electronic Health Record (EHR) sign on page for utilization of their respective individual logon to the system.	02/24/17 & Ongoing	
contacted Richmond requesting computer access for the survey team. Asst. director stated that she was informed two days' notice was needed to establish access. She also stated if surveyors had a COV (Commonwealth of Virginia) account, she would be able to get access. Surveyors informed asst. director that they do have COV accounts. Asst. director stated she would return with requested access. At approximately 1140 on 02/08/17, the asst. director came to survey team, requesting personal information in order to establish computer access. At this time, the survey team contacted their supervisor at the Office of Licensure and Certification.			The individual Surveyor logon to the OneMind Electronic Health Record (EHR) will expire within 5 business days of the access being granted unless a longer period of time is requested by the Facility. Facility staff shall inform the Director of Health Information Technology or the OneMind Development and Support Manager when the Surveyors are finished and Surveyor's individual logon access will be disabled at the time.	02/24/17 & Ongoing	
,	call was held with the administrative team, a and Certification. The stated they would sup survey team in order clinical records. At approximately 1330	5 on 02/08/17, a conference survey team, facility and the Office of Licensure facility administrative team oply staff assistants to the to grant access to the	SWVMHI Assistant Director for Administrative Services to complete periodic testing to verify consistent effectiveness to logon access with the Critical Ticket Request process. This testing to include evenings, weekends, and all shifts! Testing to be discontinued upon 3 consecutive	03/14/17 & Ongoing	

records with the assistance of facility staff. At

testings of 100% compliance achieved.

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	T WEDTOTTE SETTING		DIMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	49E131	B WING	02/09/2017
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY STATE ZIP CODE	1 02/03/2017
SW VAMHINST GERITRT C	TR	340 BAGLEY CIRCLE	
CUMMING	TOUGHT	MARION, VA 24354	
PRÉFIX (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
F 514 Continued From pa	-	F 514	
approximately 1545 with individual login	the surveyors were provided credentials	DBHDS Central Office leadership staff,	03/24/17
with individual logili	credentials.	Suzanne Battaglia, Director, Health	& Ongoing
		Information Technology, Department	
		of Behavioral Health and	
		Developmental Services, providing	
		direct supervision to the Director of Health Information Technology and	
		serving as the Reviewer to the	
		OneMind Development and Support	
		Manager will ensure consistent	
		implementation of these actions for	
		unrestricted access by Surveyors to	
		individual electronic medical records	
		for the individuals residing in Program.	5
		subject to the CMS Surveyor review.	
		•	
	,		

How can you apply for Medicare/Medicaid benefits?

- Enroll online at HealthCare.gov or Cover Virginia or
- By phone at 1-800-318-2596 (HealthCare.gov)
 or 1-855-242-8282 (Cover Virginia) or
- Mail a paper application to your local Department of Social Services office or apply in person at a Department of Social Services office.
- Social Work Staff are available to facilitate your interaction with DBHDS Reimbursement Staff to pursue refunds for any previous payments covered by Medicare/Medicaid.

By my signature below, I acknowledge that	t I have reviewed this information.
Patient	Date/Time
Patient's Authorized Representative	Date/Time

How to Apply for Medicare/Medicaid Benefits (REV) Page 1 of 1



Chart Copy

Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354 **USE LABEL OR PRINT PATIENT ID HERE**